



headline

SASOP

OFFICIAL NEWSLETTER OF THE SOUTH AFRICAN SOCIETY OF PSYCHIATRISTS

SASOP ANTI-STIGMA INITIATIVE



Emotional Health
BE THE BEST
YOU CAN

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The National Executive Committee has had a busy two months! A face to face meeting was held on 22nd May and a short teleconference was held on 26th June 2008. Here are some of the chief topics that were under discussion:

Nomination of office bearers: The time has rolled around again when we have to elect a new executive – this will happen at the AGM to be held at the Congress at Fancourt, George, on Wednesday 13th August 2008. The elected officials are the President Elect, Hon. Secretary and Hon. Treasurer. Nominations for President Elect have closed with two nominations having been received: Prof Y Moosa and Dr I Westmore. Nominations can still be made for the positions of Hon. Secretary and Hon. Treasurer.

Changing of subgroups/demarcation along DOH lines: The President envisages changing the existing demarcation to one that would accommodate all the geographical regions of SA. This would also facilitate better engagement with the Dept of Health in the various regions and ensure that there is representation when issues need to be addressed at a more local level. This will be discussed further at the July meeting, and possibly at the congress.

Guidelines for companies sponsoring CME weekends: This document which has appeared in draft form is being reworked following input and comments from colleagues and members of the industry. The Academic Development Committee will be meeting in due course to finalize it. It is hoped that there will be better co-ordination of industry sponsored SASOP endorsed CME events in future, following on from this collaborative process.

SASOP and rating scales: It has been agreed that SASOP should draw up a position statement re the use of rating scales, particularly as it seems that these are increasingly being required by funders and the like. P3 is to draw up the position statement which will be made available as soon as it has been completed.

Making the constitution compatible with Section 21: The current constitution is being revised and developed into a format that would reflect SASOP's new status as a section 21 company. These "Articles of Association" have already been distributed to the subgroups and other groups in SASOP for perusal and comment. A lawyer, Mr Marius Otto who has been working on this will be present at the AGM to present this document and show us where the changes are, and what the implications are, before it is adopted.

Mental Health Care Act: Adj Prof Moosa is heading a review of aspects of this Act (e.g. the forms being made more user friendly; implementation of the Act) and has distributed these to the subgroups for review and comment.

SASOP Treatment Guidelines: These have been developed and are ready for review. **Members and subgroups are requested to review these and to comment on them before the congress.** A session will be held at the congress to explain, and to finalize, these long awaited guidelines.

Please remember the AGM to be held on the 13th August at Fancourt at 16h00 – venue to be advised.

Dr Ian Westmore
HONORARY SECRETARY

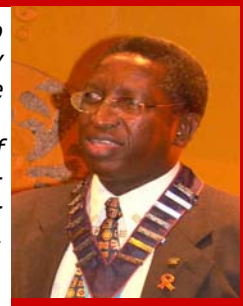
XENOPHOBIA AND THE PSYCHIATRIST: A PSYCHO-POLITICAL PERSPECTIVE

From the President's Desk

Siphatho Handi said, "One has also noted claims that the violent xenophobia is in response to the fact that foreigners are responsible for criminality in our communities. That they occupy RDP houses and rob South Africans of employment opportunities. Our view is that these are simplistic analyses that fail to grasp the root causes of the problem.

While we understand that our poorer communities are under serious pressure as the price of food and transport escalate, it is not going to help to conduct a witch-hunt trying to find somebody to blame. Indeed, the organised manner in which much of the violence has unfolded suggests there is an instigating hand behind it; not unlike the days prior to the 1994 elections, when anti-democratic forces aimed to destabilise the country."

Siphatho Handi is the ANC provincial secretary DAILY Dispatch on line 2008/05/23



Psychoiatry is a Public Health issue. The psychiatrist cannot ignore the politician and the "masses" and make an impact on the mental health of the nation. By remaining aloof from the happenings around him or herself, the psychiatrist leaves fertile ground for thought disorders and bankrupt attitudes to destroy the community and the chances of "a better life for all."

For starters, the psychiatrist has to be jealous that a term XENOPHOBIA has been bundled around recently, and associated with vicious, violet crime! In clinical psychiatry, PHOBIA is classified as a *specific disturbance in content of thought*, and is defined as a *persistent, irrational, exaggerated, and invariably pathological dread of some specific type of stimulus or situation, and results in a compelling desire to avoid the feared stimulus*. (Sadock&Kaplan) However, the definition says nothing about a desire to annihilate the stimulus or situation! XENOPHOBIA is succinctly defined as **dread of strangers**. Accepting that people meet strangers almost every hour of the day, and that, "**a stranger's just a friend you do not know**," it is odd that some South African residents attacked and sought to exterminate people from other countries, most of whom they had, anyway, already become accustomed to. Why at all there was the outbreak of violence and mayhem in May 2008, is an issue for the psychiatrist to figure out – but the intrigue lies in the fact that the patient this time is the Community; the Public and not the familiar individual Person or Family! The Community is at once the victim and the perpetrator. The therapy will have to be directed at the *body politik*. You and I have to figure out how we can intervene in a creative, effective, sustainable way. Where do we begin?

The Minister of Intelligence, Comrade Ronnie Kasrils says that, "socio-economic deprivation" was part of the constituents of tinder which underwent "spontaneous combustion" and resulted in the strife. The law and order agencies are working hard to contain the violence and find out who may be behind it. We are in the Health, Human Rights and Social Welfare sector, and more interested in what we can do NOW to help the displaced and bereaved. While we help the victims we must also seek ways to do secondary prevention of the Tsunami.

Let us visit the office of Mrs.N.Maphisa-Ngakula and her deputy minister of Home Affairs Mr. M.K.N.Gigaba. How they have defined and dealt with "refugees" and "illegal immigrants" has over the years laid the foundation for the conflict between citizens and immigrants. On their website they make the following observations:

"Refugee Affairs: Prior to June 2005, the Directorate of Refugee Affairs was characterised by a number of serious challenges, amongst others the lack of adequate capacity at management level and a lack of integrated systems. Those challenges played a significant role in the backlog that resulted in a backlog in asylum applications. It was established that the lack of a planning and structural model **in setting up refugee reception offices** had contributed to the current asylum crisis. Refugee Affairs is faced with multifaceted challenges. A dysfunctional operational structure (office structural design not catering for mass influx of asylum seekers and imbalances in the staffing of offices) and the poor business value of IT systems have impacted negatively on the efficient and effective management of refugee services.

"To ensure that clients are serviced in line with the Batho Pele principles, Service Delivery Standards and a Hand-Over Plan and Strategy on the Integration of Refugees were developed and discussed with the relevant stakeholders. Refugee Affairs provided inputs in the amendment of the Refugee Act and took an active part in international and tripartite meetings on refugee matters."

"Refuge Backlog Project The Ministry continued to coordinate the Refugee Backlog Project aimed at addressing the current backlog with regard to the finalization of applications for refugee status determination. The project was the result of an acknowledgement on the part of the Ministry of Home Affairs that the backlog in processing asylum seekers and refugees applications undermined our legal and international obligations to those who seek protection in our country."

Well, the refugees now internally displaced are flocking to police stations, churches and community halls. One of the Gauteng politicians said that they would also be put in, "disused government buildings which were **suitable for human consumption!**"

There is an irony is how the Mozambican government is handling the issue. They have declared this a national disaster akin to the floods they experienced recently. They are mobilizing the Disaster Management Team nationally, setting up "returnees" into Reception Centres" and mobilizing the Red Cross and Red Crescent and other NGO formations to manage the people. On the South Africa side, the Mozambicans are waiting at various places to board the buses ostensibly made available by the government for their return to motherland. Zimbabweans, on the other hand, are "between a rock and a hard place!" They must be taken care of urgently and preferably along the lines that the Mozambicans are being attended.

A year or two ago, while the stream of “illegal immigrants and refugees” was turning into a flood, several politicians when asked to set up **reception centres** or **camps** or **villages**, balked at the idea. They said it would be un-African, and in bad taste to do that. I think it is the same attitude in South Africa which informed the authorities to **deinstitutionalise the severely psychiatrically ill** and **integrate** them into homelessness and oblivion! Meanwhile, the flood dispersed all over Gauteng, especially to the informal settlements inhabited by South African Citizens – who probably should have been considered to have already been “internally displaced.”

I suggest that the Health, Welfare and Home Affairs departments as well as their Military equivalents, go ahead and set up **reception centres** in the periurban areas and in border areas where the refugees and immigrants can be housed and assisted. At such centres, a more humane accommodation could be available. Health and Welfare activists from the NGO's – including the South African Medical Association (SAMA), SASOP, the Red Cross, South African Council of Churches SACC, Red Cross, Red Crescent and the Islamic Relief Services – would then be able to assist in an orderly fashion and environment.

There is a tendency in some centres of power to equate the observance of law, order, discipline and decency with a violation of the constitutional and human rights of people! One has seen how a neighbouring country such as Botswana has a zero tolerance to anarchy, and is able to ensure a sustained growth and progress as well as peace of mind in their people.

It looks like as psychiatrists, we will have to include the question, “**do you dread strangers?**” routinely as we interview our patients and clients. Xenophobia **is** a psychiatric condition. Psychiatrists must get involved in managing it, and in influencing the politicians to be proactive in dealing with those communities in which socio-economic deprivation coexists with a poor or non-delivery of Social Welfare and Health services.

Dr Thabo Rangaka
SASOP PRESIDENT



SHOULD I BE ENCOURAGING MY DEPRESSED PATIENTS TO EXERCISE?

Patients often enquire of me how I manage to reduce my stress load, and being an avid cyclist, I respond that I try and get as much exercise as possible. I certainly find that I am better equipped to deal with stress when I am physically active and have recommended to patients who are “stressed out”; anxious and depressed

to follow suit. Is there any evidence to support this recommendation?

A topical issue currently is “metabolic syndrome” and we have been encouraged to especially monitor our patients that suffer from schizophrenia and/or those on atypical antipsychotic drugs rigorously to address those factors that make them vulnerable as far as this syndrome is concerned. It has also recently emerged that patients suffering from depression are at greater risk of suffering from **metabolic syndrome**, at a rate that is similar to that of schizophrenia¹. It would therefore be worth our while to consider anything, including physical exercise, which would reduce this risk in depressed individuals.

In a recent article by Greer and Trivedi, the **benefits of exercise for mood disorders** was considered². The authors allude to the fact that exercise has been associated with a reduced risk of depression, as well as reductions in depressive symptoms. This seems to be true for exercise as an entity on its own, but also in combination with antidepressant medication. It is however, agreed that rigorously controlled trials are needed to better understand the impact of exercise on this disorder.

When considering **exercise as monotherapy**, it was found to be efficacious for **mild to moderate major depressive disorder**. What was interesting is that in the study reviewed, age or gender did not have a significant effect - neither did exercise frequency, suggesting that the **amount** rather than the frequency of exercise is critical to mood improvement. Another study showed that efficacy of exercise is similar to that of sertraline.

When considering **exercise as an augmentation or combination treatment**, several of the reviewed studies showed positive findings. A study by Blumenthal et al. amongst older (aged 50-77 years) depressed patients who had mild to moderate major depression, found that group exercise was as efficacious as both medication and combined treatment in reducing symptoms of depression (although it remains to be answered whether the treatment effects were due to exercise, the social effects of the group, or a combination of the two). An extension of the study revealed that in an “exercise alone group” there was a significantly increased likelihood of recovery compared with the medication alone group, as well as a reduced likelihood of relapse in this group. The study also showed that regular aerobic activity was associated with a decreased likelihood of being classified as depressed at follow up².

Pretorius et al. looked at the effect of moderate exercise on the response to escitalopram in patients with major depression in an outpatient population, and found that the MADRS score from baseline was greater in the exercise group than the control group who did not exercise at week 1 and 2, but this did not reach statistical significance³.

Trivedi et al. conducted a study in patients who have shown a partial response to antidepressant medication. A beneficial effect of the addition of exercise was demonstrated by a reduction of 5.8 points in HAM-D₁₇ scores in the intent-to-treat analysis, and improvements in quality of life were also observed².

The potential benefits and clinical applications of exercise are explored by Stein et al in what is referred to as the “**cognitive-affective neuroscience of exercise**”. They reviewed several studies which have demonstrated that in humans, exercise results in acute changes in cerebral blood flow and glucose uptake and can improve brain function and cognitive performance. It is postulated that a range of neurotrophic, neuroendocrine, neuropeptide, and neurotransmitter systems could be implicated⁴. The authors suggest that “it can be argued that an **assessment of exercise should be part of the psychiatric interview**”. They conclude that “current understandings of the cognitive-affective neuroscience of exercise consistently emphasize the positive value of an active lifestyle on brain and cognitive-affective function, and, thus, as an important determinant of the quality of life if not its duration”.

Does it matter what **time of day** we exercise? A review by Trine and Morgan on the influence of time of day on psychological responses to exercise conclude that research on circadian rhythms of perceived exertion and mood states are equivocal, and the limited research on anxiety suggests that the anxiolytic response to exercise is not influenced by the time of day⁵. I found this interesting, because I have always understood that the best time to exercise for the *metabolic* benefits is in the morning, whilst the best time for *stress reduction* is in the early evening.

I have also been under the impression that it is agreed that aerobic exercise is more beneficial for patients with mood disorders, compared to anaerobic exercise. What about **yoga** then? Pilkington et al. reviewed the research evidence for yoga on depression, and found that overall, there seem to be potentially beneficial effects of yoga interventions on depressive disorders⁶. When considering physical activity dose-response effects on outcomes of depression and anxiety, Dunn et al. concluded that both resistance training and aerobic exercise can reduce symptoms of depression⁷.

Hoffman and Hoffman suggest that aerobic exercise may be beneficial for our patients who have a **mood disorder and chronic pain**. They state that aerobic exercise can cause an acute improvement in mood as well as a reduction in the perception of pain from a painful stimulus, and that regular exercise training may also offer some protection from depression⁸.

Daley et al reviewed the literature on the role of exercise in **treating postpartum depression**. So-called “pram walking” seems to be useful as an adjunctive treatment for postpartum depression. Two small randomized controlled trials conducted in Australia support exercise as a useful treatment for women with postpartum depression⁹.

There is considerable support for the use of exercise in mood disorders. There are several **neurochemical systems** relevant to depression that are altered by exercise. Physical activity has been associated with increased levels of neurotrophic factors, neuromodulators, and neuroamines, including brain-derived neurotrophic factor (BDNF mRNA, particularly in the hippocampus), noradrenaline, serotonin, and phenylethylamine². Duman posits that exercise and enriched environment increase neurotrophic support and **neurogenesis**, which could contribute to the blockade of the effects of stress and aging and produce antidepressant effects¹⁰.

Most of the work done as far as exercise and mood disorders is concerned relate to depression. There seems to be very little investigation related to **bipolar disorder**. There has been one pilot study that evaluated symptoms in inpatients diagnosed with bipolar disorder who elected to regularly participate in a walking program in addition to their ongoing treatment. Regular participants in the walking program had significantly lower Depression Anxiety Stress Scales (DASS) than did non-participants, although neither CGI improvement nor CGI severity were significantly different between groups².

Can exercise be bad for you? There *are* indications that **physical activity can compromise mental health, especially when performed in a more intense manner**. The Centers for Disease Control and Prevention (CDC) and the American College of Sports Medicine (ACSM) have endorsed the following consensus “public health message”: “every North American adult should accumulate 30 minutes or more of moderate-intensity physical activity on most, preferably all, days of the week”. But, according to Peluso and de Andrade, on a medium and long-term basis, mood improvement seems to be associated with moderate-intense physical activity, while *worsened* mood has been reported after high-intensity exercise lasting for 10 days to some weeks¹¹. This is a phenomenon seen in “excessive training” or the so-called “**overtraining syndrome**”. Symptoms include problems such as sleep disturbance, loss of weight and appetite, reduced libido, irritability, heavy and painful musculature, emotional lability, and depression. Rest seems to be the only known treatment for this condition.

Conclusion

In their review, Greer and Trivedi come to the following conclusions, which should be helpful to us in making a decision about the “prescription of exercise” to our depressed patients:

- The amount of exercise consistent with current public health dose guidelines in the USA i.e. approximately 30 min/day on most days of the week, appears to be helpful in reducing depressive symptoms.
- Physicians should encourage the use of supervised or group exercise to facilitate adherence to an exercise program.
- Encouraging patients to track their exercise behaviour is helpful to ensure continuation.

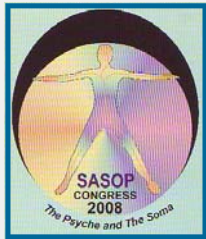
But, as the authors point out, there is still a need for a great deal of research in this area. Future clinical trials should aim to be better at defining the amount and type of exercise that depressed patients should be engaging in, as well as long term studies that determine the potential of exercise to prevent relapse and recurrence of depressive episodes².

As for me, I will continue to advise depressed patients to engage in moderate, regular exercise as part of the comprehensive approach to treating this ever increasing disease. Admittedly, this is difficult as depressed patients often do not feel like doing *anything* – let alone exercise, but I think that it is worth the effort.

References available upon request.

Dr Ian Westmore

SASOP Congress 2008



George. The beautiful surroundings and varied leisure activities available at and close to the congress venue should allow for a truly relaxed atmosphere in which to enjoy a variety of stimulating topics. The topics were carefully selected to specifically complement the congress theme of "psyche and the soma".

As such we have a number of invited national and international speakers focusing on what the psychiatrist should know with regard to:

1. cardiovascular risks (including ECG interpretation for the psychiatrist) – Dr Bodenstern
2. diabetes and related risks (how, what & when) – Dr Lombard
3. basic life support (newest guidelines to resuscitation) – Dr Louw
4. sleep disturbances – Dr Cunningham

As each of us is well aware the medical (and specifically psychiatric) profession in Africa is faced with, amongst others, a serious manpower shortage. In response to this ongoing challenge Prof Patel has been invited to address us on the issues of service delivery and finding answers to the brain drain dilemma in Africa. An extended parallel session on poverty and mental health has also been included. Prof Gureje will also highlight the impact of culture on depression.

Dr Allers will deal with the challenges in private practice and a session has been dedicated to ethical dilemmas within our field. State psychiatrists will be pleased to note that Prof Szabo has put together a session addressing SESIG concerns which includes a discussion on the proposed occupation specific dispensation. Within the child & adolescent field focus will be placed on ADHD and psychopharmacology updates. Those with an interest in psychogeriatrics can look forward to an in-congress workshop with a variety of topics chaired by Dr Potocnik.

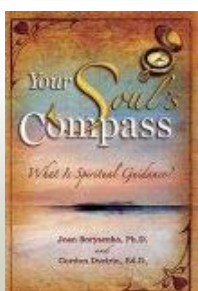
We are pleased to announce that we will be introducing the first presidential session (in the future to re-occur at each congress). This will take place on Tuesday afternoon and will consist of topics and speakers selected by the president of SASOP (Dr. Rangaka) in line with the theme of his presidency.

We also invite delegates to join us for the pre-congress workshops. Prof Seedat has put together an informative workshop dealing with all aspects of clinical trials, while Dr Joubert will address issues related to treatment-resistant depression.

It need not be work only, the welcome reception will also take place at Fancourt and should not be missed as Marc Lottering will provide local flavour to the entertainment! Delegates will also be spoiled for choice as several breakfast symposiums will be sponsored by the trade. The gala dinner will be on Wednesday at the historical railroad museum in George.

We encourage all the delegates who wish to apply for sponsorship to urgently check whether their SASOP membership has been paid for 2008 and to then apply via the SASOP website. Updated sponsorship lists are available in the secure section of the SASOP website. The organizing committee would like to take this opportunity to also thank the industry for their excellent support thus far and look forward to welcoming everyone at Fancourt!

Dr Dana Niehaus & Prof Piet Oosthuizen
CONGRESS CONVENORS



Your Soul's Compass

by Joan Borysenko, Ph.D. & Gordan Dveirin, Ed.D.

Hay House, 2007

"An elegant, simple, and practical guide to get in touch with your higher self and experience the field of infinite possibilities." – *Deepak Chopra*

Book Club



The past few months have been challenging due to the many changes in the macro- and micro environment.

As the Department of Health is struggling to contain the cost of healthcare in the private and public sector, the challenges of ever increasing inflation has made the task very difficult. The threat to the sustainability of the private sector and service delivery in the public sector has been high on the agenda of the Department of Health.

The primary focus of the Department of Health appears to be fixing the problems in the private sector and not that of the public sector. This is confusing, especially in the light of the Department having management control over the public sector.

Several important events have prompted SASOP P3 to adopt a strategy to analyse the problems with a proactive stance and to suggest solutions to the Department and other roleplayers in the market. The threat from the Department of Health's apparent solutions for us has forced this proactive approach. The fear is that these solutions will not be appropriate and could jeopardise our standing.

The need from the Department is to broaden access to health care and to reduce cost, in our case, specifically psychiatric care and cost. We thus need to devise models where we can broaden access and streamline costs to provide services at a reduced cost, while still retaining our income, and prove that we have addressed the needs of the Department and the demands of South Africans.

One of the problems with the present model of funding of patients in the private sector is the fee-for-service model. The fee-for-service model has inherent problems of over-servicing, but has the advantage of good service. The model on the other extreme of the spectrum is capitation. Capitation presents a model where a specific number of patients are assigned to a specific health care provider and the total amount to care for those patients is given to the provider in advance. The provider is then expected to pay for all the care, special investigations and treatment of the patient, including specialist care. This leads to severe under-servicing of patients with poor quality of care. A model incorporating a system between these two extremes has to be investigated and explored. As there could be many models on this spectrum, none of the models are proposed as the only model, and some or all of the models can be operational at any given time. On the extreme, it does not have to exclude the two models either.

To be able to find solutions to these problems, we need information and input from every psychiatrist in order to get advice and to move forward. In this process we also need to keep the aims and intentions of the Department of Health in mind in creating a National Health System. We need to define private practice in this environment as we do not want our position to be compromised.

COST STUDIES

The 2008 for 2009 cost study was submitted to the NHRPL Committee at the DoH. The cost study shows that psychiatrists in private practice are under-remunerated and we motivated an increase for the Rand Conversion Factor from R13-54 to R21-21, an increase of 57% for 2009. We have to keep in mind that the DoH did not previously calculate VAT on the submission for 2006, thus an increase of 43% is asked for and a correction for VAT.

We want to thank psychiatrists who submitted their data to Healthman to enable us to submit our cost study. We eventually had 76 cost studies and Healthman could use 70 of the submissions.

We did a comprehensive search to determine which psychiatrists still work in the private sector and the number of psychiatrists in full time private practice was established at 187. The number of psychiatrists in part time private practice is apparently 56 members, thus 243 are estimated to be psychiatrists in private practice. The data was gathered from the databases of medical schemes of psychiatrists who have submitted any claims to the medical schemes in the past year and cross matched with the SASOP database.

41% of psychiatrists in full time private practice responded thus far to the request for submitting a cost study, placing us by far at the very top of all specialties compared to the response rates of other specialties. Again, thank you for the response.

The Healthman report on the cost study is available on www.sasop.co.za under the SASOP P3 closed section. Any queries can be directed to Dr Eugene Allers, kopshop@global.co.za.

PMB's

The Council for Medical Schemes is again working in a new set of PMB's. We are actively working with the CMS to change and update the present set of PMB's. We are not too hopeful to get the changes we want as the CMS has not even yet published the bipolar algorithm, but we will work relentlessly on the issue.

A new set of PMB's have been drafted with better wording and ICD-10 and DSM compliancy. We have also motivated for ADHD to be included as a PMB condition.

continued on pg 7

PROCEDURAL CODING

SASOP P3 is actively working with SAMA on a new coding structure with all role-players in the industry.



A meeting with representation of most of the specialist groups, general practitioners groups, the dentist and dental specialists, the pharmacists, the psychologists, the all the hospital groups, medical schemes that represent more than 50% of the industry and consultants were held in Johannesburg.

Work on this is planned to finish in 3 years time. The process is important to ensure that the determination of the scope of practice of doctors remain within the domain of doctors.

We are investigating the ACHI, the ICD-10-PCS, the CCAM and CPT4 procedural coding structures for use in South Africa as part of the national procedural coding structure.

SERENITY

The Serenity is now a publication of SASOP, with a full sponsorship from Wyeth until the end of this year. Dr Eugene Allers is the Editor.

CODES FOR PMB'S

It has come to the attention of P3 that medical schemes ask for PMB codes on chronic forms. Apart from the ICD-10 code which is asked for (still illegally and unethically of course), they also ask for the codes as per the Medical Schemes Act regulations. As we are forced to supply the codes to ensure re-imburement for the patient for services rendered, tests performed and treatment given, we hereby also attach the list of codes to be used if requested by the medical scheme.

CODE:	DIAGNOSIS:	TREATMENT:
182T	Abuse or dependence on psychoactive substance, including alcohol	Hospital-based management up to 3 weeks/year
910T	Acute delusional mood, anxiety, personality, perception disorders and organic mental disorder caused by drugs;	Treatment: hospital-based management up to 3 days
901T	Acute stress disorder accompanied by recent significant trauma, Including physical or sexual abuse	Hospital admission for medical/psychotherapy up to 3 days; counselling
910T	Alcohol withdrawal delirium; alcohol intoxication delirium	Hospital-based management up to 3 days leading to rehabilitation
908T	Anorexia nervosa and bulimia nervosa	Hospital-based management up to 3 weeks/year or minimum of 15 outpatient contacts per year
903T	Attempted suicide, irrespective of cause	Hospital-based management up to 3 days or up to 6 outpatient contacts
184T	Brief reactive psychosis	Hospital-based management up to 3 weeks/year
910T	Delirium: amphetamine, cocaine, or other psychoactive substance	Hospital-based management up to 3 days
902T	Major affective disorders, including unipolar and bipolar depression	Hospital-based medical management up to 3 weeks/year (including inpatient electroconvulsive therapy and inpatient psychotherapy) or outpatient psychotherapy of up to 15 contacts
907T	Schizophrenic and paranoid delusional disorders	Hospital-based medical management up to 3 weeks/year
909T	Treatable dementia	Admission for initial diagnosis; management of acute psychotic symptoms – up to 1 week

NATIONAL HEALTH AMENDMENT BILL

The Department of Health published an amendment to the National Health Act to establish a facilitator and tribunal to determine the fees for doctors on private practice.

SASOP joined SAMA and other specialist groups to comment on the Bill and we have already had a meeting with the DoH on this issue.

We are deeply concerned that this act might lead to an end of private practice in South Africa. The purpose of the act is positive and agreeable, but the methods used to achieve these goals are not perceived to solve the problems in the Health Sector.

Dr Eugene Allers - CONVENOR: P3



To lose is not a sin, but to give up is a tragedy. - Robert A Schuller

Anytime you doubt your capabilities or downplay your accomplishments or show indifference to your potential, you become your own worst enemy. - Robert A Schuller

Set aside fifteen minutes every day when you will not be bothered by anybody, for anything. - Martha Beck

Every day, give yourself at least three really good treats; one for every risk you take, and two just because you're you. No exceptions, no excuses. - Martha Beck

ARE SASOP TREATMENT GUIDELINES READY???

The Guidelines, Protocols and Algorithms for the treatment of psychiatric disorders were initiated by the Clinical Peer Review Committee of the South African Society of Psychiatrists (SASOP), the Anti-Stigma Initiative of SASOP, SASOP P3 (Psychiatrists in Private Practice) and the SASOP Academic Development Task Team.

A consensus meeting was held from the 15th to 18th of June 2006 in Gauteng to develop the first draft of the guidelines.

The following disciplines participated: Psychiatrists (state, private and military); Clinical Psychologists; General Practitioners; Occupational Therapists; Social Workers and Physiotherapists; Psychiatric Nurses; Medical Advisors / Risk Management Consultants; BHF; the Pharmaceutical Industry; Hospital Services Managers / Psychiatric Case Managers; and a Representative for Council for Medical Schemes on PMBs and chronic care.

The 12 Disorders Covered by the Guidelines are Major Depression, Bipolar Disorder, Schizophrenia, Panic Disorder, GAD, OCD, PTSD, Eating Disorders, Delirium, Dementia, ADHD and Substance Abuse Disorders.

The SASOP Guidelines "Working Group" consisting of Dr Eugene Allers (Convenor), Dr Thabo Rangaka, Prof Margaret Nair, Dr Franco Colin, Dr Gerhard Grobler (assisted by a clinical psychologist, Mr Gerhard Grundling) then **fine-tuned the guidelines** emerging from the consensus meeting, and ensured that the guidelines were in keeping with **the latest scientific clinical research and international guidelines**.

The SASOP Guidelines are Unique in that the guidelines have two arms or wings;

1. The Diagnostic & Treatment algorithm, and 2. The Level of Care algorithm – unique to SASOP guidelines.

On 29th May 2008, Dr Gerhard Grobler wrote to **all subgroups** asking that certain psychiatrists from the 'working group' present the treatment guidelines - i.e. the process of how the guidelines were developed and examples of actual guidelines - to subgroup members. Sponsorship for the meetings was obtained by the working group. **Approval from SASOP members was felt to be of critical importance** as the guidelines could then be **formally adopted at the SASOP annual general meeting at the congress**. Only the Eastern Cape subgroup responded. A reminder was sent out on 17th June 2008 and still no other responses were received. The President, Dr Thabo Rangaka then sent out a letter to all subgroup chairpersons from the president's office asking for the guidelines to be presented to SASOP members. There are still no other responses. The guidelines will be presented to the **Eastern Cape Subgroup** on 26/07/08. **SASOP members should kindly note that permission for feedback from the working group to members has been sought**. The President, Dr Rangaka, thanks the subgroup that responded (via Prof Alonso). A treatment guidelines presentation workshop has now been arranged for the SASOP National Congress at Fancourt.

P3 AND ACADEMIC DEVELOPMENT COMMITTEE

headline Editorial Team

Editor: Margaret Nair kapdoc@mweb.co.za

Assistant Editor: Eugene Allers kopshop@global.co.za

Honorary Secretary: Ian Westmore westmore@axxess.co.za

Webmaster: Gerhard Grobler gpgrabler@absamail.co.za

Administrative Secretary: Alta Valsamis Aletta.Maritz@wits.ac.za

Editor's Assistant (Typing, Layout and Graphics): Winston Padayachee

