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THE SOUTH AFRICAN DEPRESSION AND ANXIETY GROUP

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Making Mental Health Matter

A NEW MENTAL HEALTH POLICY FOR SOUTH AFRICA

On 30 March 2023 a new national Mental Health Policy and Strategic Plan framework (2023-2030) was adopted by the Department of Health's National Health Council. This marks an historic development for mental health in South Africa, as the policy sets out a new vision, mission, and strategic plan for improving the mental health of the nation.

The new policy framework is an update of the previous National Mental Health Policy Framework (2013-2020), which had lapsed. The previous policy had been developed following an extensive consultation process involving 8 provincial mental health summits and engagement with over 4,000 stakeholders across the country in 2012 and 2013. Unfortunately, there were major challenges with the implementation of the previous policy. Many of the targets set out in that policy were not achieved and the Life Esidimeni tragedy occurred in 2016, during the tenure of this policy. Many have argued that if the previous policy had been properly implemented, with its targets of developing community based mental health care, Life Esidimeni would never have happened.

Nevertheless, the new mental health policy represents an opportunity for all of us engaged in mental health work in South Africa to come together, learn from the experiences of the past, and to renew our commitment to improving mental health care, protecting the human rights of people living with mental health challenges, and preventing mental health conditions in our communities.

So, what is in the new policy, and how does it differ from the old one? The new policy document begins by setting out the scope of the policy and the context within which this policy has been developed. It includes updated epidemiological data on the prevalence and determinants of mental health conditions, updated evidence on levels of current service provision, and recent research demonstrating effective interventions in our country. It also sets out the links with relevant norms, policies and legislation mandates in South Africa.

Importantly, the policy provides new data on the economic costs of mental illness and the potential return on investment from scaling up mental health services in South Africa. This evidence was generated by a national mental health investment case commissioned by the National Treasury and the Department of Health in 2019. The investment

Professor Crick Lund
Clinical Psychologist and Researcher
King's College London and University of Cape Town

case shows that the economic value of restored productivity over a 15 year scale up (from 2020 to 2035) amounts to R117.7 billion when quantifying the social value of the investment. In other words, it makes good economic sense to invest in mental healthcare and prevention.

The new mental health policy document also sets out a new vision: "Comprehensive, high quality, integrated mental health promotion, prevention, care, treatment and rehabilitation for all in South Africa by 2030." The mission of the policy states: "From infancy to old age, the mental health and well-being of all South Africans will be enabled through the provision of evidence-based affordable and effective promotion, prevention, treatment and rehabilitation interventions. In partnerships between providers, people with lived experience, carers and communities, the human rights of people with mental health conditions will be upheld; they will be provided with care and support and they will be integrated into normal community life."

The new policy document also sets out "Areas for Action", including organisation of services, financing, promotion and prevention, intersectoral collaboration, advocacy, human rights, special populations, quality improvement, monitoring and evaluation, human resources and training, psychotropic medication, and research and evaluation of policy and services.

The final section of the policy document is a strategic plan which includes 8 specific objectives, with related key activities, targets, dates and indicators. The objectives are:

1. To strengthen district and primary healthcare based mental healthcare services including the establishment of one District Mental Health Team in each district in the country. The role of District Mental Health Teams is to adopt a public health approach to the mental health of their district: conducting a situation analysis, coordinating mental health stakeholders and developing and implementing a district mental health plan – a crucial and proven means of coordinating and delivering services at local level.
2. To build institutional capacity for mental health at national, provincial and district levels, including the establishment of Provincial Mental Health Directorates in each province and ensuring the availability and functionality of the Mental Health Review Boards in keeping with the Mental Health Care Act of 2002.
3. To conduct mental health surveillance and research and to strengthen innovation, including establishing a national mental health research agenda in partnership with all relevant research stakeholders.
4. To develop and improve infrastructure and capacity of mental health facilities, including mental health inpatient units in designated district and regional hospitals and revitalising dilapidated mental health facilities in all provinces.
5. To monitor and improve the availability of mental health technology, equipment and medicines.
6. To strengthen intersectoral collaboration at national, provincial, and local levels.
7. To increase and strengthen human resources for mental health including training of primary healthcare staff in basic mental health care to improve detection, care, and referral of people with mental health needs.
8. And finally to strengthen mental health promotion, prevention and advocacy; including establishing a national education programme for mental health to improve knowledge about mental health and reduce stigma and discrimination against people living with mental health conditions. This includes a strong emphasis on the prevention of suicide including through the establishment of a suicide helpline.

The new Mental Health Policy Framework and Strategic Plan (2023-2030) was presented to the public for the first time at the National Mental Health Conference attended by approximately 700 delegates in Johannesburg on 24 to 25 April 2023. Although the policy was generally welcomed, those attending the conference expressed frustration with the poor implementation of the previous policy. Many also spoke about the urgency of implementing the new policy, given the daily reality faced by thousands of people living with mental health conditions: inadequate services, a treatment gap exceeding 90%, and widespread stigma, depriving people of their right to care and dignity.

This is the challenge that now faces all of us: how do we translate a mental health policy with its lofty ideals into reality in our communities? In short, how do we ensure that it makes a real difference in people's lives? A key barrier in implementing the previous policy was the failure of some provincial Departments of Health to allocate budgets to implement the policy. Indeed, some provinces actually cut mental health spending, with the Life Esidimeni tragedy in Gauteng being a case in point. It is therefore vital that we hold provincial governments to account to deliver on the policy, particularly for vulnerable groups such as children and adolescents, people living in poverty and older adults.

Now more than ever before we know what needs to be done to provide effective and humane care and to prevent mental health conditions across the life course. With a new policy providing direction to government and civil society, we have an opportunity to unite behind the policy from diverse sectors of society and implement it. Mental health is everybody's business. The time to act is now.

References available on request. MHM

SADAG CONTACT DETAILS
www.sadag.org
Tel: 0800 21 22 23
Tel: 011 234 4837
Email: zane@sadag.org

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Dr Alicia Porter
Psychiatrist
Johannesburg

SELF-HARM 'THE NEW ADOLESCENT MENTAL HEALTH PANDEMIC'

There has been a significant increase in self-harm in the last decade among adolescents with the prevalence rates increasing due to the heightened levels of stress, anxiety, and depression within their age group. It's one of those symptoms that create a sense of helplessness in parents, caregivers and teachers as well as healthcare professionals with self-harm amongst the commonest reason for referral to child and adolescent mental health services.

Adolescent self-harm is a major public health concern, and prevention and treatment require universal measures aimed at youth in general and targeted interventions in those groups identified as high risk. The risk factors for self-harm include genetic vulnerability, psychiatric, psychological, familial, social and cultural factors. The effects of media and contagion play an important contemporary role. Self-harm often creates confusion among healthcare professionals, and it's important for healthcare professionals to gain a better understanding of what self-harm is, the function and triggers of self-harm, and the assessment and management of adolescents who self-harm.

WHAT IS SELF-HARM?

Self-harm is defined as any form of intentional non-fatal self-poisoning or self-injury (such as cutting, taking an overdose, hanging, self-strangulation, restricting, etc.), regardless of motivation or the degree of intention to die. Only a small percentage of individuals who self-harm present to the hospital and this behaviour is largely hidden (from clinical services) at the community level. Fear of stigma, and reactions of parents, peers, and other adults are among the reasons that adolescents who self-harm, don't seek help.

HOW COMMON IS SELF-HARM?

The age of onset is approximately 12 years, although there is a stronger association with puberty rather than chronological age. Self-harm is more common in adolescent females than males and community studies show a prevalence of 10% of adolescents reporting self-harm. The male: female ratio in 12–15-year-olds is 1:5-6. Presentation to the hospital only occurs in approximately one in eight adolescents who self-harm, with overdose being the commonest presentation. Research shows that fifty percent of adolescents who self-harm will use self-harm repeatedly.

WHAT ARE THE FUNCTIONS OF SELF-HARM?

The major purpose of self-harm appears to be affect regulation and management of distressing thoughts. When an adolescent feels overwhelmed by negative feelings, self-harm can be an effective, although maladaptive strategy to stop or reduce the negative thoughts and emotions. Experimental data support the affect regulating aspect of self-harm, as adolescents with self-harm demonstrated higher levels of physiological arousal during a stressful task compared to adolescents without self-harm. Self-harm is associated with a rapid decrease in heart rate. Self-harm may also regulate emotions by increasing the affective experience, as they may have a subjective experience of being 'emotionally numb' or 'empty'

or feeling disconnected from others. Others may feel a sense of 'pain relief', or a sense of control, or excitement or to stop a dissociative experience. It may also serve as an interpersonal function for the adolescent, as it may elicit positive re-enforcement, in the form of attention from others, or may assist in avoiding difficult situations, or the threat of self-harm may cause adults or peers to decrease interpersonal pressure.

FUNCTIONS OF SELF HARM
AFFECT REGULATION • Anxiety • Frustration • Depression
CHANGE COGNITIONS • Distraction from problems • Stopping suicidal thoughts
SELF PUNISHMENT
STOP DISSOCIATION
INTERPERSONAL • Secure care and attention • Fit in with pee

RISK FACTORS FOR SELF HARM

There are multiple and variable predisposing factors that contribute to self-harm and includes the following:

1. Sociodemographic and educational factors
   a. Female gender
   b. Low socioeconomic status
   c. LGBTQ+ adolescents
   d. Poor academic achievement
2. Individual negative life events and family adversity
   a. Parental separation or divorce
   b. Death of a parent
   c. Adverse childhood experiences
   d. History of physical or sexual abuse
   e. Parental psychopathology
   f. Marital or family discord
   g. Bullying
   h. Interpersonal difficulties
3. Psychological and psychiatric factors
   a. Psychiatric disorders especially anxiety, depression, and ADHD
   b. Drug and alcohol misuse
   c. Low self-esteem
   d. Poor problem solving
   e. Perfectionism
   f. Hopelessness

THE SIGNS TO LOOK OUT FOR?

1. Unexplained cuts, bruises, or burns, often on wrists, arms, thighs and chest
2. Wearing long sleeves and trousers or tights, even in hot weather
3. Refusing to get changed in front of other people, for example for PE or in changing rooms
4. Signs of hair pulling
5. Changes in eating habits - over-eating or under-eating
6. Exercising excessively

CASE EXAMPLE

Rachel was a 15-year-old girl whose parents were currently going through a divorce. Her father had moved out of the house and she was seeing him once a week. They had shared a very close relationship and Rachel secretly hoped that her parents would get back together. She was at home when her father came to fetch her for her weekly visits when she heard her parents arguing. She immediately went upstairs to her bedroom, locked the door, and cut herself on the wrist several times with a razor blade. Although she wore long sleeves to his house that evening, her father spotted the wounds and brought his daughter to the emergency room, saying his daughter had tried to kill herself. Rachel, however, stated emphatically that she did not want to die. "I cut myself because it made me feel better," she said.

A consulting psychiatrist interviewed Rachel in the emergency room. A nurse had warned the psychiatrist that Rachel was "borderline" and "gamey," stating, "She just cut herself for attention. Don't let her manipulate you." However, after an extensive interview with Rachel, there were insufficient criteria to merit a diagnosis of borderline personality disorder. In fact, despite her obvious problems coping with distress, Rachel did not meet the criteria for any major mental disorder in the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition. (DSMV)

Rachel explained to the psychiatrist that she cut herself because it was "calming." She said that a year ago she first started pinching herself as a way to hurt herself. One day she saw her brother's razor blades and started cutting herself on her arms. "It helps me chill," she said. "My mind slows down, I stop crying, and I just feel better." She said the razor slicing into her skin did not hurt badly—just enough for her to "feel alive." She felt so much better after cutting herself that afternoon that she was able to concentrate on her homework and not think any more of her parent's conflictual relationship and impending divorce.

ASSESSMENT AND TREATMENT OF SELF HARM

1. Complete a comprehensive assessment that includes the following:
   a. History and physical examination
   b. Identify co-morbid psychiatric conditions
   c. Suicide risk assessment
   d. History of physical or sexual abuse
   e. Substance abuse history
   f. Evaluation of risk factors
   g. Evaluation of social support and family functioning
2. Identify the function and characteristics of the self-harm
   a. Antecedents- situations/ stressors leading to self-harm
   b. Characteristics-frequency, intensity, duration
3. Develop a therapeutic alliance based on acceptance and validation strategies (non-judgmental)
4. Treat co-morbid psychiatric conditions
5. Target behavioural interventions for self-harm based on behavioural analysis and the need for the following:
   a. Affective language skills
   b. Self-soothing skills
   c. Communication skills
6. Provide psychoeducation for the patient and the family
7. Monitor response to behavioural interventions for reducing self-harm
8. Consider dialectical behaviour therapy(DBT) (treatment of choice for self-harm) and family therapy

CONCLUSION

Self-harm among adolescents is common and has increased significantly. While many adolescents with self-harm may not have severe psychopathology, adolescents presenting with self-harm should have a thorough psychiatric assessment that includes screening for suicidal ideation and risk factors. It's important to assess family and other interpersonal supports as part of the treatment plan. Pharmacological treatment is indicated for the treatment of comorbid psychiatric conditions. Psychotherapy is the treatment of choice, to assist with the development of more adaptive coping skills and should be initiated early.

References available on request. MHM

Ronel Aylward
Registered Nurse, General Nursing, Midwifery and Psychiatry.
Nursing Administration and Community Health, Stellenbosch University.

ADHD IN ADULTS

NAVIGATING CHALLENGES IN A HOSPITAL SETTING

Attention-Deficit/Hyperactivity Disorder (ADHD) is often associated with children, but it is a condition that can persist into adulthood.

In 2015, Dr Schoeman conducted the first study in South Africa to investigate the prevalence and treatment of specifically adult ADHD. According to the study, the prevalence of adult ADHD was estimated at 1.09% lower than previously thought. However, according to the study, the lower prevalence rate may be attributed to lack of awareness of the disorder, lack of access to diagnosis and treatment, and poor coding habits of healthcare practitioners…

According to Dr Schoeman, even though adult ADHD is established as a recognised disorder abroad, In South Africa, the diagnosis of ADHD is hampered by a lack of awareness of the disorder, non-recognition of the disorder, and a lack of access to diagnosis.

CHALLENGES FACED BY ADULTS WITH ADHD IN A HOSPITAL SETTING

One of the primary challenges is managing daily routines and schedules, which are often highly structured and regimented in a hospital. Patients with ADHD may struggle with time management, keeping track of appointments, and adhering to medication schedules, which can impact their overall care and recovery process.

Coping with the sensory environment of a hospital can be overwhelming with bright lights, loud noises, different smells, dietary restrictions, and constant activity, which can be distracting and trigger sensory sensitivities in individuals with ADHD. These sensory distractions can disrupt their ability to concentrate, relax or even sleep while in hospital.

Patients with ADHD rely on medication to manage their symptoms, but in hospital, medication schedules may be changed, and access to medication may be restricted. This can disrupt their established medication routines and affect their symptom management, potentially leading to increased difficulties in coping with their condition. Shift changes, disruptions to routine, and unfamiliar environments may make it difficult for individuals to adhere to their medication schedule, potentially leading to a worsening of symptoms.

Communication can also be challenging for adults with ADHD in a hospital setting. They may struggle with verbal instructions, miss valuable information during conversations, or have difficulty expressing their needs and concerns clearly. This can impact their ability to communicate effectively with healthcare providers, understand their treatment plans, and participate in decision-making about their care.

Individuals with ADHD may struggle with processing information and following instructions, particularly in a fast-paced and high-stress environment like a hospital. They may have difficulty focusing on key details, listening attentively, or organising their thoughts effectively, which can impact their ability to communicate with healthcare providers.

Impulsivity and hyperactivity are common symptoms of ADHD. In a hospital, these traits can be challenging to manage, especially when patients need to stay still or remain calm during procedures, tests, or treatments. The need for extended periods of sitting or lying down can be particularly demanding for individuals with ADHD, leading to restlessness and difficulty complying with medical instructions.

Hospital settings often involve multiple appointments, procedures, and tests. Adults with ADHD may struggle with time management and organisation, leading to missed appointments or difficulties in adhering to schedules. This can result in delays in receiving appropriate care and increased frustration for both the patient and the healthcare team.

Emotional dysregulation is another common challenge for adults with ADHD. Stress, pain, and uncertainty in a hospital setting can exacerbate these emotional difficulties. Managing anxiety, frustration, and other intense emotions can be a significant challenge, potentially impacting the overall well-being and cooperation of the patient.

Transitioning from the hospital back to everyday life can be challenging for individuals with ADHD. They may struggle with maintaining follow-up care, understanding discharge instructions, or organising necessary appointments and medications.

STRATEGIES THAT CAN BE HELPFUL IN SUPPORTING ADHD PATIENTS IN A GENERAL HOSPITAL SETTING

Creating a consistent and structured daily routine can be immensely helpful for individuals with ADHD. Healthcare providers can collaborate with patients to establish a schedule that includes regular mealtimes, medication administration, and other activities. Visual aids, such as calendars or schedules, are useful for the health care providers to help patients keep track of their daily routines.

Providing a quiet and calm environment, with dimmer lights and reduced noise levels, can help minimise sensory distractions for patients with ADHD. Dimming lights for an hour during the day and displaying a notice board "quiet time" would be a good example. Access to sensory aids, such as noise-cancelling headphones or fidget tools, can also be beneficial. Admitting the patient in a private or semi-private room will alleviate the noise disturbances.

Changes in the dietary requirements of the patient should be discussed, and involving a dietician would be beneficial to the patient.

Healthcare providers should be aware of the unique medication needs of patients with ADHD. Efforts should be made by the health care worker to maintain consistency in medication schedules and dosages, and patients should be educated about any changes in their medication routine.

Healthcare providers should use clear and simple language when communicating with patients with ADHD. Patients should be encouraged to ask questions and express their concerns, and healthcare providers should actively listen and provide additional support as needed. Patients should be kept informed of the activities and should there be any change in the activities it must be clearly communicated to the patient.

Recognising that every patient with ADHD is unique, individualised care plans should be developed to address their specific needs.

TIPS TO SHARE WITH YOUR ADHD PATIENTS WHEN IN HOSPITAL:

Navigating challenges related to ADHD in a hospital setting can be demanding, but with proper strategies and support, you can effectively manage your symptoms and ensure a successful experience.

- Inform the hospital staff: Notify the hospital staff about your ADHD diagnosis and any specific accommodations you may require.
- If you take medication for ADHD, ensure that you have an adequate supply with you during your hospital stay. Should the medication be prescribed as chronic your own supply will be used.
- Plan to minimise stress and disorganisation by making use of tools like calendars, reminders, or smartphone apps to keep track of appointments, tests, and medication schedules.
- Be your own advocate and communicate your needs clearly. If you require a quieter space or additional support express these needs to the hospital staff. Don't hesitate to ask for clarification if you don't understand something.
- Hospitals can be overwhelming, so having familiar items that provide comfort and reduce anxiety can be helpful as per hospital policies.
- Hospitals are often busy and noisy environments. Consider using noise-cancelling headphones, earplugs, or playing calming music to minimise distractions and improve focus.
- Large or complex tasks can be overwhelming, breaking them down into smaller, more manageable steps, can make them less daunting. Prioritise your tasks and tackle them one at a time.
- When visiting the medical practitioner, the patient should be informed and encouraged to make use of the pre-admission app on the preferred providers' web site. This will ensure that most of the administrative tasks will be on record on the day of admission and will lessen the anxiety for the patient.

Remember, everyone's experience with ADHD is unique, so it is important to find strategies that work for you.

References available on request. MHM

Dr Japie Greeff
Deputy Director – School of Computer Science and Information Systems
North-West University
japie.greeff@nwu.ac.za

THERAPY BY CHATBOT

The need for mental health support services in South Africa is dire, and during the course of the Covid-19 epidemic the prevalence of mental health distress only grew while the capacity to support patients stayed largely the same, especially in the public health sector. Simultaneously we have seen an explosion of technology based interventions that seek to help people with mental health and wellness support in a variety of ways. It has become time to bring the worlds of traditional treatment and these interventions closer together by exploring what these tools can do to support patients when traditional care is not always as available as it should be.

The ecosystem of technology supports for health and wellness cover areas from physical health and wellness, to tracking moods and other activities like taking medication, to journaling apps and all the way up to chatbots with a focus on mental well-being. The reason for the rise in these sorts of technologies is varied, but things that contribute are:

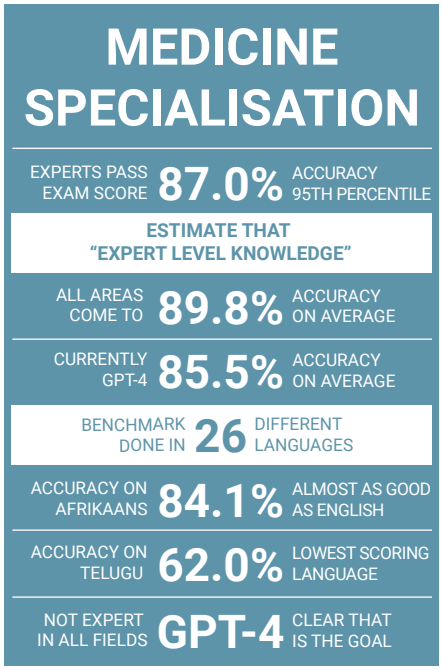
- The growing demand for mental health services
- The technological advancements in the field that has made this possible
- The accessibility of these technologies
- The cost-effective nature of these technologies
- The ability of these technologies to overcome some of the traditional barriers associated with therapy

The conceptual history of chatbots really started in 1950 when Alan Turing put forth the concept of the Imitation Game - what would later be known as the Turing Test. In it, a person is presented with a console that has a keyboard and a monitor with which they can chat via text to two agents that are not visible to them, one a machine and the other human. They would be given time to converse with both agents using natural language through this interface and be asked to judge which agent was the machine and which one human. If the judge could not tell the difference, then it was proposed that intelligence was achieved.

It may be surprising to learn that although this current wave of chatbots for mental health purposes is quite new, the first chatbot ever created was written in 1965 in the form of a Rogerian psychotherapist and was called ELIZA. It caused quite a sensation because even though its author claimed that there was no real intelligence in the chatbot, people still seemed to attribute much deeper meaning to the responses given and believed it was truly intelligent. This phenomenon came to be known as the ELIZA effect.

We have come quite a long way since ELIZA with some people feeling that the current generation

of chatbots started overcoming the original Turing test as early as 2014. There have been a number of incidents where people have been uncertain as to whether content they are seeing, whether it be in the form of text or even now in the form of images, is something that was created by a human or by a machine. Additionally, the level of intelligence (in as much as we understand the concept of intelligence) that is displayed by these artificial intelligences is growing at an incredible rate. The concept of what an "expert" is, is something that is being challenged and we will need to explore what it means for us in all of our respective fields as we see artificial intelligence encroaching. To show just how deeply this touches us, we need only look at the MMLU (Massive Multitask Language Understanding) benchmark that is used to test Large Language Models on their general and specific knowledge. In this benchmark 57 specialised areas are represented with just over 14,000 multiple choice questions with four possible answers. As such, one would expect someone to get at least 25% by just randomly guessing the answers. Based on tests done with unspecialised humans that have taken the test, the average accuracy obtained by them comes to 34.5%. With experts however in their own field this value becomes much higher.



When looking at the knowledge that is included in the medicine specialisation, the questions are taken from the US Medical Licensing Exam for which experts that pass the exam score an 87% accuracy at the 95th percentile. From the paper written on the test by the authors, they estimate that "expert level knowledge" in all areas should come to about 89.8% accuracy on average. Currently, GPT-4 is able to attain an average accuracy of 85.5% in all areas measured. Additionally, this benchmark was not only done in English, but in 26 different languages. The accuracy on Afrikaans was almost as good as English at 84.1%, but the lowest scoring language was Telugu where it only managed to obtain 62% accuracy. This means that we cannot yet claim GPT-4 is an expert in all fields, but it is clear that this is the goal.

What does this mean for us? It does not seem that artificial intelligence is likely to take all jobs that require knowledge and skills that are represented in natural language, but it is definitely going to impact these jobs. Practitioners that explore this new technology and understand how it can supplement their practice are more likely to be successful in future in knowing where these tools can help them and their patients, than those who simply ignore them or use them indiscriminately. What we need to do is explore tools that are available, evaluate them to see whether they are fit for purpose in the South African context, and use what is valuable to lighten the load on our existing ecosystem.

With this in mind, I would like to put forward four technology interventions that have potential, and could be explored in this way. These are:

- **Daylio:** A mood and activity tracker that allows one to write a journal, as well as capture custom activities and moods that allows for the most relevant data for the patient in question to be tracked.
- **Woebot:** a Chatbot that uses Cognitive Behavioural Therapy, Interpersonal Psychotherapy and Dialectical Behaviour Therapy techniques along with natural language and artificial intelligence to create a safe space to explore negative emotions and find coping strategies. It also allows one to journal and track moods.
- **Replika:** a more general purpose chatbot that has some mental health activities integrated into it, but is more focussed on addressing loneliness as it tries to build a relationship with the user by learning about them over time.
- **Cass:** a chatbot that that is extensively trained on recorded interactions between patients and clinicians and attempts to replicate this experience. The approach taken by this tool is to integrate it into an existing support system to allow the chatbot to act as a first-line interaction with the patient, which then allows it to offer a triage service. This is not a tool that a patient just downloads, but instead is based on an enterprise relationship and integration into an organisation's wellness ecosystem.

Daylio and Woebot (recently only available in the US) are free apps that can be downloaded by a patient and used at no cost, Replica has a free and paid version ($7.99/month or $49.99/year), and Cass doesn't sell directly to patients and instead needs to be integrated into a practice.

These are not the only tools that are available, but what is becoming clear is that technology is constantly progressing, and with it comes new opportunities to supplement ones practice. Technology is not going to replace clinicians just yet, but will hopefully be able to take on the role of partner in care rather than competition.

Links to the above mentioned apps:
https://play.google.com/store/apps/details?id=net.daylio
https://play.google.com/store/apps/details?id=ai.replika.app
https://woebothealth.com/
https://www.cass.ai/

References available on request. MHM

Sally Field (Research Associate); Associate Professor Simone Honikman (Director)
Perinatal Mental Health Project
Alan J. Flisher Centre for Public Mental Health
University of Cape Town
Simone.Honikman@uct.ac.za

IT'S TOO COSTLY TO DO NOTHING ABOUT PERINATAL MENTAL HEALTH PROBLEMS IN SOUTH AFRICA

It's too costly to do nothing about perinatal mental health problems in South Africa

Perinatal mental health problems can have serious consequences for the health and wellbeing of mothers and their children. In South Africa, the estimated prevalence of the common conditions: perinatal depression, stress and anxiety, is one in three women, although in some communities it is up to one in two. High rates are linked to the burden of socio-economic adversities faced by women. The COVID-19 pandemic further worsened the situation. Considerable evidence demonstrates the relationship between perinatal mental health problems and poor pregnancy outcomes, infant growth and development problems, poor child physical and mental health, and reduced children's educational achievement.

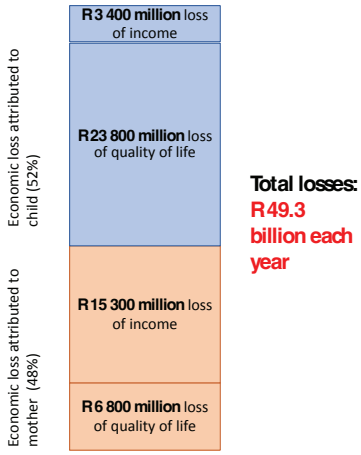
We recently conducted a study in collaboration with colleagues from the London School of Economics and the South African Medical Research Council. We looked at the financial impact for South Africa of common mental health problems during pregnancy and after childbirth: depression, anxiety, Post Traumatic Stress Disorder and completed suicide. We used data

from cohort studies, as well as epidemiological and economic data from South Africa, and international studies, when local data wasn't available. We modelled the financial impact on a hypothetical cohort of women giving birth within one year. Impacts were accounted for 10 years for women, and 40 years for children. The economic consequences costed that were linked to mothers included losses in quantity and quality of life and losses in financial productivity. For children, costs were calculated in the same way and we also included the costs of increased hospital care.

For every year of births, South African society bears economic costs of R 49.3 billion! About 48% of these costs may be attributed to the consequences related to the mother and 52% may be attributed to the consequences related the child. There were relatively low costs falling on the health system (R59,5 million) as little is currently being offered to address perinatal mental health problems in public health sector.

The costing calculations are summarised in the image below.

Inaction has intergenerational impacts and costs



That's just under R 51 000 per baby. It's too costly to do nothing!

By investing in evidence-based strategies to address maternal mental problems, we may alleviate transgenerational suffering, and also save on the costs of inaction. There are several approaches that have shown impact.

The status of care in South Africa

In South Africa, mental health care is not currently routinely provided to women as part of maternity. However, we have a new Maternal, Perinatal and Neonatal Health Policy (2021) which centres maternal mental healthcare as one of 16 'Essential Life-Saving Intervention Packages'.

From this policy, maternal, perinatal and neonatal guidelines are currently being developed that include substantive content on mental health, including the introduction of routine mental health screening into primary-level antenatal care. For this, a locally developed and validated screening tool has been integrated into the Maternity Case Records booklet (the standard public sector obstetric care document that includes investigation, clinical notes and care provided to pregnant and labouring women).

The Standard Treatment Guidelines (Hospital Level) includes specific advice for managing mental health conditions in pregnant and breastfeeding women, including a prescribing algorithm for antidepressants for women with moderate to severe depression and anxiety.

The role of the frontline provider

General healthcare providers (nurses, doctors, OTs, social workers, community health workers etc.) have a vital role to play in preventing and managing common perinatal mental health problems in the primary care setting. Mental health providers may play a vital role in supporting non-specialists to do this work and may themselves be suited to addressing moderate to severe conditions.

What can you do to help?

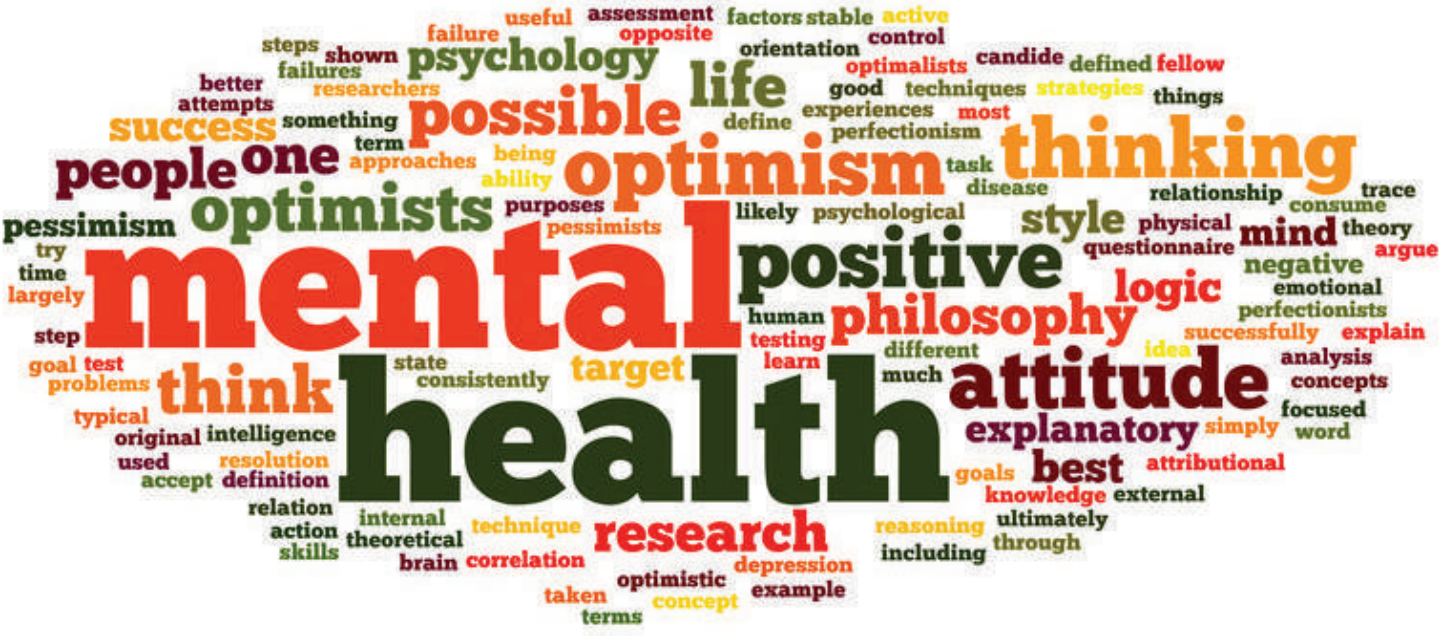
1. Promote awareness and reduce stigma. Healthcare providers can play a significant role in promoting awareness of mental health problems and reducing the stigma associated with mental illness. Educate perinatal women, their families and the broader community about the importance of well-being during and after pregnancy.
   - Share useful information about mental health issues and self-care.
   - Explain that emotional difficulties are not a sign of weakness (or any other myth, e.g. laziness).
   - Explain that symptoms may be similar to those experienced by many others in the same circumstances.
   - Explain that too much stress can affect how people think and their actions. It can affect their work and relationships and is not good for the baby. This is true for all people in the home.
   - Provide a reminder that people living with mental health problems can and do get better with good support and/or treatment from trusted family, friends and health workers.
   - Give the person the chance to talk about how they feel about their mental health challenges and treatment and effect on their life.
   - Provide information on treatment, prognosis and coping methods.
2. Be aware of the risk factors associated with perinatal mental health problems. These include
   - Poverty and food insecurity
   - Being a teenager
   - Living with a chronic disease, including HIV
   - Poor support / poor relationships with partner, family or community
   - Unwanted / unintended pregnancy
   - Difficult life events / trauma (e.g. bereavement and current or past abuse)

- Intimate partner violence / domestic violence
- Alcohol or substance abuse
- Past history of mental health problems
- Serious physical problem in mother or baby
- Being a refugee, asylum seeker, displaced person
- Previous or current pregnancy loss, miscarriage, still birth and neonatal death
- Preterm birth, birth defects or physical illness in neonate

3. Incorporate mental health screening as part of routine maternity care. First develop rapport with the woman: the way in which screening is offered is linked to how a woman will respond. If the screener has a gentle and kind attitude, the woman is much more likely to respond openly and take up any referrals.
   - A brief three-question mental health screen is available in the Maternity Case Record.
   - Use your clinical judgement and refer women that you're worried about for support, even if their screening test is negative.
4. Enable access to evidence based interventions.
   This may include psychosocial care, psychotherapy, medication or a combination of these.
   It is helpful to do a mapping exercise of resources in your location – keep a record of names, numbers and other relevant details. Get to know the providers. This can save valuable time!
   If some time is spent in making a quality referral, the woman is more likely to take up the opportunity. Give the woman reasons, options and explain the service in as much detail as possible and follow-up.
   - Connect women to social support services (social grants, community services, relevant NGOs) and other activities to strengthen social support (women's groups, support groups, faith-based activities and include partners and families).
   - Become trained in one of the evidence-based 'talking therapies' or refer to someone who can provide these.
   - Become comfortable with prescribing anti-depressants for moderate to severe depression and anxiety. See the algorithm in the Hospital Level (Adults) Standard Treatment Guidelines (2019), Chapter 15 on Mental Health.
5. Mother-infant matters. Assess mother-child interaction as part of post-natal care and refer when appropriate and resources available.
   - For women with existing mental health conditions, a multidisciplinary approach to care is essential, with a clear treatment plan and continuity of care across different clinical settings.
   - Arrange for observation of infants exposed to psychoactive medications or illicit substances during pregnancy.
   - If a mother with a severe postnatal episode requires hospital admission, avoid separation from her infant, where possible.
   - Provide gentle breastfeeding support to all women with mental health problems. Breastfeeding challenges are common in women with mental health conditions.
   - Women (and their partners) who have experienced a pregnancy loss, miscarriage, stillbirth or neonatal death, require special attention and support for bereavement.

Perinatal mental health problems are a significant public health issue in South Africa with substantial economic and societal costs. We have a responsibility to address these conditions and provide appropriate care and support to affected women and their families. This will help to improve the well-being of mothers and children and contribute to a healthier, more productive society.

References available on request. MHM



Interview with Dr Michelle King
Specialist psychiatrist (SASOP)
Johannesburg

DEPRESSION AND ANXIETY

THE UNTOLD BURDEN OF CANCER

With more than 30% of cancer patients diagnosed with depression, the South African Society of Psychiatrists calls for greater awareness of patients suffering from mental health disorders.

Cancer is the second leading cause of death globally, with an estimated one in six deaths (9.6 million). The most recent statistics available indicate that in South Africa 108 168 men and women were diagnosed in 2020 with cancer.

Dr Michelle King, specialist psychiatrist and member of the South African Society of Psychiatrists says being diagnosed with cancer and being a survivor is a scary and emotional experience, and some people may go through a period of grief before being able to accept their diagnosis. Others may become depressed and anxious.

"Healthcare professionals may miss the diagnosis of depression and anxiety because they have a false belief that these disorders are normal when facing death. If left untreated or undiagnosed it can impact the patient's ability to function on a daily basis, including going through treatment."

"The sudden nature in which the cancer is diagnosed, and the uncertainty associated, can trigger fear which could lead to depression and maladaptive anxiety. Patients may feel hopeless, despair, a sense of failure and grief as their chance to a long and healthy life is under threat. Getting through the day becomes a struggle since they must deal with treatment, symptoms, and the uncertainty of their longevity."

"Pain, fatigue, loss of appetite and insomnia are common symptoms experienced by many patients diagnosed with cancer. Poorly controlled pain could lead to or worsen mental health conditions such as depression and anxiety. Those who are survivors might alternate between disheartenment, isolation and fear, to times of hopefulness when returning from a successful follow-up screening. The goal is to find a middle-ground for one's mental health between treatments, remission or possible relapse."

Dr King says early referral to palliative care services can have a significant improvement in terms of reducing suffering and prolonging the patient's life.

"Palliative care is specialised care

for people living with a life limiting illness. It focuses on providing support and helping patients, and their families, make informed decisions about their treatment. As well as providing relief from physical symptoms and psychological and emotional distress. The team provides an extra layer of support, working closely with the patient's doctor, and is based on the needs of the patient, rather than the prognosis."

"This type of care is appropriate at any age and at any stage in a life limiting illness, and it can be provided along with curative treatment. The goal is to improve the quality of life of the patient, and their family, by means of a multi-disciplinary team. This team provides emotional support and help the patient and their family come to terms with the reality of cancer."

She says that undiagnosed depression and anxiety can impact the patient's ability to cope emotionally. These conditions may also worsen physical symptoms such as pain and fatigue, impacting quality of life, relationships, and daily functioning.

Making the diagnosis of depression is challenging as there is an overlap between many of the physical symptoms caused by the medical condition with those experience with a depressive episode.

These symptoms may include:

- Loss of energy
- Insomnia
- Fatigue
- Loss of libido
- Weight change
- Appetite change

Patients experiencing the above symptoms together with any of the following symptoms, are encouraged to seek support:

- Excessive feelings of hopelessness, guilt, and worthlessness
- An ongoing depressed or dysphoric mood
- Wishing for a hastened death
- Suicidal thoughts or plans
- Social withdrawal
- Loss of pleasure in daily activities
- Irritability and agitation
- Anxiety
- Psychotic features (delusions, paranoia) with a depressed mood

Where patients can seek further help:

The South African Depression and Anxiety Group also has a Chronic Illness Support Group. If you have a patient that you think could benefit from this Group, please provide them with the Support Group leader's details: Erna – 0834506451.

PALPRAC, has a list of palliative care providers and services in various area (see link below). In addition to working with a palliative care team, patients and, or, their family members, can reach out to the CANSA Help Desk on 0800 22 66 22 to book an appointment or send an email to info@cansa.org.za.

Join their support groups on social media by visiting.
https://www.facebook.com/groups/ChampionsofHope/
https://www.facebook.com/groups/CANSACaregivers/
https://www.palprac.org

References available on request. MHM

Ms Claudia Sartor
Deputy CEO: Global Mental Health Peer Network
Email: claudia.sartor@gmhpn.org

THE GLOBAL MENTAL HEALTH PEER NETWORK:

A BEST PRACTICE MODEL FOR GLOBAL MENTAL HEALTH LIVED EXPERIENCE LEADERSHIP

The Global Mental Health Peer Network (GMHPN) is an international lived experience organisation, based in South Africa. The organisation's work is primarily focused on empowering persons with lived experience and advancing global lived experience leadership in mental health. It mobilises its efforts through capacity building, peer led activities and through a mentorship programme encouraging open dialogue on important mental health topics and further emphasising lived experience empowerment.

Definition of Lived Experience
The GMHPN regards "lived experience' as being an experience, personal in nature, through which the individual has or has had experience of symptoms of a mental health condition and for which care and treatment has been sought. Treatment is however not limited to clinical care and extends to psychosocial assistance, therapy, and other forms of non-medical services.

Through years of work and collective efforts from advocacy groups, including persons with lived experience, there is worldwide established consensus on the importance and value of lived experience expertise in the domain of global mental health.

The report of the Lancet Commission on Ending Stigma and Discrimination in mental health, launched in 2022 presents key findings that state persons with lived experience ought to be leading and/or co-leading on anti-stigma programmes for advancing change in the status quo of mental health across the world. There is strong global recognition that mental health related discussion ought to be inclusive of people with lived experience of a mental health condition as they have rich experiential value and perspectives to share.

Why GMHPN was established
With a purpose to create a safe space for dialogue, advocacy, engagement, leadership and mentorship and support, GMHPN has become recognised as a leading example of an organisation exhibiting best practice as it pertains the role of persons with lived experience in mental health. It provides a platform for recognition of the value of persons with lived experience worldwide.

Member profile
The GMHPN has a global footprint across Africa, Europe, South East Asia, Western Pacific, Eastern Mediterranean and the Americas region; covering the six listed World Health Organisation regions. Its members come from different backgrounds and hold diverse cultural belief systems, thereby broadening our level of expertise. While they join us a volunteer, we provide them with access to a platform that offers opportunities for growth and development as leaders in mental health advocacy.

To date, the GMHPN is represented largely by females and youth and a large representation is throughout

Africa; all members having commonality in having a lived experience. See illustration of GMHPN representation to the right.

Our impact and what we do
People with lived experience are experts stemming from their personal journeys in navigating mental health systems in seeking treatment and care. Our members provide opinions and practical solutions on mental health themes that are trending globally; advocating for a world in which they can thrive and reach their full potential and not merely exist and live. GMHPN's objective is to improve mental health and human rights literacy across the world, and to review and reform policies and practices, to destigmatise mental health and reduce discrimination against persons living with mental health conditions.

GMHPN areas of expertise include Advocacy and awareness; Empowerment, Engagement; Research; Human Rights; Mentorship and service delivery.

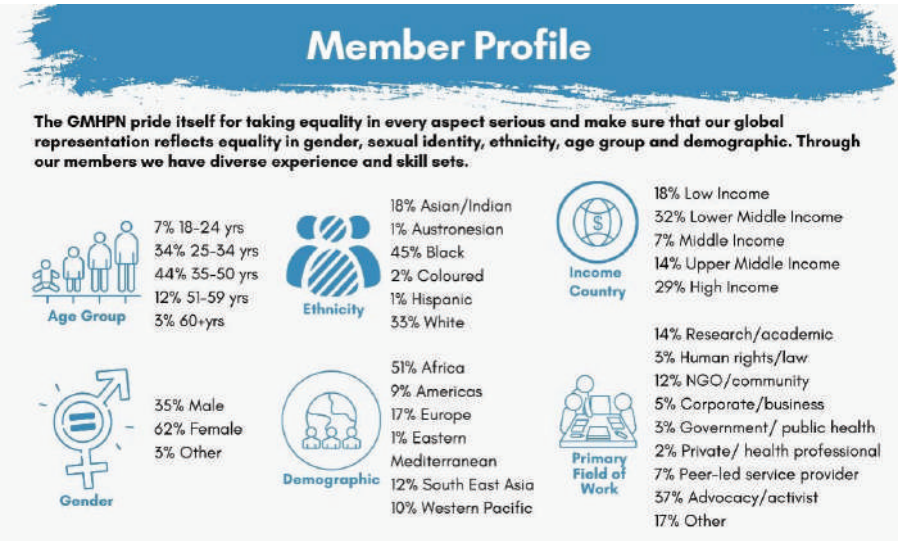
Advocacy and awareness: for influencing policy and practice in mental health, worldwide. GMHPN has developed policies and guidelines to assist researchers, academics, corporate and other relevant stakeholders, on how to effectively work with and alongside people with lived experience. Thereby ensuring effective, authentic and meaningful inclusion of people living with mental health in matters by which they are affected directly.

Empowerment: through capacity building and leadership development among people with lived experience. Engagement: through the delivery of consultancy services by means of the expertise of people with lived experience.

Research: by contributing both academic and non-academic expertise through the perspectives of people with lived experience.

Human rights: by integrating principles of human rights into mental health and our work in the mental health field.

Support: by offering a platform to members where peer-to-peer knowledge exchange is encouraged and supported.



Mentorship: by offering members the opportunity to attend and/or themselves host monthly workshops on trending mental health topics and topics which they identify as important.

Experts by Experience Consultancy Services: by providing opportunities for member collaboration, engagement, service delivery and public speaking at local and global events, conferences and workshops. A list of our services can be found on our website via the following link www.gmhpn.org.

It is worth mentioning the importance of complying with the principle of "equal pay for equal work" for full enjoyment of employment and services rendered. At the GMHPN, we promote and advocate strongly for betterment in the acknowledgment of both the experiential and monetary value that is associated with lived experience expertise. After years of advocacy efforts, there still remains a gap in non-remunerating the work done and participation of people with lived experience in service delivery. This is not merely an issue of fairness but actually a principle of human rights, protected by international human rights instruments such as the United Nations Convention of the Rights of Persons with Disabilities (CRPD) and particularly, Article 7 (seven) of the International Covenant on Economic, Social and Cultural Rights.

Member Feedback:
GMHPN management team monitors and evaluates the progress of its impact and the dis/satisfaction of its members via biannual surveys, through which we collect data so as to improve upon areas that members feel need attention. This ensures that we maintain our integrity as a lived experience peer led organisation, truly empowering individuals to thrive in their personal and professional growth.

We would like to share some feedback from our members on their experience with GMHPN and within the network and they replied with what they believe is the best part of being part of the GMHPN. In summary, we received great feedback stating that they really enjoy being part of a community that is empowered and able to rely on their perspectives in being part of change and transformation in mental health. Other individuals are content with the consultancy services, that they as people with lived experience are valued and respected just as much as the next person.

Members have indicated that the GMHPN has impacted them in various domains and that they are proud to be associated with the GMHPN, that they would recommend the GMHPN to fellow peers, that they feel like part of a global family in the GMHPN.

GMHPN, pledges to continue to fight against the inequalities that continue to exist it mental health.

References available on request. MHM

Professor Rita Thom
Psychiatrist
Johannesburg

ENHANCING THE MENTAL HEALTH WORKFORCE IN SOUTH AFRICA:

CHALLENGES, FINDINGS, AND RECOMMENDATIONS

Introduction
South Africa is currently grappling with a critical shortage of skilled mental health professionals, leading to an unequal distribution of resources, predominantly concentrated in urban areas and private practices. This scarcity severely impacts mental health service delivery, particularly in rural areas where access is limited. Despite mental health policies promoting community-based care, the existing funding and human resource model in the public sector remains predominantly hospital-centric. To overcome these challenges, recent studies have underscored the need for investment in mental health and the adoption of innovative solutions. This article delves into the scope of the problem, recent studies, proposed solutions, and recommendations aimed at bolstering the mental health workforce in South Africa.

Current Situation and Challenges
A comprehensive study conducted by the South African Society of Psychiatrists (SASOP) in 2020 revealed an alarming disparity in the ratio of psychiatrists per 100,000 people. The public sector had a mere 0.33 psychiatrists per 100,000 uninsured individuals, while the private sector boasted 4.93 psychiatrists per 100,000 insured individuals. Moreover, an ageing workforce, with 39% of psychiatrists over 50 years old, and the emigration of younger psychiatrists present additional challenges for the future. To meet the target of 1.9 psychiatrists per 100,000 population by 2050, substantial efforts are required to address the current shortage.

Proposed Solutions
South Africa's mental health policy suggests task-shifting or task-sharing as a potential solution to mitigate the scarcity of skilled human resources. Task-shifting involves delegating certain mental health tasks to non-specialists, such as community health workers and nurses, to improve access to care. Additionally, integrating mental health into primary healthcare is recognised as a long-term strategy for enhancing accessibility. This approach necessitates training generalist healthcare workers in primary mental health care, while specialists' roles evolve to provide consultation on complex patients, guidance and support.

DISPARITY IN THE RATIO OF PSYCHIATRISTS

PUBLIC SECTOR
UNINSURED INDIVIDUALS
PSYCHIATRISTS PER 100,000 POPULATION
0.33

PRIVATE SECTOR
INSURED INDIVIDUALS
PSYCHIATRISTS PER 100,000 POPULATION
4.93

AGEING WORKFORCE
PSYCHIATRISTS OVER 50 YEARS OLD
39.0%

TARGET PSYCHIATRISTS
PER 100,000 POPULATION BY 2050
1.9

EMIGRATION OF YOUNGER PSYCHIATRISTS PRESENT ADDITIONAL CHALLENGES FOR THE FUTURE

ASSAf Consensus Study

The Academy of Science of South Africa (ASSAf) commissioned a consensus study, initiated in 2015 and completed in 2019, addressing the need for competence in mental health care among healthcare workers. The study emphasised the multi-sectoral and multi-disciplinary nature of mental health care, highlighting the significance of social determinants, promotion, and prevention interventions. While the study mainly focused on adult mental health services within the public sector, it underscored the need for similar research on child and adolescent mental health services.

Vision for Mental Health Care and Provider Categories:

South Africa's vision for mental health care revolves around a framework grounded in human rights and community-based care. The aim is to provide services in the least restrictive setting possible, close to individuals' homes, with an emphasis on ambulatory and voluntary care. Striking a balance between outpatient and inpatient services, the vision promotes timely referral back to the district health service. The recovery model and psychosocial rehabilitation services play pivotal roles, while long-term institutional care is reserved for those who cannot be adequately supported in the community.

To achieve these objectives, various provider categories have been identified who together can provide optimal mental health care in South Africa (within available resources):

1. Community Health Workers (CHWs) and Nurses:
   - CHWs play a crucial role in bridging the gap between communities and mental health services.
   - Nurses, particularly those in primary healthcare, form the backbone of the healthcare system and require ongoing review of their mental health competencies.
2. Medical Professionals:
   - General practitioners, graduates of the Diploma in Mental Health programme, and family physicians can contribute to primary mental health care.
   - Specialist and subspecialist psychiatrists offer specialised mental health services.
3. Psychological Services:
   - Behavioural health counsellors, registered counsellors, counselling psychologists, and clinical psychologists cater to different levels of care, from community-based services to specialised services in district health services and hospitals.
   - Ensuring consistent and evidence-based training across academic and training institutions is essential.
4. Rehabilitation Services:
   - Community rehabilitation workers, occupational therapy assistants, occupational therapy technicians, and occupational therapists are integral to providing rehabilitation services.
   - Current training courses for these roles need to be reviewed and offered to meet the demand.
5. Social Services:
   - Auxiliary social workers, youth care workers, social workers, and clinical social workers contribute to addressing social determinants of mental health.
   - Establishing stronger connections between the Department of Social Development and the Department of Health is crucial.

Findings and Recommendations

The consensus study by ASSAf highlighted key findings and made pertinent recommendations to optimise the mental health workforce:

1. Training and Competencies:
   - The training of various provider categories, including CHWs, nurses, medical professionals, psychological service providers, rehabilitation workers, and social workers, requires improvement to equip them with the specific competencies needed for effective mental health care delivery.
   - Emphasis should be placed on evidence-based interventions tailored to the South African context.
2. Barriers to Implementation:
   - Inadequate funding poses a significant challenge, as the current allocation does not align with mental health policies and strategies.
   - Attracting specialists to work in rural and underserved areas remains difficult, necessitating alternative reimbursement mechanisms and incentives.
   - Insufficient training programmes and a lack of posts for new proposed categories hinder the expansion of the mental health workforce.
   - Remuneration for specialists is often limited to full-time or sessional in-person positions, limiting flexibility and access to their expertise.

The following recommendations are put forth to address these barriers

1. Funding and Resources:
   - Shift funding from hospitals to community and district-based services, accompanied by bridging finance to support the transition.
   - Explore alternative reimbursement mechanisms to attract specialists to underserved areas.
2. Training and Education:
   - Align training programmes with service needs and ensure ongoing review of curricula to enhance mental health competencies.
   - Foster collaboration between academic institutions, training centres, and district/community-based platforms.
3. Technology and Innovation:
   - Utilise telemedicine and digital platforms to increase access to specialist care in remote areas, minimising geographical barriers.

Conclusion

Addressing the shortage of skilled mental health professionals in South Africa requires a multi-faceted approach. By implementing evidence-based strategies, promoting inter-sectoral collaboration, and allocating adequate funding in an appropriate manner, it is possible to bridge the gap and ensure access to quality mental health care for all South Africans. Task-shifting, integrating mental health into primary care, and strengthening the training and support of various provider categories are essential steps towards building a robust and equitable mental health workforce.

References available on request. MHM

SADAG SUPPORT GROUPS

For Those Living With HIV/AIDS

SADAG has over 160 Support Groups around the country dealing with a variety of Mental Health related issues, as well as Support Groups specifically for family members and loved ones.

SADAG guides and trains new Support Group Leaders on running a group step-by-step. We help with training webinars, materials, handouts, information and more.

Receiving an HIV or AIDS diagnosis can be isolating and scary. There is still widespread misinformation and stigma attached to the illness and it's vital that those diagnosed receive the appropriate support and information.

This month's featured Group is the **Support Group for Those Living with HIV/AIDS** hosted by Louise (insert surname).

Louise's Support Group offers a safe space for those who have been diagnosed with HIV/AIDS and empowers them to know they still have a bright future. The Group is aimed at providing members with the correct information about their diagnosis and treatment, and the much-needed support that can make all the difference – especially when first diagnosed. Here, members receive guidance, support, and wisdom from those who have lived with the illness for a long time. Receiving the right information and support goes a long way in aiding to the successful management of HIV/AIDS.

Some words from Louise:

Why did you start this particular Support Group?
During my time working in the field of HIV, I identified the need for this kind of Support Group due to the high number of positive diagnoses and the low support available. I personally experienced the benefits of an HIV Support Group when I was first diagnosed in 2003. I believed I'd been handed a death sentence. It wasn't until I started attending a Support Group, received the correct information and heard other people's stories that I began to have hope. It was here that I was empowered to live with my condition and continue with my life.

What are the benefits of joining this Support Group?
The stigma associated with HIV often leaves people isolated and full of fear; this Group offers people a space where they can be open knowing they will not be judged. The Group provides people with the correct information about our condition from our facilitators and fellow members, and provides the realisation that life can go on. We also aim to break the stigma associated with HIV/AIDS.

Who can join this Group?
For confidentiality purposes, only those 18 years and older who have been diagnosed positive with HIV/Aids. Anyone who meets these criteria is welcome.

What do you hope to achieve with this Group?
I want this Group to be a safe space where everybody is free to express whatever they're going through and talk about their challenges without judgement. I'd also like to achieve a platform where stigma is broken, and correct information is given to members. I want to empower members so they can also go out into communities, share the information they have received and encourage others to get the support they need. I want to create a platform where people don't need to feel isolated; where they know their voices are heard, and that they are loved and cared for. MHM

BIPOLAR DISORDER

A STORY OF HOPE FROM SADAG'S DIEPSLOOT COUNSELLING CONTAINER

When Newyear Sithole was 18 years old she was diagnosed with bipolar disorder. This was in 1979 when the illness was not well understood by society at large. In Newyear's community, no one around her understood what this meant. For 37 years, Newyear didn't understand what her diagnosis meant either. She struggled with periods of depression and episodes of mania all the while raising a family and going to work without much assistance. Her journey was long and difficult, but she pushed on.

In 2016, at the age of 55, Newyear was informed by the company she was employed at, that she would have to take early retirement due to her illness. Even at this time, she didn't understand what it meant to have bipolar or that there was treatment for it. Her son, whom she lives with, didn't understand why his mother would sometimes be extremely down and at other times have excessive energy and say and do things that were considered strange and destructive. Nevertheless, he expected her to contribute to the household, and by his own admission, didn't have much sympathy for her or her behaviour.

After an explosive argument with her son, Newyear was told by an acquaintance about the "Blue Container" in Diepsloot where the staff could assist with emotional difficulties. It was only once she had a session with a counsellor at the container that she finally came to understand that her changes in mood and odd behaviour were the result of the bipolar diagnosis that she had received so many years ago.

The team at the container took Newyear under their wing and took her to the local clinic where she received medication for her illness. This is when things began to improve and Newyear felt like she could lead a more sustainable life. The team also consulted with her son and explained Newyear's diagnosis to him. For the first time in their relationship, Newyear and her son both understood what all the years of difficulty in Newyear's life was from. Her son finally felt compassion for his mother and understood that she needed support and understanding to get better.

With this help and support, Newyear was able to start saving her pension money. Eventually she paid off all her debts and built three small rooms in the back of her property, which she now rents out and makes an income off.

Today, Newyear is doing so much better and attends one of the container's monthly support groups, where she can share her experiences with others without fear of judgement and feeling isolated. Through this support group, Newyear has found people who are always there to support and guide her through her difficulties.

This year, Newyear became a grandmother and has been able to enjoy her new grandchild knowing she is stable and in a good place. She has also become very active in the community and is currently part of a team supporting a men's support group by teaching vegetable gardening.

Newyear is extremely grateful for the help and support that she has received over the past 7 years from the Counselling Container and hopes that she too can have a positive impact on the lives of her community's members.

References available on request. MHM

A very happy Newyear posing for a picture with Diepsloot Counselling Container team leader, Nono. Newyear is grateful for the years of support she has received from the team.