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HOW CAN WE MAINTAIN A SUSTAINABLE PRIVATE PRACTICE IN THE CURRENT POLITICAL AND ECONOMIC CLIMATE?

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In the past few years, the sustainability of private practice in South Africa has been questioned, due to spiralling cost and a real reduction in the membership of medical schemes. An ever-increasing number of patients are opting out of medical schemes and now prefer to carry the risk of health expenditure themselves. This trend has implications for psychiatrists in private practice in the short, medium and long term. The realities of the past and current economic climates are discussed in relation to these realities.[1]

Government has committed itself again in December 2007, at the ANC Polokwane conference, to implementing a National Health Insurance System and to move much faster on the proposals than in the past. A set of amendment bills and regulations are currently before parliament for debate and promulgation. This legislation has profound implications for a sustainable private practice. Government has indicated that a sustainable and healthy private sector needs to be part of a health National Health System and needs to industry to adapt to the new challenges for the future. A critical review of these changes is presented and the impact on private practice.

The National Health Reference List is currently under review, and SASOP P3 presented a detailed investigation to the Department of Health about the cost of running and managing a private psychiatric practice. The relevance of a NHRPL in the current economic and political climate is discussed and, due to these changes and challenges, alternative international and other models are discussed.

SASOP CLINICAL GUIDELINES, PROTOCOLS AND ALGORITHMS: DEVELOPMENT OF TREATMENT GUIDELINES FOR BIPOLAR MOOD DISORDER AND MAJOR DEPRESSION

Eugene Allers, Margaret Nair, Gerhard Grobler

The development of the SASOP clinical guidelines is presented. The specific guidelines on bipolar mood disorder and major depression are then discussed. Currently, the guidelines for major depression and bipolar mood disorder for 2008 are on the SASOP website for review and comment.

The algorithms will be presented as they appear on the website, with a discussion on the differences between other international guidelines.

THE REVOLVING DOOR PHENOMENON IN PSYCHIATRY: COMPARING LOW-FREQUENCY AND HIGH-FREQUENCY USERS OF PSYCHIATRIC INPATIENT SERVICES IN A DEVELOPING COUNTRY

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BACKGROUND: A major obstacle to establishing successful community-based treatment in South Africa has been that the reduction in number of inpatient beds did not coincide with the development of adequate community resources. This fact, in combination with our patients' poor socio-economic circumstances, has contributed to a substantial increase in the so-called 'revolving door' or high-frequency use phenomenon in state psychiatric facilities. In an attempt to address this problem, the APH in the Western Cape appointed three community treatment teams. Although these teams have faced many challenges, overall there has been a very positive response from service users, their families and other staff, leading us to conclude that this initiative seems to be a much-needed step in the right direction. However, this initiative concerns not only service delivery but also understanding the whole phenomenon better, with a view to adapting protocols appropriately. Therefore, the aim of this study was to evaluate the clinical and demographic differences between the High Frequency Users (HFUs) and Low Frequency Users (LFUs) of mental health services in a developing country.

METHOD: Patients admitted with schizophrenia were divided into two groups: (1) those who met a modified version of Weiden's high-frequency criteria = HFUs; and (2) those not = LFUs. Information with regard to demographics, past psychiatric history and substance use was collected. Scales measuring psychotic and mood symptoms as well as quality of life were performed.

RESULTS: Data were collected from 51 LFUs and 95 HFUs. HFUs had higher PANSS scores and were significantly more likely to abuse substances (p=0.01069) and be on mood stabilisers (p=0.00052). LFUs were significantly more likely to be receiving depot medication (p=0.00182).

CONCLUSIONS: Our results indicate that HFUs may have a more severe form of illness. Also, the pattern of frequent relapses may be perpetuated by abuse of substances, and the need for more than one medication may affect compliance. Results seem to support that HFU-specific interventions are needed to address substance as well as compliance issues.

NEUROPHYSIOLOGY OF EMOTION AND SENSES – THE INTERFACE BETWEEN PSYCHE AND SOMA

Eugene Allers

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The brain is a complex system of anatomical structures connected through circuitry, connections and neurotransmitters. The limbic system comprises several cortical and subcortical structures that form two separate and interactive networks. The emotional control network is centered in the amygdala and the declarative memory in the hippocampal formation. The amygdala is central to the control and interpretation of emotion and relays information to the rest of the brain. It is central to classical fear conditioning and rapidly acquired and long-lasting associative memory.

The amygdala receives direct input from all the sensory modalities – olfactory, taste, visceral and nociceptive stimuli. Visceral, auditory and somatosensory inputs reach the amygdala at relatively advanced stages of cortical processing via the respective sensory association areas. The amygdala-orbito-medial-prefrontal-cortex circuit is important in decision making on the basis of previously experienced somatic sensations.

The role of the cingulate cortex, the hippocampus, the hypothalamus, the nucleus accumbens, and other structures of the limbic system as well as the influence of neurotransmitters are discussed in relation to emotion and pathology, as well as the anatomical structures and their relationship with neurotransmitters, emotion, learning and symptoms including pain and somatisation.

SUICIDE PREVENTION; FROM AND BEYOND THE PSYCHIATRIST'S HANDS

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Suicide is a major cause of death in South Africa; suicide attempts also contribute to disability and emotional pain in families and communities. The aim of this presentation is to motivate psychiatrists and other important role players including politicians to engage in a national strategy to prevent suicide.

According to data from the WHO, 85% of suicides worldwide occur in low- and middle-income countries, but much less than 10% of published research on suicide comes from these countries. The first national suicide prevention strategy was initiated in Finland in 1986; the Finnish initiative provided a huge amount of information that has been helpful in developing similar strategies in other countries. Cuba implemented its first National Suicide Prevention Program in 1989 after nationwide research that lasted more than a year. There is no mention in the literature of national suicide prevention programmes in Africa.

Suicide prevention programmes at a national level in developed and developing countries are briefly reviewed in order to highlight the common and most important components. Data from local research in suicide were analysed as well as information from the Durban Parasuicide Study – so far the most authoritative suicide research group in the country. Given the complex interactions of biological, psychological and social risk factors for suicide, prevention programmes that simultaneously address the multiple factors would appear to be most appropriate. According to existing knowledge, the public health approach seems to be the most suitable. A multidisciplinary, cultural-sensitive, community- and research-based approach is proposed.

TREATMENT OF FIRST-EPISODE PSYCHOSIS: EFFICACY AND TOLERABILITY OF A LONG-ACTING TYPICAL ANTIPSYCHOTIC

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OBJECTIVE: To examine treatment efficacy and tolerability in first-episode psychosis patients treated with a long-acting typical antipsychotic.

METHOD: We are conducting a prospective, longitudinal study of patients with first-episode psychosis treated with flupenthixol decanoate, a long-acting typical antipsychotic, according to a fixed protocol over 12 - 24 months. In this report, we discuss the preliminary results over a 3-month period in the first 20 patients included in our study. Clinical variables were measured using the Positive and Negative Syndrome Scale (PANSS), the Clinical Global Impression Severity Scale (CGI-S), the Calgary Depression Scale for Schizophrenia (CDSS) and the Extrapyramidal Symptom Rating Scale (ESRS).

RESULTS: The mean PANSS total scores reduced by 41.14% from 103.60 (SD 19.86) at baseline to 59.65 at 3 months. The mean CGI-S scores reduced from 5 (SD 4.04) at baseline to 3 (0.81) at 3 months. The CDSS scores reduced from 4.4 (SD 4.04) at baseline to 0.85 (SD 2.03) at 3 months. The mean ESRS scores were 9.85 (SD 6.45) at baseline and 8.05 (SD 8.08) at 3 months. The highest mean ESRS score was 13.95 (SD 8.72) at 4 weeks. The mean weight and body mass index at baseline were 59.80 kg (SD 11.48) and 22.40 (SD 4.73) respectively. The mean weight and body mass index at 3 months were 63.83 kg (SD 11.53) and 23.86 (SD 4.54).

CONCLUSION: Overall, the treatment of first-episode psychosis patients with flupenthixol decanoate is effective and fairly well tolerated.

TREATMENT OF ATTENTION DEFICIT HYPERACTIVITY DISORDER IN THE YOUNG CHILD

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In a busy child psychiatric clinic, the presence of a very hyperactive, impulsive and destructive 3-year-old often makes one afraid to think of how his observed behaviour, as well as the reaction of his caregiver, is playing itself out in the rest of the spaces that the child enters. Professionals may often feel that they are operating in the dark in an area where so little is clear and there are so few guidelines to go by. We increasingly recognise psychiatric illness, specifically ADHD, in the younger child, particularly as more and more of them are referred to our clinics for help. The difficulty is that they present with symptoms, not disorders, and these symptoms exist on a continuum with normal childhood experience and development. Symptoms are often highly stable over time and predict for later psychopathology. Symptoms produce dysfunction and an inability to function and develop within any given system over time. This is what necessitates intervention , often quite urgently, in the interests of the child's safety. One has also to consider the impact of emergent and changing comorbidity on the presentation, as well as the context of the family system to whose frequent dysfunction young children are particularly sensitive and reactive. The use of psychotropic medication, specifically stimulants, in young children is affected by the relative lack of safety and efficacy data in this age group. There has also been significant concern about the pharmacodynamic effect of these agents on the developing brain. Stimulants do not have regulatory approval for use in children <6 years old.

Recent years have seen the event of newer studies, particularly in the area of stimulants in young children with ADHD. The most significant and sophisticated of these has been the Preschool ADHD Treatment Study (PATS). Through complex design and 303 patients, it showed efficacy of methylphenidate in ADHD preschoolers. It was shown to be safe and well tolerated. It also highlighted the role of nonpharmacological measures (parent training) in management. A number of concerns regarding the short and longer term consequences of stimulant use in young children were also addressed.

This presentation reviews current and emergent knowledge on the assessment and management of young children with ADHD, with specific emphasis on the use of stimulant medications. I hope to show how this knowledge can be used to create an area of developing expertise in a real clinical setting in our country where resources and access to services are limited.

HOLISTIC/ALTERNATIVE TREATMENT IN PSYCHIATRY: THE VALUE OF INDIGENOUS KNOWLEDGE SYSTEMS IN COLLABORATION WITH MORAL, ETHICAL AND RELIGIOUS APPROACHES IN THE MILITARY SERVICES

J Dill

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INTRODUCTION: In 2002, the Chaplains Service of the SANDF began the process of developing a spiritual and value-based response to the rapidly expanding HIV epidemic. From the inception of the project (called CHATSEC (combating HIV & AIDS through spiritual & ethical conduct), it was the intention of the Chaplains Service to rigorously evaluate the programme, to determine its effectiveness. This was done through KAP Studies from 2004 to date, and included contracting the Military Psychological Institute (MPI) to develop a lifestyle orientation scale (LOS) to determine whether the CHATSEC programme promotes its intended behavioural change.

There is a problem when discussing values in modern-day society. We live in an increasingly diverse society, and it seems that values might have become totally relative. Can we still talk of so-called value-driven lives today? This approach says we can; it is only the choice between moral foundational principles and finding generic collaborative principles that can lead us to generic values of importance to all. This approach also distinguishes between personal values and generic value frameworks in society, and then focuses on using generic, core societal values to help us make sound ethical decisions. The approach also integrates three behaviour change models that could lead to value-conscious decision-making.

METHODS: KAP studies during 2004 - 2006 and validation studies of the LOS scale and literature studies.

RESULTS: Since 2004, KAP studies found that the CHATSEC programme contributed significantly to an increase in: knowledge regarding HIV prevention,

changing attitudes towards a positive non-risk value-based lifestyle, and better practices reducing sexual risk behaviour.

Preliminary results from the incomplete validation of the LOS scale found that it can be regarded as a valid instrument to measure the effectiveness of the CHATSEC programme. However, of the four primary LOS constructs measured in the scale, only spirituality seems currently to increase significantly (thus contributing to behaviour change) because of the programme. Only when the study is fully completed, can the reasons for this be validated and explained.

Recent literature studies also confirm that the design principles of the CHATSEC programme are in line with results elsewhere in Africa, which proves that social and moral interventions to change behaviour do contribute to reduction in the prevalence and incidence of HIV and AIDS (*The Invisible Cure*. Epstein H. Penguin Books, London, 2007).

DISCUSSION: It cannot be disputed that major targeted public health programmes such as condom promotion, HIV testing, peer education of core HIV and AIDS knowledge and sexually transmitted disease services, play an important role in controlling the African AIDS epidemic. But what may be rather underestimated is the role of non-commodities-based approaches to prevent HIV. We agree with Epstein (2007: 258) when she argues: 'Treatments for African diseases tend to rely less on their chemical activity than on symbolism and ritual.' Here, the old African philosophical concept of Ubuntu is still important: umntu ngumntu ngabantnu (I am a person through other persons) is crucial if we want to make a difference in this disease.

The CHATSEC programme can be regarded as a cultural, religious and ethical programme that acknowledges personal morals and values of participants. By providing the space to talk openly about social and ethical behaviour patterns, a basis for common social consciousness and further social mobilisation to positive behaviour is promoted. The follow-up after the initial presentation of the CHATSEC programme, however, is of extreme importance.

CONCLUSION: The CHATSEC programme of the SANDF Chaplains Service is an important tool in enhancing the age-old Ubuntu morality, positive spirituality, sound ethical decision-making, and a value conscious lifestyle. Many different human pathological conditions can benefit from this approach.

TREATING SCHIZOPHRENIA: HAVE WE GOT IT WRONG?

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Schizophrenia is a chronic and debilitating illness, contributing significantly to the global disease burden owing to its early onset, devastating effects and usually lifelong course. For the majority of patients, the illness is characterized by frequent relapses and hospitalizations, persistent positive and negative symptoms, enduring cognitive deficits and psychosocial impairments. This poor outcome is observed despite the fact that antipsychotics work rapidly and are effective in the short term, particularly in the early stages of the illness.

While there is a burgeoning evidence base regarding treatment of schizophrenia, it would seem that the translation of this improved knowledge into appropriate actions has not always occurred. Recent pragmatic clinical trials have highlighted the shortcomings of current antipsychotic treatments, and have failed to identify clearcut advantages for the second generation antipsychotics over their predecessors. However, this could be explained at least in part by shortcomings in trial designs. Perhaps the major obstacle to effective treatment is not related to limited medication efficacy but rather to poor medication adherence. The majority of patients are inadequately compliant, placing themselves at risk of relapse and partial response. At least half of relapses can be associated with lack of compliance. Each relapse may have catastrophic consequences for individuals. Whether due to a progressive neurodegenerative disorder, or whether due to its psychosocial consequences, patients frequently show progressive deterioration after each episode. Various interventions may improve compliance. These include psycho-education, family involvement, compliance therapy, and reduction of medication side-effects (e.g. by switching to second generation antipsychotics). Frequently in clinical settings scant attention is given to these aspects of management. Also, despite the fact that the best way of guaranteeing medication delivery is by means of a long-acting injection, depot antipsychotics are hopelessly under-utilised in clinical settings.

TERMINAL QUESTIONS IN THE ELDERLY

Mike Ewart Smith

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When a physically ill elderly patient is judged to be incompetent, others must make decisions on appropriate medical management. In this session, case histories are used to illustrate how potential conflicts of interest may complicate decision-making processes. The approach to cases where there is a living will is discussed and also the related issue of euthanasia.

MENTAL HEALTH POLICY DEVELOPMENT AND IMPLEMENTATION IN GHANA, SOUTH AFRICA, UGANDA AND ZAMBIA

Alan J Flisher,[1] Crick Lund,[1] Michelle Funk,[2] Arvin Bhana,[3] Victor Doku,[4] Natalie Drew,[2] Fred N Kigozi,[5] Martin Knapp,[6] Mayeh Omar,[7] Inge Petersen,[3] Andrew Green,[7] and the MHaPP Research Programme Consortium

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The purpose of the research presented in this symposium is to provide new knowledge regarding comprehensive multi-sectoral approaches towards breaking the negative cycle of poverty and mental ill-health. The findings are part of a five-year four-country study entitled the Mental Health and Poverty Project, which is a research programme consortium funded by the UK Department for International Development (DfID).

There are five further presentation in this symposium: Crick Lund will present a systematic literature review addressing the relationship between poverty and mental ill-health; Alan Flisher will present the findings regarding child and adolescent mental health services; Ritsuko Kakuma will examine the impact of stigma on the development and implementation of mental health policy and law in South Africa; Crick Lund will consider lessons from South Africa addressing the issue of the relative importance of mental health policy and legislation in attaining public mental health goals; and Ritsuko Kakumo will assess the extent to which mental health issues are addressed in the national health plans in the four countries under consideration.

WHAT INDICATORS SHOULD BE USED TO MONITOR PROGRESS IN SCALING UP SERVICES FOR PEOPLE WITH MENTAL DISORDERS?

Lancet Global Mental Health Group (Alan J Flisher,[2] Dan Chisholm,[1] Crick Lund,[2] Vikram Patel,[3] Shekhar Saxena,[1] Graham Thornicroft,[4] Mark Tomlinson[5])

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INTRODUCTION: Reliable and valid indicators need to be used to monitor the

progress on scaling up services for people with mental disorders. We set out to identify a set of core mental health indicators, primarily aimed at monitoring the attainment of targets related to scaling up the coverage of basic, evidence-based services for mental disorders, and which would allow each country to measure its own progress towards agreed targets and to compare its status with other countries. The format proposed, using broad goals, specific targets, and measurable indicators, reflects that of the Millennium Development Goals (MDGs).

METHODS: Our group initially identified 16 potential indicators. Group members were asked to take part in a Delphi exercise to rate each of these indicators against six criteria: meaningfulness to health planners, acceptability to stakeholders, validity, reliability of source of information for the indicator, comparability over time, and sensitivity for change. Each criterion was rated on a 10-point scale. From this exercise, we selected five core indicators and 6 secondary indicators.

RESULTS: The core indicators were presence of official policy, programme or plan for mental health, specified budget for mental health as a proportion of total health budget, mental health and related professionals per 100 000 population, proportion of primary health care clinics in which a physician or an equivalent health worker is available where at least one psychotropic medicine of each therapeutic category (anti-psychotic, antidepressant, mood stabiliser, anxiolytic and anti-epileptic medicines) is available in the facility or in a nearby pharmacy all year long, and people treated each year for schizophrenia as a percentage of total estimated annual prevalence of schizophrenia. The secondary indicators were: proportion of total mental health expenditure spend on community based services, including primary/general health care; at least 5% of the aggregate total training time basic medical and nursing training degree courses is devoted to mental health; proportion of psychiatrists nationally who work in mental health facilities that are based in or near the largest cities; involuntary admissions as a percentage of all annual admissions; presence of a national body for monitoring and protecting the human rights of people with mental disorders issuing reports at least annually; and deaths by suicide and self-inflicted injury rate.

CONCLUSION: Taken together, these 11 indicators address the 4 most important over-arching goals: sufficient planning and investment for mental health care; a work force to provide mental health services; mental health care inputs and processes consistent with best practice and human rights protection; and improved outcomes for people with mental disorders.

DOES UNIPOLAR MANIA MERIT RESEARCH IN SOUTH AFRICA? A LOOK AT THE LITERATURE

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INTRODUCTION: The concept of unipolar mania has received scant attention in the literature. The occurrence of a manic-only course in bipolar disorder is considered rare and estimated to be in the region of 5% (Akiskal). Reported prevalence rates vary widely, ranging from a low of 1% (Perris, 1982) to a high of 53% (Makanjuola, 1985), probably depending on the criteria used for the definition of the disorder and the designs of the different studies. Several reports indicate a considerable prevalence of unipolar mania in non-Western countries such as Nigeria, India, China, the Fiji Islands and Turkey.

LITERATURE REVIEW: In 1966, two large studies, one by Angst and the other by Perris, showed that 'unipolar mania' was clinically strongly related to bipolar disorders, so the assumption regarding the separation of the group of unipolar mania was an artifact. After this categorical position statement, only a few studies have appeared on unipolar mania in the last 40 years; these are almost exclusively from Western countries, with a few exceptions. The studies from Western countries invariably reports findings such as 'unipolar mania clinically homogeneous with bipolar disorder' (Abrahams and Taylor, 1974), 'no difference in the age of onset, family history or response to lithium to support unipolar mania as a distinct clinical entity' (Nurnberger, 1979), and 'few clinically meaningful differences and unipolar mania not supported as a separate entity from bipolar disorder' (Pfohl, 1982).

Conversely, studies from non-Western countries have consistently reported higher rates of a unipolar manic course compared with rates from Western countries. Makanjuola (1982) stated that recurrent manic disorder without depressive episodes is the **rule rather than the exception** among Nigerian patients.

In a study by Lee (Hong Kong, 1992), it was found that 36% of patients manifested manic-only episodes during affective relapse. Aghanwa (2001) found the rate of recurrent unipolar mania to be 47.2% in the Fiji Islands. Yazici (2002) concluded that unipolar mania may be a nosologically distinct entity.

CONCLUSION: It follows, therefore, that there is ample reason to research the phenomenon of a manic-only course in bipolar disorder in South Africa. In conversation with other South African psychiatrists (in particular those working in rural areas, and in agreement with the author's experience), many will concur that bipolar depression is hardly ever seen. To this end, a research protocol has been written entitled: *The clinical characteristics of a South African population presenting with manic features – bipolar mood disorder, unipolar manic disorder or schizo-affective disorder; bipolar type?*, as the time is ripe for a study from South Africa exploring the concept of unipolar mania.

REVISITING THE CARTESIAN DUALITY OF MIND AND BODY

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Recent research indicates that the view suggesting that the mind is distinct from the body is mistaken. Epidemiological evidence from diverse areas of medicine informs us that this Cartesian dualism is a far cry from the common reality of illness experience where the presence of one chronic disorder, mental or physical, increases the likelihood of the co-occurrence of another disorder, mental or physical. Indeed, there is evidence that racial and cultural factors do not diminish the interrelationship of mind and body, as it is now known that the commonly held notion that mental disorders are more likely to be expressed in somatic language by some cultures rather than others is an empirically weak proposition. Current knowledge now allows us to provide answers, albeit tentatively, to questions such as: What does knowledge of the unitary nature of mind and body mean? What underlies this unity? What aetiological factors make this possible, and what are the implications for our understanding of the trajectory of human vulnerability to illness?

CHILD AND ADOLESCENT PSYCHOPHARMACOLOGY: CURRENT TRENDS AND COMPLEXITIES

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INTRODUCTION: The use of psychotropic drugs in children and adolescents has increased in some areas of the developed world by as much as 70% over the last 5 years. This is largely due to expanding indications for individual drugs and increased rates of diagnosis of psychiatric disorders, as well as symptomatic use of drugs for young patients whose presentations do not fit well into established diagnostic systems. At the same time, ongoing analysis of available data has revealed treatment-emergent risks including increased suicidality with serotonin reuptake inhibitors, cardiovascular risk with stimulant drugs, and metabolic abnormalities with many antipsychotic drugs. Efficacy data regarding the use of various medications in paediatric bipolar disorder are rendered less useful by ongoing controversies concerning the criteria on which this diagnosis is based. New data are disseminated at an ever-increasing rate, and clinicians are often caught in a web of conflicting advice and ill-informed public perceptions. This paper provides a summary of recent trends and controversies around the use of psychotropic drugs in children and adolescents.

METHOD: PubMed and other databases were searched for relevant clinical trials and meta-analyses published between 2005 and 2008, and clinical trial listings were searched for ongoing or unpublished trials. A synthesis of relevant

new information was compiled with respect to: serotonin reuptake inhibitors, mood stabilisers and anticonvulsants, stimulant and non-stimulant medications for disruptive behavioural disorders and antipsychotic drugs.

RESULTS: Indications, efficacy and safety of relevant drugs are discussed with reference to the management of disruptive behavioural disorders, substance use disorders, early onset psychotic disorders, mood disorders and anxiety disorders. Guidelines are proposed and areas in which the data are still insufficient for definitive conclusions are highlighted.

CONCLUSION: The approved indications for the use of psychotropic drugs in children and adolescents are expanding rapidly; risk-benefit assessments in individual cases can be complex and time-consuming. This paper attempts to place new information in perspective and to provide clinicians with a synthesis of recent developments as well as guidelines for the use of psychotropic agents in children and adolescents.

INTEGRATING MENTAL ILLNESS, SUICIDE AND RELIGION

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BACKGROUND: Mental illnesses are common and associated with high levels of morbidity and mortality across various cultures and religious traditions. Numerous biopsychosocial strategies have been proposed and implemented in an attempt to reduce the burden of resultant suffering and complications e.g. suicide awareness days, screening instruments, diagnostic and treatment protocols, intervention targets, various medications and psychotherapy. Despite our best efforts thus far, mental disorders remain common and burdensome. Many people claim a religious affiliation, yet religion and spirituality seem to have been underutilised in trying to reduce the impact of mental illness and its tragic consequences. A better understanding of various religious world views is thus likely to contribute to our efforts at preventing and treating mental disorders.

METHOD: A review of relevant religious texts, interpretations and ethics, with specific reference to mental illness, suicide and ethics.

RESULTS: This presentation attempts to create a better understanding of religious belief systems and their influence on the thoughts, beliefs and actions of their adherents. It will specifically refer to mental illness, suicide and religious ethics within various religious traditions.

DISCUSSION: To reduce and prevent mental illness, its associated stigma and complications, a better understanding of various religious views with regard to mental illness and suicide may be helpful. Such an understanding of our patients' world views is likely to assist in the prevention and successful treatment of mental disorders across the world.

COST OF ACUTE INPATIENT MENTAL HEALTH CARE IN A 72-HOUR ASSESSMENT UNIT

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BACKGROUND: Hospital services are disproportionately expensive, and substantial inefficiencies have been reported in the delivery of those services. There has been no relative increase in health care funding allocation to regional and tertiary level institutions, and public hospitals have demonstrated a consistent over-expenditure in their annual budgetary allocations. An understanding of the costs of the various activities in hospitals will assist hospital managers to determine the relative efficiency of the component units of the hospitals. There are, however, many problems with traditional cost systems. Activity based costing (ABC) is a method that is able to provide cost estimation that more accurately estimates full unit costs. ABC divides expenditure in direct and indirect costs and assumes that cost objects generate activities that in turn consume costly resources.

A pilot study to provide baseline information for future cost centre management of mental health care at Helen Joseph Hospital, covering a 1-year period, was undertaken prior to the implementation of the Mental Health Act, No. 17 of 2002 (MHCA) in December 2004. This analysis of expenditure on mental health care at Helen Joseph Hospital proved to be only a provisional and proportional calculation of cost, as no comprehensive cost centre data for acute inpatient mental health care existed at the time.

METHODS: This follow-up study reviewed data over a 4-year period (January 2004 to December 2007) and applied principles of activity-based costing to: describe resource usage and assign cost to the different mental health care activities; calculate the total cost incurred by inpatient mental health care in terms of total hospital expenditure; and calculate average cost per admission and diagnostic category. Cost categories were defined and assigned as fixed and variable, or direct and indirect. Indirect costs were allocated to the mental health care unit as a cost centre on a proportional basis according to the activities being performed.

RESULTS: The main items included as direct costs included: salaries, supplies, domestic (meals, cleaning, laundry), maintenance, security, telephone, unit management, pharmacy, laboratory, radiology and transport. The direct and indirect cost of acute inpatient mental health care at Helen Joseph Hospital will be discussed in the context of the psychiatric unit's designation as a 72-hour assessment unit according to the MHCA.

CONCLUSIONS: Although services as a 72-hour assessment unit have been extended in quantity and content to include a three-tiered voluntary, assisted and involuntary assessment treatment programme, no additional funds were made available to this unit to comply with the requirements of current legislation. This needs to be addressed urgently in order to align service delivery with the current legal and ethical framework for public mental health care practice in South Africa.

MANAGEMENT OF SCHIZOPHRENIA ACCORDING TO SOUTH AFRICAN STANDARD TREATMENT GUIDELINES

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BACKGROUND: The DSM IVTR criteria for schizophrenia require two or more of: delusions, hallucinations, disorganised speech, disorganised/catatonic behavior or negative symptoms, plus social/occupational dysfunction and minimum duration of 6 months. Prescribing guidelines for schizophrenia became necessary as mental health authorities had to operationalise clinical research data within the reality of budgetary constraints. Guidelines for the treatment of schizophrenia in the South African public sector were also established. The existing regional drug list included a primary and secondary level. Helen Joseph Hospital in Gauteng Province has a 30-bed acute adult psychiatric admission unit. Different variables for monitoring treatment outcome such as demographic, baseline clinical findings, early symptom reduction and treatment response have been considered in other settings for their predictive value.

METHODS: As a retrospective clinical review over a 4-year period (January 2004 to December 2007), the quality of the diagnosis of schizophrenia routinely made in this acute unit was assessed. The management of schizophrenia according to existing treatment guidelines and the outcome of services rendered were also reviewed, including the cost. Through univariate analysis, different variables were assessed for their predictive value for treatment outcome as related to length of stay and cost.

RESULTS: Based on a 2004 clinical audit of the unit which covered a 1-year study period, the total length of stay for all users (*N*=438) was 18.5 days. Schizophrenia was a diagnosis in 23.9%. Substance abuse as an associated factor was noted in 40% of users and non-compliance in 47%.(*N*=105). Over the subsequent 3 years, a steady increase in numbers was observed, of which on average 20% (*N*=436) of users were diagnosed with schizophrenia. Proportionally only about 2% of the hospital budget was spent on mental health services, of which 80% was on staff

salaries. Only 9% was spent on pharmaceutical compounds, with anti-psychotics being 74% of these items. The demographic, clinical and management variables that were assessed for their predictive value in terms of treatment outcome in this setting will be discussed.

CONCLUSIONS: Because of an undefined hospital catchment area, it was not possible to calculate incidence and prevalence rates, or to determine whether the 20% of inpatients who were diagnosed with schizophrenia is on a par with other comparable settings. The study, however, established a basis for ongoing prospective investigation of this local group of schizophrenia sufferers, while contributing to the review of outcome and costing of schizophrenia management according to SA treatment guidelines.

STRUCTURAL BRAIN IMAGING IN THE CLINICAL MANAGEMENT OF PSYCHIATRIC ILLNESS

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The introduction of neuroimaging techniques in the 1960s revolutionised the study of the biology of psychiatric disorders, which has implications for the practice of psychiatry. Since then, clinically meaningful findings, such as early identification of psychiatric disorder and response to a specific treatment, have begun to emerge. The aim of this paper was to review published data that have demonstrated the use of these techniques in clinical psychiatry.

There are two basic types of brain imaging, namely structural and functional. Structural imaging deals with the structure of the brain and the diagnosis of gross (large-scale) intracranial disease (such as tumour), and injury. It consists of CT and MRI and can only show gross anatomic details. Functional imaging enables the processing of information by centres in the brain to be visualised directly. The rapidly evolving field of functional neuroimaging includes fMRI, PET, SPECT, magnetic resonance spectrometry (MRS), and magnetoencephalography (MEG). The use of both forms of neuroimaging in some of the common psychiatric disorders such as schizophrenia, depression, bipolar mood disorders and anxiety disorders is discussed.

The integrated use of neuroimaging in conjunction with clinical assessments promises to improve clinical care and markedly alter psychiatric practice. It is recommended that clinicians be aware of the potential applications, benefits and limitations of modern neuroimaging techniques.

ADHD: CHANGE IN SYMPTOMS FROM CHILD TO ADULTHOOD

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BACKGROUND: As many as 75% of children with attention deficit/hyperactivity disorder (ADHD) experience persistent ADHD into their adult years. Disturbingly, however, there is a dearth of research on the clinical diagnosis and management of these individuals. Therefore, effective diagnosis and management of these patients requires recognising how the core ADHD symptoms of hyperactivity, inattention and impulsivity transform from their childhood manifestations to their adult signs and symptoms. Rates of ADHD persistence through adulthood vary widely, and range from 5% to 75% (Am J Psych 1993; 150: 1792-1798). This can be at least partially accounted for by considering that self-reporting tends to under-recognise prevalence, while external informants such as parents or spouses are more likely to recognise symptoms of ADHD. Using either reporting method will likewise yield different rates of persistence.

DIFFICULTIES IN DIAGNOSIS: Apart from the different symptomatology that should be looked for, diagnosing the adult ADHD patient differs from childhood diagnosis in other ways. For example, adults with ADHD tend to have a greater level of self-awareness and insight into their own behaviour than children. This lessens the need for external sources in the diagnostic process. Since a history of childhood ADHD is a significant risk factor for adult ADHD, the first step in diagnosis of the adult patient involves obtaining their developmental history. Once a history of ADHD is established, there is the need to meet Diagnostic and Statistical Manual – IV (DSM-IV) criteria for ADHD. However, this is often difficult because many of the items and criteria in the DSM-IV do not likely apply to adults. For example, 'often runs about or climbs excessively, often has difficulty playing or engaging in leisure activities quietly, often avoids or strongly dislikes tasks that require sustained mental effort, such as schoolwork or homework', are usually not applicable to adults. Because the diagnostic criteria do not always describe the behaviour of adult ADHD patients, a diagnosis of ADHD: not otherwise specified (NOS), is often required.

Supplementing the *DSM* criteria with scales such as the Brown Attention Deficit Disorder Scale and the Conners' ADHD rating scales can be helpful in diagnosing cases of persistent ADHD. Similarly, asking the right questions can help elucidate the extent of functional impairment in the suspected adult ADHD patient.

DIFFERENT CO-MORBIDITIES: Importantly, the paediatric and adult ADHD populations differ in the prevalence of co-morbid disorders. In children, co-morbid psychiatric disorders include oppositional defiant disorder (approximately 60%), conduct disorder (15%), mood disorders (25%), anxiety disorders (27%) and learning disorders (25%) are the most common. In contrast, the most prevalent co-morbidities among adults are anxiety disorders (50%), mood disorders (32%), antisocial disorders (28%) and substance abuse (26%) (Biol Psych 2005; 57: 1215-1220). Adults with ADHD are also more likely than children to initially present with these other co-morbidities, while children who spend their days in the classroom are more likely to be referred for ADHD as the treatment focus. In children, therefore, co-morbidities may be left untreated, while adults may leave ADHD untreated. A careful medical and personal history in these patients often reveals both ADHD and the co-morbid disorder, both of which may require treatment.

CHILDREN JUMP WHILE ADULTS SPEED: While the core ADHD symptoms of hyperactivity, inattention and impulsivity are present in both adults and children, they manifest differently. Since children are limited mainly to the school setting, manifestations such as excessive jumping, running and climbing are quite visible. In contrast, adults are involved in a number of environments during their days. In the workplace they fidget and pace, excessively shake their legs, play with rubber bands, rustle papers, talk out of turn, blurt out inappropriate comments, miss appointments and deadlines, and repeatedly fail to file taxes. All of these manifestations can make it difficult for adult ADHD patients to hold onto a job. Outside of work, adult hyperactivity and impulsivity can lead to stimulus-seeking behaviour, consequent poor health, vehicle speeding and accidents, unwillingness to wait in queues, emotional overreaction and a low tolerance to stress. All of these symptoms can impair a patient's ability to learn social skills and to adapt to social norms, leading to a high rate of divorce and multiple marriages.

Clearly, the preponderance of children who grow into adults with ADHD can experience significant functional impairment if their ADHD is left untreated and assumed to be a disorder of childhood. In light of the possibility of such severe functional impairment in adults with ADHD, clinicians must consider all aspects of a suspected ADHD patient's functioning in determining the presence and severity of adult ADHD.

HIV-POSITIVE PSYCHIATRIC PATIENTS ON ANTIRETROVIRALS

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AIM: To describe the characteristics of a group of HIV-positive psychiatric patients on highly active antiretroviral therapy (HAART).

METHOD: All mentally ill patients admitted to the psychiatric unit at CHB who were HIV positive where included in the audit. Patients who met the following criteria were initiated on HAART: CD4 of 200 or less cells/mm^3; and diagnosis of a WHO Stage 4 condition (inc. HIV-associated dementia and HIV encephalopathy). The presenting psychiatric symptoms, past psychiatric diagnosis, previous psychotropic

medication and special investigations such as viral load and CD4 counts, CT scans and lumbar punctures, prior to commencement were recorded. Follow-up CD4 counts and/or viral loads, if done, were also recorded.

RESULTS: Since inception of the service, the hospital admitted 171 mentally ill patients, of whom 16 (9.4%) where confirmed as HIV-positive. Mean age of the group was 36.4 years, with a male: female ratio of 1:4.3. The majority (62.5%) of the patients presented with disorganized behavior symptoms, 31.3% presented with maniform symptoms, and only 6.25% with psychotic symptoms. For 12 patients, this was their first episode of mental illness. Previous psychiatric illness included bipolar mood disorder (*N*=3) and schizophrenia (*N*=1). Commonly used psychotropic medication prior to inclusion in the HIV programme was sodium valproate and risperidone. Only 4 (25%) patients were subjected to either a CT scan and/or a lumbar puncture. In this group of HIV-positive patients, 13 met the eligibility criteria and were commenced on HAART: 12 were treated with regimen 1b and 1 on regimen 1a. Three patients had subsequent CD4 counts and viral loads performed. The viral loads of these 3 patients had reached the required decrease in log value at 6 weeks of HAART.

CONCLUSION: A significant percentage of all mentally ill patients admitted to the psychiatric unit at CHB are HIV-positive despite the fact that HIV screening is not done routinely on all patients. The majority of these patients have advanced disease and are eligible for HAART. This clearly indicates the need for this service at CHB and the establishment of similar services at other psychiatric units.

A ONE-YEAR REVIEW OF PATIENTS ADMITTED TO TERTIARY HIV/NEUROPSYCHIATRY BEDS IN THE WESTERN CAPE

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INTRODUCTION: The burden of psychiatric co-morbidity in HIV/AIDS is high. Health services for patients with HIV-related mental disorders are seldom integrated, are costly and may require multidisciplinary teams. The aim of this review is to describe the clinical features of patients with HIV/AIDS and mental disorders admitted to the two tertiary referral teaching hospitals in the Western Cape over a 12 month period. The diagnostic status, spectrum of investigations performed and medications used will be described, as well as the role of multi-disciplinary input and referral patterns.

METHODS: A retrospective chart review of the period 1 February 2007 to 31 January 2008 was performed on admissions to HIV/neuropsychiatry beds at Groote Schuur and Tygerberg Hospitals. Variables analysed included route of and reason for referral, demographic characteristics, length of stay, use of special investigations, use of anti-retrovirals (ARVs) and psychotropic medication. Data on the use of specialist medical referral and discharge diagnosis were also obtained. The correlation between HIV-related diagnosis and CD4 count was ascertained.

RESULTS: Data were obtained on 44 admissions during the specified time period. The most common reasons for admission were psychosis (39.5%) and depression (25.5%). The mean CD4 count of patients was 354 (9 - 1074). Almost a third required referral to another specialist medical service (13/43). Most patients received an anti-psychotic (32 out of 43), which was usually haloperidol (20 patients). A quarter received an anti-depressant (*N*=10). Prior to admission, 13 (30.2%) patients were on antiretrovirals, and a further 4 were commenced during the admission. The discharge diagnosis was HIV-related in almost half the patients (*N*=21), with the remainder being diagnosed with primary psychosis (*N*=4), primary depression (*N*=5) and bipolar disorder (*N*=5). Of those with a CD4 count <300, the diagnosis was HIV-related in 73.7%, while in those with a higher CD4 count, HIV-related disorders were present in only 29.2%. Patients with HIV-related diagnoses stayed on average 10 days longer than those without (28.1 v. 18.9).

CONCLUSIONS: Mental health services are experiencing a growing number of patients with HIV-related disorders. Many are patients in whom the CD4 count is higher than the threshold for commencement on ARVs, and as such reflects the burden of mental illness in earlier stages of HIV disease. Some are admitted to psychiatric hospitals, but a need for tertiary support remains. This is evidenced by the numbers of patients with comorbid medical problems, the need for rapid special investigations, referral to medical specialities, and diagnostic input from neuropsychiatrists. Protocols for the investigation and treatment of patients with HIV-related severe mental illness need to be refined. In an era of ARVs, services for this patient population are becoming essential.

STAR*D – CRITICAL REVIEW AND TREATMENT IMPLICATIONS

André Joubert

Lundbeck Institute, Copenhagen, Denmark

After great anticipation and high expectations, the initial results of the Star*D (depression) study have been published. Many results have been inconclusive but, more importantly, some data have been highly controversial – from the inclusion criteria, patient selection and outcome measures used for evaluating efficacy, to the lack of full randomisation and the doses used.

This presentation will present a review of the study's results, covering the data that have been published so far, and address some of the controversies. The question remains: Should this major study's results have an effect on treatment options in psychiatry?

OPTIONS FOR TREATMENT-RESISTANT DEPRESSION: LESSONS FROM STAR*D; AN INTERACTIVE SESSION

André Joubert

Lundbeck Institute, Copenhagen

There are several decisions regarding treatment-resistant depression (TRD) that do not have a sufficient evidence base. Therefore we rely on expert opinions and common sense. Also, some of the emerging evidence is changing previous guidelines. The Star*D data answer a few of these questions, but raise even more. The session starts by proposing a recent consensus definition of TRD (Mendlewicz *et al*. In press) and continues with a review of the current literature regarding the available treatment options for TRD. Based on a critical review of the Star*D data, this presentation will combine international treatment guidelines and evidence regarding the treatment options available.

• When does antidepressant effect start?

How long after starting an antidepressant can 'response' be evaluated?

When should the dose be increased?

When is switching medication recommended?

• What is the first decision in the case of non-response and partial response?

Most will first optimise the dose of the antidepressant. When to choose which option?

• Increase dose

• Augmentation

• The role of the new generation antipsychotics in TRD

• Switching antidepressants

• Combination treatment with antidepressants

MY BRAIN MADE ME DO IT: HOW NEUROSCIENCE MAY CHANGE THE INSANITY DEFENCE

Sean Kaliski

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The law assumes that everyone acts rationally and is accordingly able to control untoward impulses. Consequently, to be not guilty of a crime that an accused has committed generally requires that he did not possess *mens rea* at the time. Mental illness or 'defect' has long been accepted as a defence in that an accused

may not have had the requisite criminal capacity at the time of committing the offence. However, courts have increasingly been willing to consider a panoply of other factors that in particular cases similarly absolve defendants. Research in neuroscience is increasingly confirming that most decision-making (followed by action) occurs subcortically, and that the conscious awareness of having considered options occurs afterwards. Neuroimaging, for example, may provide evidence that could be presented in court to prove this. In other words, rational decision-making (with impulse control) may actually be an illusion. This talk examines some of the recent research in decision-making and impulse control and suggests how the determinism of neuroscience could be reconciled with the law's insistence that everyone possesses 'free will'.

CHILD AND ADOLESCENT MENTAL HEALTH SERVICES IN FOUR AFRICAN COUNTRIES

Sharon Kleintjies,[1] Alan J Flisher,[1] Victoria Campbell-Hall,[2] Arvin Bhana,[2] Phillippa Bird,[3] Victor Doku,[4] Natalie Drew,[5] Michelle Funk,[5] Andrew Green,[3] Fred Kigozi,[6] Crick Lund,[1] Angela Ofori-Atta,[7] Mayeh Omar,[3] Inge Petersen[2], Mental Health and Poverty Research Programme Consortium

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INTRODUCTION: Up to 20% of adults, adolescents and children worldwide are estimated to suffer from a disabling mental disorder. Despite this burden, governments and policymakers have inadequately prioritized policy and service development for mental health, with the burden of mental disorders in children and adolescents receiving even less attention. This presentation reports on the child and adolescent findings of a situational analysis in 4 African countries: Ghana, South Africa, Uganda and Zambia. The findings are part of a 5-year 4-country study (the Mental Health and Poverty Research Programme Consortium), which aims to provide new knowledge regarding comprehensive multi-sectoral approaches to breaking the negative cycle of poverty and mental ill-health in Africa.

METHODS: The World Health Organization's Assessment Instrument for Mental Health Systems was used to collect quantitative information, while documentary analysis, focus groups and semi-structured interviews were used to collect qualitative information.

RESULTS: Although there is recognition of the importance of child and adolescent mental health in all 4 countries, there is a large variation between the countries in terms of the extent to which child and adolescent issues are apparent at the levels of legislation, policy and services. The total numbers of outpatient facilities in South Africa, Ghana and Uganda are 3 460, 70 and 289 respectively. The proportions of such facilities for children and adolescents only are 1.4% for South Africa and 0% for the other countries. The total numbers of inpatient units in general hospitals are 41, 5 and 27 in the 3 countries respectively, while the proportions of beds for children and adolescents are 4%, 0% and 15% respectively.

CONCLUSION: Data indicate that there is an urgent need for interventions that could break the negative cycle of mental ill-health and poverty in the 4 countries. Interventions are under way in the areas of developing mental health information systems, assisting countries to develop modern mental health policies and legislation, and establishing pilot projects for district-based mental health service systems.

INDIVIDUALISTIC THEORIES OF RISK BEHAVIOUR

Liezl Kramer, Volker Hitzeroth

Psychiatrists in private practice

BACKGROUND: Public health strategies for reducing substance use-related harms are based on an appreciation of the factors which influence people's risk behaviours. Risk behaviour and subsequent behaviour change can be approached from both individual and social perspectives. Individualistic theories of risk behaviour aim to understand factors which determine why individuals engage in risk behaviours at the individual level. Individualistic interventions are those approaches which target individuals and individual behaviour change. Such theories of risk behaviour provide a rationale for why public health strategies designed to promote risk reduction for substance use-related harms are useful.

METHOD: This presentation will provide an overview of the individualistic psychological theories of risk-taking behaviour. It will include an understanding of the underlying concepts and principles of the Health Belief Model, Self-efficacy Theory, Theory of Reasoned Action and other psychological approaches to risk-taking behaviour and change.

RESULTS: The presentation will investigate the strengths and limitations of these individual risk-taking theories. It will provide answers to the reasons why individuals take risks and how to assist those individuals to change their behaviour. Reasons will be suggested as to why social and cultural theories of risk behaviour are also necessary to overcome these limitations. Specific reference to substance use and its associated risk behaviour will be made.

CONCLUSIONS: A critical analysis of the theories of individual risk-taking behaviour will clarify why they are relevant to, and can easily be applied in, understanding individual risk-taking behaviour and public health strategies to promote behaviour change. However, these theories in isolation are not the answer, but rather need to be complemented in everyday practice by the social theories of risk behaviour so that they can contribute optimally to the reduction of risky behaviour and subsequent harms in the community.

DEVELOPMENT AND IMPLEMENTATION OF MENTAL HEALTH POLICY AND LAW IN SOUTH AFRICA: WHAT IS THE IMPACT OF STIGMA?

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INTRODUCTION: In developing countries, mental ill-health is among the most important causes of ill-health, disability, and even premature death. Yet it has received very little attention by policy makers in South Africa. Stigma plays a major role in the persistent suffering, disability and economic loss associated with mental illnesses. Mentally ill individuals are often victimised for their illnesses and face unfair discrimination, such as difficulties in accessing housing, employment, and other societal roles. As part of the Mental Health and Poverty Project, this study examines the manner in which stigma and discrimination contribute to the level of prioritisation of mental health issues in this country.

METHODS: Sixty-four semi-structured interviews with national and provincial level stakeholders were conducted to assess stakeholder views on the impact of stigma on the development and implementation of national policy and legislation for mental health care. A framework analysis approach was used to analyse the interviews.

RESULTS: Stigma towards mental illnesses was consistently identified as a challenge in the development of appropriate policy and legislation. It prevents mentally ill individuals from gaining access to the already scarce resources in

poor communities, such as employment, social services and housing. Structural and personal stigma have also contributed to the shortage of mental health care professionals in this country, and lack of training/experience and stigmatising attitudes of health professionals have led to poor quality of care. There is currently no national mental health policy, and mental health service provision is often informed by the Mental Health Care Act of 2002. Success in implementation of the Act has varied across the country, with many provinces experiencing difficulties because of the stigmatising attitudes held by policy makers, programme managers, and health care providers as well as insufficient efforts to address the shortage of mental health care professionals.

CONCLUSIONS: The results of this study clearly demonstrate the need to focus on stigma reduction at national and provincial levels in all sectors. Education, awareness-raising and advocacy work targeted at policy makers and professionals and promotion of intersectoral collaboration are key strategies to push the mental health agenda forward. Active involvement of mental health care users and caregivers is critical in increasing prioritisation of the development and implementation of both mental heath policy and legislation.

FACTORS CONTRIBUTING TO COMMUNITY REINTEGRATION OF LONG-TERM MENTAL HEALTH CARE USERS OF WESKOPPIES HOSPITAL

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INTRODUCTION: A relatively small percentage of long-term mental health care users (MHCUs) appear to re-adapt to the community after placement out of a psychiatric hospital. As part of a comprehensive study evaluating rehabilitation services to long-term MHCUs in Weskoppies Hospital, this study aimed to identify the common factors shared by users who were placed out of the hospital, and whether these factors could be used in screening placement candidates to ensure placement success. Of a population of 256 studied MHCUs, 18 were accepted for placement. These 18 made up the sample studied. The study period (1 April to 30 September 2007) coincided with an instruction by the Health Department to transfer long-term MHCUs to Life Esidimeni facilities.

METHODS: This research entailed a document-based case study investigating demographic information, psychiatric history and behaviour of those long-term MHCUs who were placed out of the psychiatric hospital. Data were also collected on the number of placement enquiries to achieve these placements. Data were recorded from daily social work activities and captured electronically and analysed to identify common factors shared by the sample MHCUs.

RESULTS: All placement enquiries made up 156 interviews out of a total of 721 interviews conducted during the study period. The most prominent psychiatric diagnosis was schizophrenia (*N*=14), and the most common co-morbid diagnosis was personality disorder (*N*=2). Poor insight was considered a factor with 14 MHCUs. Regarding the MHCUs' relation to their most involved relative, MHCUs' children were the most involved relatives (*N*=7), followed by both siblings and parents (*N*=6), extended family (*N*=3), and friends (*N*=1). Visits by fellow MHCUs were not rated. In 9 cases, no relatives or friends were involved. Spouses and partners were notably absent in the lives of those placed.

Concerning the MHCUs' reasons for 16 previous re-admissions, poor level of functioning played a role in 8 of the re-admissions. The successful placement candidates' reasons for previous re-admissions did not prevent their subsequent placement. Regarding the behaviour of the successful placement candidates while in the hospital, 3 had been repeatedly involved in fights with fellow-users, while all other measured problematic behaviours were absent.

CONCLUSIONS: Although most of the usual factors complicating placement were absent, placement of the 18 MHCUs still required 156 social work interviews. Placement of long-term MHCUs is labour-intensive. Instead of being directly reintegrated into the community, the majority of these MHCUs were merely transferred to a different institution. In this, the co-incidental instruction by the Health Department for placement at Life Esidimeni played a major role. Using common factors to screen MHCUs' suitability for placement, based on this study, appears to be unrealistic. The individual MHCU should rather be matched with the individual placement facility to place a user appropriately.

WHAT EVERY PSYCHIATRIST NEEDS TO KNOW ABOUT RESUSCITATION

Theresa Louw

Department of Anaesthesiology, Stellenbosch University and Tygerberg Hospital

The newest resuscitation algorithms as developed by the South African Resuscitation Council will be discussed. Practical guidelines as to the basic essential skills, equipment and drugs needed by psychiatrists for the management of on-site emergencies will be given.

MENTAL HEALTH AND POVERTY: A SYSTEMATIC REVIEW OF THE RESEARCH IN LOW- AND MIDDLE-INCOME COUNTRIES

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INTRODUCTION: There is widespread recognition that mental disorders make a significant contribution to the burden of disease and disability in low- and middle-income countries (LMICs). The contribution of poverty to mental ill-health is particularly pertinent in LMICs, where poverty is widespread. Only in the last 10 - 15 years has a clear body of research begun to emerge on the relationship between poverty and mental health in these countries. There has not yet been a systematic review of this literature. The aim of the study was to provide a systematic review of the literature on the relationship between poverty and mental health in LMICs, with a view to identifying some of the mechanisms of this relationship and making national and international policy recommendations.

METHODS: A systematic literature review was conducted using the MEDLINE, Econlit and PsycInfo databases. To be included, studies had to be published between 1990 and 2007, conducted in LMICs (according to World Bank criteria) and provide epidemiological data on measures of poverty and mental health status and their relationship. Abstracts from 2 413 studies identified by searches were reviewed independently by two authors (CL and AB), and 268 studies from 56 countries were included in the final review.

RESULTS: There is clear evidence from LMICs, confirming the findings from high-income countries, that poverty increases the risk for both common and severe mental disorders across the age ranges in urban and rural settings. People with mental disorders in turn are at greater risk of sliding into poverty, creating a vicious cycle of poverty and mental ill-health. There is therefore a strong relationship between poverty and mental ill-health, which moves in both directions, is complex, dynamic and multi-dimensional. Because of the lack of longitudinal studies in LMICs, it is not possible to demonstrate that poverty causes poor mental health. However, many of the features of poverty have been shown to carry strong associations with poor mental health. These features include low education; unemployment and under-employment; stress

associated with low or insecure income; low socio-economic status; and inadequate housing.

CONCLUSION: In the past, mental disorders were regarded as a phenomenon that applies only to the middle class. However, recent evidence indicates that mental ill-health is over-represented among poorer communities, is inextricably linked to the conditions of poverty, and plays a role in perpetuating social and economic inequality in LMICs. The implications are that health and development policies need to address the wider social determinants of mental health. There is a need for longitudinal studies to explore the direction of causality in the relationship between poverty and mental ill-health, and the mechanisms of the relationship in LMICs.

THE COST OF SCALING UP MENTAL HEALTH CARE IN LOW– AND MIDDLE-INCOME COUNTRIES

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INTRODUCTION: No systematic attempt has been made to calculate the costs of scaling-up mental health services in low- and middle-income countries (LMIC). The aim of this study was to estimate the expenditures needed to scale-up the delivery of an essential mental health care package over a 10-year period (2006 - 2015) in 12 LMICs.

METHODS: A core package was defined, comprising pharmacological and/or psychosocial treatment of schizophrenia, bipolar disorder, depression and hazardous alcohol use. Current service levels in 12 selected LMIC were established using the WHO-AIMS assessment tool. Target-level resource needs were derived from published need assessments and economic evaluations.

RESULTS: The cost per capita of providing the core package at target coverage levels (in US dollars) ranged from $1.85 - 2.60 in low-income countries and $3.20 - 6.25 in lower middle-income countries (an additional annual investment of $0.18 - 0.55 per capita).

CONCLUSION: Although significant new resources need to be invested, the absolute amount is not large when considered at the population level and against other health investment strategies.

'TIKKING' CLOCK: THE IMPACT OF A METHAMPHETAMINE EPIDEMIC AT A PSYCHIATRIC HOSPITAL IN THE WESTERN CAPE

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Lentegeur Hospital (LH) is one of three major psychiatric hospitals in the Western Cape. Epidemiological evidence has shown an increasing prevalence of methamphetamine abuse in the province, which has had an impact on the psychiatric inpatient services at the hospital.

Clinical information from the LH discharge summary database (DSD), recorded over four years from March 2004, is presented to illustrate the impact of the increasing prevalence of methamphetamine abuse on the acute adult admission services.

METHODOLOGY: A retrospective survey was conducted to review the DSD with regard to all patients discharged from the adult acute services at LH from 1 May 2004 to 30 April 2008. The LH DSD was established in March 2004. It is a secure database, which captures information recorded in the patient's hospital discharge summary form. The discharge summary form is completed by case managers at the time of discharge and records comprehensive clinical and demographic information about each patient.

RESULTS: From 1 May 2004 to 30 April 2005, 4.5% of the total number of acute admissions to LH had a positive history of methamphetamine abuse. This figure rose to 11.3% in the following year and to 15.9% in the year from 1 May 2006 to 30 April 2007. The reasons for admission included psychiatric disorders arising from primary methamphetamine abuse disorder, as well as relapses in patients with a co-morbid psychiatric disorder. 64% of patients admitted with a history of methamphetamine abuse had a history of aggressive behaviour, compared with 50% of those admitted with no history of methamphetamine abuse. 77% of those with a positive history of methamphetamine abuse were male and 23% female. Their ages ranged from 15 to 55, with a median age of 23. 64% of those with a positive history of methamphetamine abuse came from the Mitchells Plain district in the Cape Town Metropole. It was also shown that the average length of stay and the rate of readmission were increased in patients with a positive history of methamphetamine abuse.

CONCLUSIONS: The methamphetamine epidemic has been the cause of increasing numbers of patients being admitted to LH, with primary methamphetamine-induced psychiatric disorders and with co-morbid methamphetamine abuse. The burden on psychiatric services as a result of the epidemic is reflected not only in increasing numbers of mentally ill patients, but also in longer lengths of stay and higher rates of relapse in patients abusing methamphetamine.

DURBAN YOUTH HEALTH-RISK BEHAVIOUR: PREVALENCE OF VIOLENCE-RELATED BEHAVIOUR

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INTRODUCTION: Youth health-risk behaviour is defined as the way young people behave that may expose them to suffering, harm, danger, illness, injury or death. Youth is a period associated with the lowest mortality rates and incidence of disease. However, it is a time associated with health-risk behaviour. The immediate consequences of health-risk behaviour are mainly traumatic: for instance traffic accidents, assaults, and suicide. Between 1984 and 1986, these contributed to 56% of adolescent male deaths in South Africa. Many risk behaviours lead to psychosocial problems. These are often accompanied by violent behaviour and family instability. The long-term effects of unhealthy lifestyles, often initiated during youthful years, can be manifested throughout the lifespan and be translated into a range of chronic diseases at an older age like depression and substance abuse. Interventions during the youth phase can yield amplified benefits.

AIM: The aim of the study was to conduct a survey of youth-risk behaviours (road behaviour, violence-related behaviour, suicide behaviour, substance use and sexual behaviour) among high school learners in Durban, South Africa, and further administer questions on depression and knowledge about HIV/AIDS. This paper reports on the prevalence of violence-related behaviours.

OBJECTIVES: To determine the prevalence of violence-related behaviour and to compare the prevalence according to age, gender, grade, and race.

METHODOLOGY: A survey research design was used, a cross-sectional, quantitative, anonymous, school-based study using a 93-item, self administered questionnaire.

SAMPLING: The target group was learners of all races in grades 9, 10, 11 and 12 at 20 secondary schools in and around Durban. Durban was divided into four clusters (north, west, central and south). All secondary schools were included, yielding a total of 292 schools. Thirty schools were randomly selected to participate and all learners in the selected grades who were present on the days of the survey were included. This method was expected to yield a total of 7 000 learners.

RESULTS: A high prevalence of violence-related behaviour was found: 33% reported being involved in a physical fight; 23% reported being threatened or injured with a weapon at school; 15% reported being hit, slapped or physically hurt by a partner; 10% had been physically forced to have sexual intercourse (rape); 7.5% reported being involved in a physical fight in which they were injured and had to be treated by a nurse or doctor; and 7% reported carrying a weapon at school.

PROFILE OF MORTALITY OF PATIENTS ADMITTED TO WESKOPPIES PSYCHIATRIC HOSPITAL IN SOUTH AFRICA OVER A 5-YEAR PERIOD (2001 - 2005)

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INTRODUCTION: Mortality in the psychiatric population, both from natural and unnatural causes, is 2 - 6 times higher than in the general population, despite improvement in the delivery of psychiatric care and treatment of mental illness in recent years.

AIM: To determine mortality rates of hospitalised patients, to establish a mortality profile of these patients, and to identify preventive measures that can be implemented to reduce mortality rates at this hospital.

METHODS: A retrospective clinical case audit was conducted of deaths that occurred at Weskoppies Hospital between 1 January 2001 and 31 December 2005. A standardised mortality ratio for the hospital population was calculated.

RESULTS: A total of 164 deaths were observed during this period. The mean age of death was 55 years, with approximately 40% of deaths occurring in patients 60 years and older. The mean length of stay at time of death was found to be approximately 6 years. The standardised mortality ratio (SMR) was 0.94 for males and 0.96 for females compared with that for the general population. The predominant natural cause of mortality was infection, especially pneumonia, accounting for approximately 18.4% of deaths. Results of the current study showed that 12.2% of the patients tested positive for HIV, although patients are not routinely tested for this illness. Cardiovascular complications were found to be the second most common cause of mortality. Ten of the deaths were due to unnatural causes. Of these, 7 were suicides, with hanging being the method of choice. The SMR for unnatural causes was 0.47. A prominent finding was the high incidence of deaths that could not be ascribed to a particular causal group owing to the nonspecific method of death reporting.

CONCLUSION: Mortality studies are important tools for determining quality of health care provision to patients. They are important tools in developing preventive measures that should focus on timeous identification and treatment of general medical conditions. These studies also assist in making recommendations for optimal clinical practice, including hyper-vigilance of high-risk patients. Results of this study showed an SMR almost equal to that of the general population (0.94 for males and 0.96 for females). Further, the SMR for deaths due to unnatural causes was almost half of that for the general population (0.47). These rates are lower than those found in other studies conducted in developed countries. This decreased rate is most likely the result of excess mortality in the general population in South Africa.

ONE FLEW OVER PSYCHIATRY'S NEST

Leverne Mountany

Fourways, Gauteng

The movie psychiatrist – Dr Dippy, Dr Devious or Dr Death? Hollywood has always had a fascination with psychiatry. Psychiatry in turn has had a love-hate relationship with films. Since the first portrayal of a psychiatrist in a film (1906), there have been thousands of attempts to capture psychiatric themes on the screen. The aim of this presentation is to explore the history of the 'movie psychiatrist', to follow psychiatrists in film over time and explore their evolution by using various film clips to illustrate the process and to encourage interactive participation by the audience.

This presentation takes the format of a forum or workshop. A similar workshop was presented by me at the International Bipolar and Schizophrenia Congress in Switzerland in February 2008. It was attended with great enthusiasm by at least 400 psychiatrists, with very positive feedback. The presentation forms part of an ongoing awareness and destigmatisation programme incorporating the use of film, and was launched in Gauteng 3 years ago.

THE ETHICAL RELATIONSHIP BETWEEN PSYCHIATRISTS AND THE PHARMACEUTICAL INDUSTRY

Margaret G Nair

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The relationship between psychiatrists and pharmaceutical companies is often a controversial one. Recently this relationship has undergone much scrutiny at an international level from professional bodies and the lay press or lay organisations. Like all relationships (much like in marriages), it has undergone good and bad times, had ups and downs, and received both criticism and praise. Sometimes there has been difficulty working together, but at the same time each side/party cannot function without the other.

The controversial aspects of the relationship include gifts; prizes; hospitability; sponsorships at regional, national and international congresses or meetings; professional integrity in contract research; ghostwriting of journal articles in order to promote a product; marketing practices/strategies; drug sampling (now outlawed by Act 90 in South Africa); and information obtained by pharmaceutical industries on individual psychiatrist's scripting habits and the possibility of alleged rewards for this.

Issues like 'Selling sickness', 'Corruption in medicine' and 'Is academic medicine for sale?' have been documented in both professional journals and the lay press/media.

What then is the best way forward in establishing a collaborative, working, and ethical relationship between psychiatrists and the industry? Transparency on both sides is critical. Progress in medicine/psychiatry will be stunted without the industry and therefore a harsh intolerant approach is not appropriate. What is the ethical responsibility of the psychiatric profession and of the pharmaceutical industry? This matter will be debated and both national and international legislation and trends will be examined.

DEVELOPING THE FRAMEWORK OF A POSTGRADUATE DIPLOMA PROGRAMME IN MENTAL HEALTH

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Department of Psychiatry, University of the Free State

Research was undertaken to develop a framework for a postgraduate diploma programme in mental health. The paucity of psychiatrists in South (and southern) Africa) and the absence of formal tuition for doctors planning to obtain a diploma in mental health from the College of Medicine in South Africa motivated the study.

The overall goal of the study was to provide a framework whereby members of the medical profession could embark on formal postgraduate training, on a part-time basis, utilising blended learning mode (including face-to-face contact sessions, directed learning and e-learning), that would support the requirements of the National Qualifications Framework (NQF), the College of Medicine, and the Professional Boards.

The objectives of the study were to conceptualise and contextualise the problem of the absence of training for a postgraduate diploma in mental health. Criteria were identified, using a survey of the literature, the researcher's own experience in psychiatry and a Delphi process, in order to compile an appropriate framework for the diploma programme. The aim of the study was thus to establish a framework for the development of a postgraduate diploma programme in mental health. The research design was based on a quantitative approach, enhanced by qualitative elements, used to ensure that sound and well-founded recommendations would be proposed in the final framework.

The use of outcomes-based education had to be considered for this programme, particularly involving methods in which electronic learning could be blended with

traditional curricula to ensure that students would be able to remain in their usual working environments but still be able to interact with tutors and fellow students enrolled in the diploma when necessary.

The Delphi questionnaire dealt with five major aspects relating to the development of the postgraduate programme. These included crucial exit level outcomes, format of the programme content of the modules, contents of the programme, education methodology, modes of delivery, and student evaluation. The findings of the Delphi study were reported and used in order to develop the framework for the programme in six phases. These phases are summarised as follows: the identification of the individual needs of the doctor as learner and the mental health care user (patient), content of the programme, description of the mode of delivery in which the programme will be presented, use of blended learning to consolidate different parts of the programme, implementation of the programme, and the final accreditation and acceptance of the programme.

This research aims to make a significant contribution towards the improvement of mental health care in South Africa, especially at primary health care level.

AN UNFOLDING STORY: THE EXPERIENCE WITH HIV-POSITIVE PATIENTS AT A PSYCHIATRIC HOSPITAL

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INTRODUCTION: Lentegeur Hospital (LH) is one of three major psychiatric hospitals in the Western Cape. The hospital's catchment area has a high prevalence of patients with HIV/AIDS, which has caused an increase in the number of HIV-positive patients admitted to the female admission unit (FAU) since March 2004.

Information from the LH discharge summary database (DSD) will be presented to illustrate the clinical presentations associated with HIV/AIDS in the psychiatric clinical setting, as well as some of the ethical and managerial challenges and dilemmas being faced.

METHODOLOGY: A retrospective survey was conducted to review the DSD of all patients discharged from the FAU at LH from 1 May 2004 to 30 April 2008. The LH DSD was established in March 2004. It is a secure database, which captures information recorded in the patient's hospital discharge summary form. This form is completed by case managers at the time of discharge and records comprehensive clinical and demographic information about each patient.

RESULTS: 110 confirmed HIV-positive patients were discharged from the FAU during the 3 years to 30 April 2007, which comprised 9% of the 1 222 female patients discharged. There were differences between language groups in those tested for HIV, as well as in the number found to be HIV positive. 43% had HIV-associated mental disorder as the primary clinical diagnosis. A review of the clinical findings in this group revealed a predominance of features associated with delirium. In the first year of the study 19% of confirmed HIV-positive patients were receiving antiretroviral treatment (ART) at discharge, and a further 19% were referred for ART. In the third year of the study 47% were receiving ART at discharge, and 35% were referred for treatment. The average length of stay (ALOS) of patients with HIV-associated mental disorders was 79 days. ALOS of patients with a primary psychiatric disorder, who were confirmed to be HIV positive, was 56 days, and of those who were not diagnosed as being HIV positive ALOS was 47 days.

CONCLUSIONS: Patients with HIV-associated psychiatric disorder, and psychiatric patients with co-morbid HIV infection, have placed a significant burden on the FAU at LH. Our data suggest that delirium is the most common presenting HIV-associated disorder. Since delirium is classified as a medical condition it is usually more appropriately and safely managed in a medical setting. However, the majority of our patients were managed in the psychiatric unit and discharged successfully. Our experience has highlighted a number of challenges, which invite ongoing investigation and debate.

FROM EVIDENCE TO ACTION IN GLOBAL MENTAL HEALTH

Vikram Patel

London School of Hygiene & Tropical Medicine (UK) and Sangath (India)

Last year, the *Lancet* published a series of 5 articles on global mental health, which documented the current evidence base for global mental health, with a focus on low- and middle-income countries (http://www.the*Lancet*.com/online/focus/mental_health). This lecture summarises the rationale and background to this important series, and the key messages of the articles. This evidence was utilised, in the 6th and final article, in a call to scale up services for patients with mental disorders. The lecture will describe the key strategies needed to achieve this scaling up, including the estimates of financial resources needed, the indicators to monitor the scaling-up process, and the research priorities needed to inform this process. It is clear that the evidence and solutions for the global mental health burden are at hand. A new Movement for GlobalMental Health is now being stitched together to take forward this call to action. The movement seeks to be broad based, aiming to build a vibrant coalition of activists, academics, users, clinicians, donors and policy makers. The strategies will include advocating packages of care for scaling up, building capacity of stakeholders (including mental health professionals and users), promoting priority research, and monitoring human rights and progress in countries. These strategies will be implemented by a network of individuals and institutions committed to the call – it is this network which will comprise the movement. Ultimately, we hope that the Movement for Global Mental Health takes its place alongside other global movements, such as those advocating access to evidence-based treatment for people living with HIV/AIDS and safe motherhood and child survival, as one of the great public health coalitions of our time. The Movement for Global Mental Health will be formally launched on World Mental Health Day 2008 and you can join on that day through its website. Together, we believe we can make a difference.

TASK SHIFTING: A PRACTICAL STRATEGY FOR SCALING UP MENTAL HEALTH CARE IN DEVELOPING COUNTRIES

Vikram Patel

London School of Hygiene & Tropical Medicine (UK) and Sangath (India)

Task shifting is a term used to describe the strategy of rational redistribution of tasks among health workforce teams, has become a popular method to address specialist health human resource shortages. Specific tasks are moved, where appropriate, from highly qualified health workers to health workers with shorter training and fewer qualifications in order to make more efficient use of the available human resources for health. A Cochrane systematic review has reported that lay health workers show promising benefits in promoting immunisation uptake and improving outcomes for acute respiratory infections and malaria, when compared to usual care. The WHO has recently released global recommendations and guidelines on task shifting for scaling up HIV care and proposes the 'adoption or expansion of a task shifting approach as one method of strengthening and expanding the health workforce to rapidly increase access to HIV and other health services'. The scarcity of specialist mental health human resources in developing countries, compounded by their inequitable distribution and inefficient utilization, has been well documented. This human resource gap will remain large for the foreseeable future, and is likely to be worsened as populations grow in many countries and as specialists emigrate. This lecture will present a perspective on the role of task-shifting to scale up mental health care, by empowering community and lay health workers to deliver specific tasks, the evidence base which supports the effectiveness of task-shifting interventions, the role of mental health specialists in such intervention programs, and future research and program opportunities.

ETHICS: INFORMED CONSENT AND COMPETENCY IN THE ELDERLY

Willie Pienaar

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For the clinician, informed consent in the elderly patient and evaluation of competency to give informed consent can be problematic. Early subtle cognitive changes are difficult to evaluate, decisions to be made may have grave

consequences for the patient and family, and the responsibilty of determining competency lies with the treating physician. During this presentation, elements of informed consent will be discussed. Different 'degrees' of competency and how to evaluate them will be discussed. The presenter will propose a questionnaire for assessing the degree of competency. Competency level will be balanced against the 'weight' of any decision to be made, so as to comply with good clinical principles of informed consent.

CONFRONTING COMMON MORAL DILEMMAS. CELEBRATING UNCERTAINTY, WHILE IN SEARCH OF PATIENT GOOD

Willie Pienaar

Faculty of Health Sciences, Stellenbosch University and Stikland Hospital, Associated Psychiatric Hospitals, Western Cape

Therapists want to be good moral agents. We strive towards virtue, being a 'good Samaritan', and take the action of good intent, weighing public interests and respecting the freedom of the individual. We aim for the best possible clinical care (standard) possible. This is often very difficult, not only because of the rising costs of health services, the dwindling bed numbers for patients with mental health disorders and the substance abuse epidemic, but because we are constantly confronted with conflicting moral scenarios. By presenting clinical cases, conflicting arguments on 'best results', human rights, action of good intent, respect for autonomy, beneficence, non-maleficence, justice and duty to care will be discussed. The aim of the presentation is to ask the questions, to build and listen to counter arguments, and to weigh and balance ideas and possible actions in our attempt to strive towards virtue despite the fact that we do not know!

MORAL DILEMMAS IN THE TREATMENT AND REPATRIATION OF PATIENTS WITH PSYCHIATRIC DISORDERS WHILE VISITING OUR COUNTRY

Duncan Ian Rodseth

Psychiatrist in private practice, Johannesburg

Patients with psychiatric illnesses are particularly vulnerable when they travel abroad. Certain illnesses associated with increased drive and psychotic ideation lead patients to travel from their home country. When they present in a foreign country, there is a multitude of difficulties associated with treating them. As a consequence of the cost of treatment, which must be covered by the patient, their family, the representative embassy or an insurance company, as well as other practical matters, pressure is often brought to bear on the treating psychiatrist to repatriate the patient before he is fully stable. The support provided during repatriation may be inadequate or inappropriate for psychiatric patients as it is geared for physically ill patients. Another situation in which patients are transported in an acute illness state is when they become ill in outlying areas (for example on the mines) and the medical resources are inadequate for management. Patients are often evacuated to a better-equipped facility. This process of evacuation is fraught with difficulties in patients who are restless and psychotic.

This discussion will include case reports and examples and will consider the ethical aspects of transportation and repatriation of patients. Some guidelines for management of these patients will be proposed.

GERIATRICS WORKSHOP (PSYCHO-LEGAL SYMPOSIUM): MEDICO-LEGAL ISSUES IN GERIATRIC PSYCHIATRY

Felix Potocnik

Psychogeriatric Unit, Department of Psychiatry, Stellenbosch University, Tygerberg

INTRODUCTION: The elderly person's competence, usually linked to the management of their assets, renders them uniquely vulnerable to medico-legal conflict. Finding the golden path that feasibly accommodates their autonomy while safeguarding them and their future provides many challenges. A thorough background in ethical principles is essential, coupled with knowledge of legal requirements and their limitations in dealing with issues such as competence (especially financial), power of attorney, curatorship, testamentary capacity and the driving of a vehicle (or possession of a firearm).

IN BRIEF: The decision-making process includes utilising the mnemonic SOCCOUR (situation, options, consequences, consistency, opinions, undue influence and reasons). Testamentary capacity evaluates the person's understanding of a will, knowledge of their assets, influence of illness, and the reasonableness of the will. Criteria for financial competence include knowledge of income, expenses, ability to handle everyday transactions and the ability to delegate financial wishes. This in turn influences the need for curatorship. Lastly, driving ability is determined by collateral information, the illness under discussion, the ability to do the pentagons on the MMSE (with a total score of about 22 or higher) and driving during 'safe-times'.

CONCLUSION: Future movements in this field are towards a multi-level alternative to the curatorship system and an enduring power of attorney.

BRAIN STIMULATION TECHNIQUES – UPDATE ON RECENT RESEARCH

P J Pretorius

Our current understanding of the abnormal brain circuitry implicated in the pathology of psychiatric conditions has revived interest in possible modification of circuitry by means of somatic therapies. Brain stimulation techniques under current investigation range from those stimulating highly circumscribed areas in the brain to those that deliver a non-circumscribed or indirect stimulus. Although electroconvulsive therapy remains the only somatic treatment with undisputed efficacy, vagus nerve stimulation, repetitive transcranial magnetic stimulation, magnetic seizure therapy and deep-brain stimulation all have potential as novel means of psychiatric treatment. The presentation will give an overview of the current evidence and new research being conducted in this field.

HOLISTIC/ALTERNATIVE TREATMENTS IN PSYCHIATRY

T Rangaka,[1] J Dill[2]

[1] *1 Military Hospital, South African Military Health Services; President of the South African Society of Psychiatrists (SASOP)*

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INTRODUCTION: Holistic alternative treatments in psychiatry include approaches that take into account the view that psychiatry and mental wellness are a public health concern. All the intervention approaches employed by public health practitioners in dealing with diseases such as malnutrition, tuberculosis, HIV and AIDS can and must be used in the management of mental and neurological illnesses.

DESIGN AND METHOD: Socio-political and economic developments as well as cultural and religious influences must be taken into account when psychiatrists and mental health care practitioners plan the treatment of their patients. There can be no normal psychiatric practice in an abnormal socio-political and economic environment.

This session will begin with an overview of the environment in which the psyche of the patient in Southern Africa is being influenced. Political, economic, cultural, religious and moral issues will be outlined. The effects of these environmental elements on the soma will be identified. Nutrition is becoming more crucial in ensuring that the illnesses caused by deficiencies are combated and that the positive effects of modern neuropsychiatric medicines are optimised. Participants will then be invited to share their experiences and ideas with the presenters.

Interventions which augment standard, conventional psychiatric treatment modalities will be presented and discussed. These include taking into account lobbying political and economic opinion makers, 'bridging the gap' between Western MHCPs and customary or traditional practitioners, exploiting the indigenous knowledge systems and thus advancing psychiatric and mental wellness.

CONCLUSION: It is intended that, at the end of the session, participants will appreciate that psychiatry and mental health are a public health matter, and must be

promoted using the public health care tools of educating users and administrators. Psychiatrists must interact increasingly with politicians and opinion-makers, the majority of whom have a scanty understanding of the importance of psychiatric and mental health wellness in the total development of their citizens and countries.

COGNITIVE BEHAVIOUR THERAPY AND OTHER BRIEF INTERVENTIONS FOR MANAGEMENT OF SUBSTANCES

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Cognitive behaviour therapy (CBT) is a short-term focused approach. It attempts to help patients to recognise the situations in which they are more likely to use addictive substances, to avoid these situations when appropriate, and to cope more effectively with the range of problems and problematic behaviours associated with substance abuse. CBT addresses several critical tasks that are essential to successful substance abuse treatment. These are: fostering the motivation for abstinence; teaching of coping skills; change of reinforcement contingencies; fostering management of painful effects; improving interpersonal functioning; and enhancing social support. The presentation will address the use of CBT for stimulant abuse. Other related brief interventions such as contingency management, motivational enhancement therapy, and brief supportive interventions will also be addressed.

A TRANSTHEORETICAL VIEW OF CHANGE

Nathan P Rogerson

Clinical psychologist in private practice

The Stages of Change model was the outcome of a collective research effort that started in 1982 and continued for 15 years. Three psychologists (James Prochaska, Carlo DiClemente and John Norcross) set out to discover how people intentionally change. The research also sought to integrate a variety of psychotherapeutic understandings of change and to show how different change processes are relevant at different stages of change. The model counters the old action paradigm, wherein change was assumed to take place dramatically and discretely.

The transtheoretical model shows that, for most people, change in behaviour occurs gradually. The person moves from being unaware, uninterested or unwilling to change (precontemplation), to considering a change (contemplation), to deciding and making preparations for change. In the action stage of change, a patient intentionally commits to certain change behaviours and then attempts to maintain these. Relapses are almost inevitable and become part of the process of working toward lifelong change. William Miller said that the transtheoretical model has fundamentally changed how Western professionals think about and address behavioural change. The developers of the model used factor and cluster analytic methods in retrospective, prospective and cross-sectional studies of the ways that people quit an addiction. The model has been validated and applied to a variety of behaviours that include smoking cessation, excessive substance use, emotional distress, anorexia, bulimia and other phenomena that are typically 'change-resistant'. Simple and effective 'stage-based' approaches derived from the Stages of Change model demonstrate widespread utility and have become the bulwark of many evidence-based rehabilitation programmes. The Stages of Change model also integrates many concepts from previously developed models. The Health Belief model, the Locus of Control model, Cognitive-behavioural models of change and 12-Step programmes fit together well within this framework.

An overview of the Stages of Change will be provided and emphasis given to show its utility in a variety of contexts. The presenter aims to make the presentation informative and value-adding. The integrative nature of the model lends itself to other integrative approaches and works well within the theme of 'Psyche and Soma'.

PROFILE OF SECURITY BREACHES IN LONG-TERM MENTAL HEALTH CARE USERS AT WESKOPPIES HOSPITAL OVER A 6-MONTH PERIOD

Deleyn Rosema,[1] Lindiwe Mthetwa,[2] Christa Krüger[3]

Weskoppies Hospital, Pretoria

INTRODUCTION: This study forms part of a comprehensive programme to improve rehabilitation of long-term mental health care users (MHCUs) in Weskoppies Hospital. The aim was to determine the frequency of security breaches over a period of 6 months in 266 MHCUs who were admitted into long-term wards, as security breaches complicate the rehabilitation/placement of MHCUs at long-term care facilities such as non-government organisations (NGOs). Security breaches are defined as: incidents occurring at the institution that compromise the safety and security of hospital personnel, MHCUs or property and that may result in losses from the department. These may include burglaries, assaults, murder, theft, damage to property, arson, drug trafficking and other serious incidents.

METHODS: Daily data on the number of security breaches were collected by professional nurses from 1 April 2007 to 30 September 2007, in 10 long-term wards: 4 open male wards, 1 semi-closed male ward, 1 closed male ward, 3 open female wards and 1 closed female ward. The data were summarised using frequencies and percentages.

RESULTS: Seventy three security breaches occurred over the 6 months: 36 (49%) incidents of fighting between MHCUs, 16 (22%) incidents of damage to hospital property, 11 (15%) incidents of assaults on fellow MHCUs, 3 (4%) incidents each of assaults on staff, MHCUs being found in possession of prohibited substances and theft . There was 1 (1%) incident of an attempted suicide, and no incidents of arson, burglary, rape and drug trafficking reported. The MHCUs who were involved in security breaches were all in Weskoppies Hospital for a period of between 4 to 37 years. The majority of MHCUs involved with security breaches had either a diagnosis of schizophrenia or mental retardation and epilepsy. Twelve MHCUs were involved with security breaches on more than one occasion.

CONCLUSIONS: The results indicated that the rehabilitation and placement of these MHCUs will be difficult due to behaviour problems that cannot be handled in the community. Future studies should be aimed at improving rehabilitation interventions to reduce the number of security breaches at Weskoppies Hospital.

MANAGEMENT OF PSYCHOGENIC AND CHRONIC PAIN – A NOVEL APPROACH

M S Salduker

Durban Pain Clinic

The problem of chronic pain and the subsequent use of opioid analgesics have long been neglected by the medical profession. Patients make use of the analgesics for many reasons, including insomnia and anxiety. The pain itself is often directly related to mood and anxiety issues. These patients often end up being managed by GPs, orthopaedic surgeons or neurosurgeons, often culminating in unnecessary surgery. The concept of rebound pain also comes into play in analgesic abuse cases.

It is for these reasons that a pain clinic was opened in Natal with emphasis on chronic pain syndromes and analgesic abuse. The clinic is headed by a psychiatrist and includes in its staff complement a psychologist, a physiotherapist, a biokineticist, a fitness expert, a neurologist and an anaesthetist. The approach is geared towards selecting the patients carefully and then getting them to discontinue using all opioid analgesics. The next phase of treatment involves physical and psychological therapies combined in repeated sessions over a 6-week period.

This talk will aim to present the psychiatric-based pain clinic model being used, together with the preliminary data from the first batch of patients who have completed the programme.

CHILDHOOD ADHD AND BIPOLAR MOOD DISORDERS: DIFFERENCES AND SIMILARITIES

L Scribante

Weskoppies Hospital, University of Pretoria

INTRODUCTION: Attention deficit hyperactivity disorder (ADHD) has long been

recognised as one of the most common psychiatric disorders seen in children. Bipolar mood disorder, on the contrary, has traditionally been seen as a rare condition in the pre-pubertal child. Recent research and literature have contradicted this last assumption. The difficulty currently faced by mental health care practitioners lies in differentiating between these two similar, but completely distinct, entities.

METHOD: By way of cases from practice and a literature review the similarities and differences between ADHD and bipolar mood disorder in children will be discussed. The approach to management of each disorder and the approach to co-morbidity between the two will also be discussed.

CONCLUSION: Although there is symptom overlap between these conditions, differentiation is possible. The occurrence of co-morbidity should also be recognised and managed accordingly. Identifying specific disorders or co-morbidtiy informs long-term decision making regarding management.

THE CHOICE OF ANTIPSYCHOTIC IN HIV-INFECTED PATIENTS AND PSYCHOPHARMACOLOGICAL RESPONSES TO ANTIPSYCHOTIC MEDICATION

Dinesh Singh, Karl Goodkin

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INTRODUCTION: Human immunodeficiency virus (HIV) infection is associated with a wide range of mental illnesses. Psychosis has been less frequently studied. Causes for psychotic symptoms in an HIV-seropositive (HIV+) patient include delirium, late-stage HIV-associated dementia, mania, recurrence of premorbid psychotic illnesses, psychoactive substance intoxication, antiretroviral (ARV) medication toxicity, and general medical conditions manifesting with psychotic symptoms. As more people are started on ARVs, HIV has become a chronic disease. Therefore, the prevalence of psychotic disorders among HIV+ patients is expected to increase, and little is known about the special issues associated with choice of antipsychotic medication in the HIV infected.

METHODS: We reviewed all published studies on the use of antipsychotics in HIV-infected patients. We searched Pubmed using HIV as key word, and did limited searches using the following key words: antipsychotics, antiretroviral therapy, aripirazole, olanzapine, ziprasidone, quetiapine, risperidone, clozapine, chlorpromazine and haloperidol. Additional searches were done of the *Cochrane Database of Systematic Reviews* and references from source articles were also reviewed. We will present only the salient points from our review and will offer a simplified overview of the literature, the current evidence and the most useful clinical recommendations.

RESULTS: An alternate classification of perhaps greater utility in our setting is psychosis that postdates versus antedates (or is premorbid to) HIV infection. Determining the aetiology is difficult in the former category because psychotic symptoms may be due to CNS complications of HIV infection, other HIV-associated illnesses, and ARV toxicities. Manic symptoms have been associated with HIV and are presumably caused by toxicity from ARVs, i.e. zidovudine, nevirapine, efavirenz and abacavir. As more patients are exposed to newly approved ARVs, a constant vigilance for psychosis from psycho-neurotoxicity will be necessary.

The quality and quantity of information on choice of antipsychotic for patients taking ARVs are limited. No antipsychotic is specifically approved for HIV-associated psychosis. Typical antipsychotics are most commonly prescribed; however, a rationale for the preference for an atypical antipsychotic has been suggested in a number of smaller case studies. Risperidone, clozapine and olanzapine have been used with varying efficacy. Atypicals must be administered cautiously because they cause the metabolic syndrome, which may exacerbate the lipodystrophy syndrome that commonly occurs owing to long-term ARV use. There may be a theoretical advantage to using atypical agents with the lowest propensity to cause the metabolic syndrome, i.e. aripirazole and ziprasidone. Other considerations are age of the patient and drug-drug interactions. Most psychotropic medication, protease inhibitors and NNRTIs are metabolised by the CYP isoenzyme, especially 3A4 and 2D6.

CONCLUSIONS: All antipsychotic medications are effective in treating psychotic symptoms in HIV+ patients. Clinicians should treat these patients aggressively.

PEARLS IN CLINICAL NEUROSCIENCE: A TEACHING COLUMN IN *CNS SPECTRUMS*

Dan J Stein

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It is difficult for the clinician to keep up with the rapidly expanding literature on the psychobiology and treatment of psychiatric disorders. 'Pearls in Clinical Neuroscience' is a regular teaching column in *CNS Spectrums*, a widely distributed open-access journal. Each column is devoted to a particular psychiatric disorder, to a particular molecule of psychiatric importance, or to the psychobiology of a psychotherapy construct. Some recent examples will be summarised, to illustrate the approach to teaching taken by the column, and the implications of recent research for clinical practice. It is clear that there have been important advances in psychobiology and in treatment. At the same time, much remains to be learned about the mechanisms underpinning psychiatric disorders, and much remains to be done to improve diagnosis and treatment.

URINARY CORTISOL SECRETION AND TRAUMATIC STRESS IN A COHORT OF SA METRO POLICEMEN: A LONGITUDINAL STUDY

Ugash Subramaney

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INTRODUCTION: Dysregulation of the HPA axis may be the basis for a link between trauma exposure and subsequent psychiatric disorder, such as post-traumatic stress disorder (PTSD). Police officers are a uniquely important population for the study of traumatic stress; they are routinely at risk for critical incidents such as being injured or witnessing the injury or death of others. Moreover, they are also understudied with respect to other groups such as combat veterans or sexual assault victims. In this research study, new cadets at the Johannesburg and Tshwane Metro Police Academy were asked to volunteer for a study assessing whether exposure to traumatic stress show alterations of HPA activity as measured by 24-hour urinary cortisol secretion.

METHODS: Socio-demographic information was obtained by means of a questionnaire. For the assessment of cortisol, a 24-hour urine sample for cortisol was obtained at baseline and every 3 months for a year. Subjects were assessed for PTSD using the clinician administered scale for PTSD (CAPS), as well as the impact of events scale – revised version (IES-R). These were administered from visit 2 to visit 5. For depressive symptoms, the 17-item Hamilton Rating scale (HAM-D) was administered, at baseline and every 3 months. Data were analysed using Stata statistical software, release 8.0.

RESULTS: 145 new cadets volunteered for the research study. The sociodemographics of the sample population are represented by means, frequencies and tables. Traumatic events appeared to be multiple, cumulative, and often predated entry into the police force. Cortisol responses did not show any significant changes over time. There appeared to be no correlation between IES scores and CAPS scores, or with HAM-D scores.

CONCLUSIONS: Lifetime PTSD scores according to the CAPS were higher than current PTSD scores at each visit, suggesting the influence of prior exposure to trauma. The study is limited by the small sample size as well as the many invalid 24-hr urine samples obtained. Salivary and blood cortisol may provide a more accurate picture.

CANNABIS USE IN PSYCHIATRIC INPATIENTS

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BACKGROUND: Cannabis use among patients admitted to psychiatric units is higher than that among the general population. This has been shown in various countries where studies on cannabis use have been undertaken. This observation has also been made by psychiatrists in South Africa and the association between cannabis use and psychotic presentation has also been observed. Cannabis use by patients in order to ameliorate the symptoms of severe or chronic medical illnesses has been documented in the literature. A study to explore the use of cannabis among psychiatric inpatients as well as medical patients was undertaken.

The purpose of this study was to firstly determine the level of cannabis use by psychiatric patients admitted to an acute admissions unit at King Edward VIII Hospital, Durban, and to correlate it with the psychiatric diagnosis. Secondly, the purpose was to compare cannabis use by patients admitted to an acute psychiatric admissions unit with that by patients admitted to a medical ward at King Edward VIII Hospital.

METHODS: A case control study was conducted at King Edward VIII Hospital, where cannabis use among 64 subjects admitted to a psychiatric ward was compared with use among a control group of 63 subjects admitted to a medical ward. Both groups were tested for urinary cannabinoids and a questionnaire was completed. The questionnaire included demographic details as well as a question on use of substances, including cannabis.

RESULTS: 17 subjects (26.6%) in the study group and 2 subjects (3.2%) in the control group tested positive for urinary cannabinoids. Cannabis use was significantly higher among males when compared with females in both the study group and the control group. Only 7 subjects in the study group reported cannabis use, and of those 7 subjects only 4 tested positive for urinary cannabinoids. The commonest diagnoses among the study group subjects were psychotic disorders.

CONCLUSION: Cannabis use is significantly higher among psychiatric patients when compared with medical patients and it is probably higher than in the general population. Self-reporting of cannabis use among psychiatric patients is low and unreliable and psychiatrists treating these patients must continue to use objective measures, such as objective testing as well as collateral information, to determine such use.

PATHWAYS TO CARE AND TREATMENT DELAYS IN FIRST AND MULTI-EPISODE PSYCHOSIS: FINDINGS FROM A DEVELOPING COUNTRY

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INTRODUCTION: In contrast with findings from the developed world where GPs and mental health professionals are central in first episode psychosis pathways, studies from Africa have found GPs to play a less prominent role with other help providers such as traditional healers being more important. Traditional healer involvement in pathways has also been associated with longer treatment delays and research has demonstrated that recurrent and incident users of psychiatric services differ in their demographic characteristics and pathways to care.

METHODS: We compared pathways to care, treatment delays and gender differences in 21 patients with first episode psychosis with 50 multi episode patients. A semi-structured pathways questionnaire based on the WHO Encounter form was used to collect data on pathways to care and duration of untreated psychosis (DUP).

RESULTS: First contact with private sector GPs was made in 38% of the first episode group and private sector GPs were significantly more likely to be the first contact (odds ratio=4.5, 95% CI=1.38-14.67) and final referring agent (odds ratio=6.8, 95% CI=1.56- 25.12) in first compared to multi episode patients. Female multi episode patients were significantly more likely to make first contact with primary care practitioners whereas male multi episode patients were more likely to first come into contact with the police(p=0.003) and be admitted compulsorily (p=0.009). Only 5.6% (N=4) of patients contacted traditional healers at some point in their pathway to care. Patients who made first contact with traditional healers had longer delays in treatment. DUP in first episode patients was longer and reached a median of 4.5 months versus a median treatment delay of 2.5 months in multi episode patients. Treatment discontinuation of antipsychotics prior to readmission occurred in 82% of multi episode patients. Despite significantly longer overall treatment delays in first episode patients the distribution of treatment delays in multi episode patients followed a similar pattern to DUP in first episode patients with a subgroup having very long delays.

CONCLUSIONS: Pathways to care in this treatment setting correspond more to findings from developed and newly industrialised countries. DUP in our sample corresponds well to findings from previous studies from developed countries. Equivalent to first episode patients a subgroup of multi episode patients had very long periods of untreated illness. Significant gender differences were found in pathways to care. Limitations of this study include small sample size and the retrospective nature of data collection.

MENTAL DISORDERS IN HIV-INFECTED INDIVIDUALS AT VARIOUS HIV TREATMENT SITES IN SOUTH AFRICA

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INTRODUCTION: International literature provides considerable evidence of an increased prevalence of mental disorder in HIV-infected individuals. There is limited evidence of this in South Africa. The aim of this study was to determine the occurrence of mental disorders (in particular depressive and anxiety disorders) in a sample of HIV-infected individuals attending primary to tertiary HIV treatment sites in South Africa. This study was undertaken at the beginning of the roll-out of antiretroviral treatment in the public sector in South Africa.

METHODS: Diagnostic psychiatric interviews were conducted using the SCID (Structured Clinical Interview for DSM). Three hundred individuals attending Wellness Clinics associated with the Perinatal HIV Research Unit and the Nthabiseng HIV Clinic at Chris Hani Baragwanath Hospital were interviewed and assessed. The occurrence of mental disorders in the sample was compared with prevalence studies of similar groups of patients as well as with a general population community prevalence study.

RESULTS: Just over 30% of study participants had a current mental disorder and the lifetime prevalence of mental disorder was 40%. Twenty-one per cent of participants had a current depressive or anxiety disorder and almost 20% had a lifetime depressive or anxiety disorder. The occurrence of current depressive and anxiety disorder was statistically significantly higher than that found in the general population prevalence study and in a similar study in a primary care population. There were interesting findings too with regard to the occurrence of substance use disorders, neuropsychiatric disorders and mental disorders secondary to general medical conditions.

CONCLUSION: Individuals who are infected with HIV suffer a considerable burden of mental disorder, which needs to be addressed. Ways of improving access to mental health care for HIV-infected individuals and the general population will be discussed.

ATTENDANCE PROFILE OF LONG-TERM MENTAL HEALTH CARE USERS AT OCCUPATIONAL THERAPY GROUP SESSIONS AT WESKOPPIES HOSPITAL

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INTRODUCTION: A comprehensive study was performed at Weskoppies Psychiatric Hospital in order to evaluate the services rendered to long-term mental health care users (MHCUs). A sub-study investigated the rehabilitation programme run by the Occupational Therapy (OT) department. One of the issues in rehabilitation

is whether the rehabilitation programme reaches all its intended recipients. The aim of this study was to determine the attendance profile of long- term MHCUs at Weskoppies Hospital at different OT sessions during the day.

METHOD: Data from MHCUs in 5 long-term wards at Weskoppies Hospital were collected over a period of 8 months. Attendance registers of these MHCUs at three daily OT sessions (09:00-10:00; 10:30-11:30 and 13:30-14:30) were used. During this time the occupational therapists and occupational therapy assistants who facilitated the sessions as well as the types of activities remained the same. The location at which sessions were facilitated also remained the same. The number of attendances at each session is presented as a percentage of the MHCUs in that ward.

RESULTS: In the high functioning male ward, 53.4% of patients attended the first session, 41.6% the second session and 4.9% the third session. In the intermediate functioning male ward, 60.9% of patients attended the first session, 39.0% the second session and 0.03% the third session. In the low functioning male ward, 55.1% of patients attended the first session, 43.2% the second session and 1.64% the third session. In the high functioning female ward, 53.0% of patients attended the first session, 42.6% the second session and 4.3% the third session. In the low functioning female ward, 56.2% of patients attended the first session, 17.2% the second session and 1.56% the third session.

CONCLUSIONS: The results of this study show that the largest group of MHCUs attended the first two sessions at Occupational Therapy. Therefore the two morning sessions should be optimised to fulfil the rehabilitation needs of the largest possible number of MHCUs. Factors that might contribute to the attendance profile may include ward routine, level of functioning of the users, institutionalisation, time of day, level of motivation and diagnosis. Theses factors should be investigated further in an attempt to improve the number of attendances of the afternoon sessions.

EPIDEMIOLOGICAL PATTERNS OF EXTRA-MEDICAL DRUG USE IN SOUTH AFRICA: RESULTS FROM THE SOUTH AFRICAN STRESS AND HEALTH STUDY

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BACKGROUND: Historically, substance abuse data in South Africa have been limited. This paper describes patterns of substance use based upon recent, nationally representative data.

METHODS: Data were derived from the 2002-2004 South Africa Stress and Health Study (SASH). A nationally representative household probability sample of 4 351 adults was interviewed using the paper and pencil version of the WMH-CIDI. Data are reported for lifetime use, socio-demographic correlates of lifetime and 12-month use, and age of cohort predicting lifetime use for each of the four classes of drugs.

RESULTS: The estimate for cumulative occurrence of alcohol use was 38.7%; tobacco smoking, 30.0%; cannabis use 8.4%, other drug use 2.0% and extra-medical use of psychoactive drugs, 19.3%. The SASH data report statistically significant associations between male gender and alcohol, tobacco, cannabis and other drug use. Coloureds and whites were more prone to have used alcohol, tobacco and other drugs compared with blacks. Strong associations were found between urbanicity and the use of alcohol, tobacco and cannabis. Clear cohort variations existed in the age of initiation of drug use; these were most marked for other drugs and extra-medical drug use (excluding alcohol and tobacco). Use of all drug types was much more common in recent cohorts, with a similar cumulative incidence of tobacco, alcohol and cannabis use across age cohorts.

CONCLUSIONS: These epidemiological patterns of alcohol, tobacco and other extra-medical drug-taking documented for the early 21st century provide the first nationally representative data in South Africa and are generally consistent with other contemporaneous data available. New findings on race and exploratory data on time trends represent a start in both concepts and methodology for such research. These estimates lead to no firm causal inferences or interpretations, but evidence of this type contributes to a more solid foundation for future research on drug use and dependence across recent decades, birth cohorts, and population subgroups is South Africa.

PERSON-CENTRED DIAGNOSIS: WHERE DO PERSONS AND MENTAL DISORDERS FIT IN THE INTERNATIONAL CLASSIFICATION OF DISEASES (ICD)?

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The chapters of ICD take the location of disease as a high order classificatory distinction whereby a chapter *zooms in* on a particular anatomical or functional body part or system. Similarly, the chapter on 'Mental and Behavioural Disorders' may suggest *zooming in* on the mind and behaviour as being such a location, but that is unsatisfactory for (i) the mind is dissimilar to body parts or systems and may not be something that qualifies conceptually as a (proper) location; (ii) the role of the brain is not vivid enough, yet the brain is an inadequate or inappropriate substitute for the more personal aspects captured by the concept 'mental'; and (iii) a holistic person-centred approach in diagnostic classification would require also *zooming out* not only in cases of mental disorder but in case of a diagnosis from any chapter of ICD.

A classification system would be more person-centred when it addresses the (ill) person and (ill) properties of the person by *zooming out* and *zooming in* respectively. Zooming in better may call for a tangible bodily location for mental disorders, such as 'Disorders of Higher Brain Functions'. Zooming out better may call for a counterpart to a diagnosis from any chapter, in which is captured personal health and contextual-environmental health aspects. The personal health aspects may include the experience of heath status; individual resources, functioning and limitations; personal identity and social preferences; dietary and substance use choices; and personality patterns. Contextual-environmental health aspects may include adverse life events; social circumstances; occupational and economic circumstances; and environmental living conditions.

WHAT EVERY PSYCHIATRIST NEEDS TO KNOW ABOUT SCANS

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Neuroimaging has become progressively important in the clinical assessment and diagnosis of psychiatric disorders. Structural imaging with CT and MRI and functional imaging techniques, such as positron emission tomography and single photon emission CT, are used to aid in the differential diagnosis and early detection of specifically dementia. Imaging techniques also can track disease progression and may be useful to monitor treatment effects. These issues will be discussed and practical points highlighted.

PSYCHIATRIC MORBIDITY IN HEALTH CARE WORKERS WITH MULTIPLE DRUG-RESISTANT TUBERCULOSIS (MDR-TB) – A CASE SERIES

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BACKGROUND: WHO estimates that of the 8 million cases of active TB diagnosed each year, over 400 000 are MDR. TB is spread by aerosol, and health care workers are most vulnerable. Treatment for MDR-TB is not universally

effective, involves periods of hospitalizations and painful intramuscular injections and has to be taken for at least 2 years. Little is known about the psychiatric morbidity associated with MDR-TB among health care workers.

METHODOLOGY: This is a case series of the first 10 health care workers assessed as part of a larger case-control study. Almost all cases of MDR-TB from across the province are referred to King George V Hospital. King George V Hospital is a hospital with tertiary level services that has a specialised MDR-TB clinic. Health care workers were identified from a register and were contacted telephonically to participate in the study. A psychiatrist then interviewed all consenting patients. They were assessed with the following: (i) mini international neuropsychiatric interview; (ii) Sheehan's disability scale; and (iii) structured study questionnaire. The University of KwaZulu-Natal ethics committee approved the study.

RESULTS: There were 2 males and 8 females. The median age was 37 years (IQR 31.5, 39). Five were inpatients, 9 participants were diagnosed with MDR-TB in the last 2 years and 1 participant had XDR-TB. The average duration of service of the health care workers was 6.5 years. Their job descriptions varied from enrolled nurses (*N*=2), student nurses (*N*=2), professional nurses (*N*=3), staff nurse (*N*=1), doctor (*N*=1), and an administration clerk (*N*=1). 80% of the sample was currently on sick leave due to having MDR-TB. The average length of sick leave taken was 4 months. The average length of hospitalisation was 4 months. These 10 participants displayed an adequate knowledge about TB. 50% (5) of the participants had a major depressive episode, current or past and one had a co-morbid anxiety disorder. 20% had an adjustment disorder with depressed mood. Using the Sheehan's disability scale, 80% of participants reported extreme levels of disruption in the work lives and 50% reported extreme levels of disruption in the social and family lives. 70% of the sample had concurrent HIV/AIDS.

CONCLUSIONS: MDR-TB is a serious health challenge facing the population of South Africa. This preliminary finding confirms there are a high proportion of undiagnosed mental disorders among health care workers. All health care workers with MDR-TB should receive a full psychiatric evaluation.

ASSOCIATION BETWEEN UTERINE ARTERY PULSATILITY INDEX AND ANTENATAL MATERNAL PSYCHOLOGICAL STRESS

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BACKGROUND: Antenatal maternal stress has been associated with poor obstetric outcomes, such as preterm labour, interuterine growth restriction and small-for-gestational age babies. (Hedegaard *et al.*1993, Lou *et al.* 1994). Altered fetoplacental blood flow has been postulated as a possible mechanism for these finding. However, studies of uterine blood flow show contradictory results (Sjorstrom *et al.* 1997, Texeira *et al.* 1999, Kent *et al.* 2002).

OBJECTIVE: To investigate whether maternal stress during pregnancy is associated with changes in uterine artery pulsatility index (PI).

METHODS: Uterine artery blood flow was assessed using colour Doppler ultrasound and maternal stress was measured using the K10 in 46 women at 13 weeks, 21 weeks and 32 weeks of gestation. A score on the K10 of >20 indicates severe psychological distress, with a >95% chance of having an Axis I psychiatric disorder.

RESULTS: Scores of >20 on the K10 were associated with significantly higher pulsatility index at 32 weeks (p=0.011) but not at 13 or 21 weeks.

CONCLUSION: The results of this study show a relationship between maternal stress and uterine artery flow during the third but not the first or second trimester. This is in keeping with previous work and suggests that effects of stress on uterine artery flow are modulated by gestational age. Further studies are needed to examine this relationship and assess the effects of confounders such as smoking and alcohol use.

APPROACHING THE DUAL DIAGNOSIS DILEMMA

Lize Weich

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Co-morbid substance disorders are very prevalent among psychiatric patients and produce a host of negative consequences for these patients. In this presentation, the results of a prevalence study on dual diagnosis at Stikland Hospital will be presented. The presenter will then give an update from the literature on how best to manage this difficult patient population.

WOMENS' MENTAL HEALTH: ONSET OF MOOD DISTURBANCE IN MIDLIFE – FACT OR FICTION

Denise White

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Women have a higher incidence of mood disturbance than men throughout their reproductive lifecycle. However, controversy exists about the occurrence of mood and memory disturbance in women during the menopausal transition. Historically, mood disturbance in women in midlife has been attributed to the psychological challenge of adjusting to such factors as 'loss of youth' and 'the empty nest'. Recent studies have shown that mood disturbance occurring during the menopausal transition is associated with declining ovarian function. The presentation will discuss the influence of somatic changes experienced by women in midlife on their psychological wellbeing.

FAILING OR FAKING: ISSUES IN THE DIAGNOSIS AND TREATMENT OF ADULT ADHD

Dora Wynchank

This presentation will examine the controversy around the diagnosis of adult ADHD. The most recent estimates of epidemiology will be discussed. Diagnostic differences between child and adult forms of the disorder will be explored. Issues arising from self-diagnosis in adult ADHD will be explored as well as appropriate rating scales. Current understanding of the neurotransmitter basis of the disorder will be discussed with reference to treatment guidelines. Different treatment modalities and clinical outcomes will be covered.