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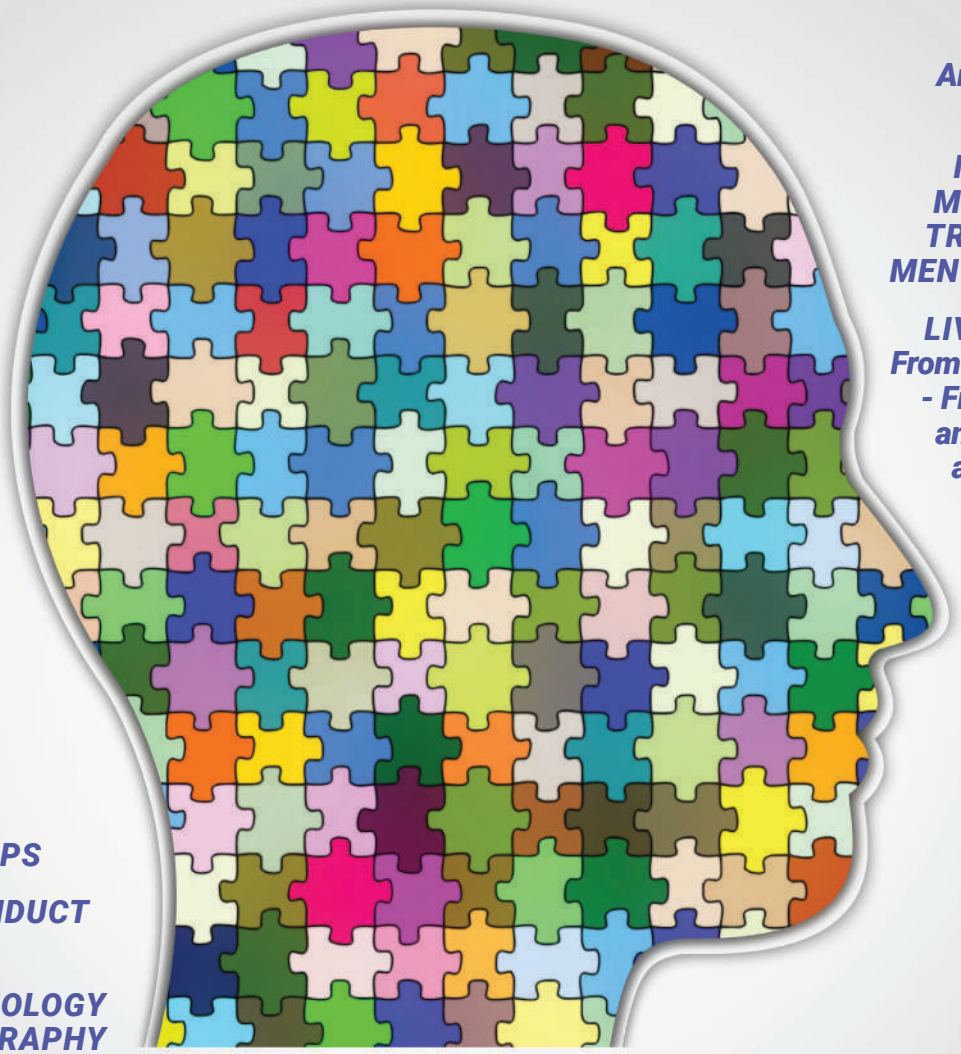
MHM

MENTAL HEALTH MATTERS



BIG BULLY
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WORKING WITH WHISTLEBLOWERS

THE SOUTH AFRICAN DEPRESSION AND ANXIETY GROUP

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Making Mental Health Matter

UNIVERSAL HEALTH COVERAGE AND THE IMPORTANCE OF NHI LEGISLATION FOR MENTAL HEALTH IN SA

WHAT IS UNIVERSAL HEALTH COVERAGE?

Universal health coverage (UHC) is a simple concept: everyone, everywhere should be able to access the highest attainable standards of health without suffering financial hardship. The World Health Organisation's Constitution defines health as "a state of complete physical, mental and social well-being, and not merely the absence of disease and infirmity."

Currently, there is a large gap in the coverage of care for mental health conditions in South Africa. It's estimated that less than 1 in 10 people living with a mental health condition in South Africa receive the care they need. A leading way to tackle this gap is to integrate and expand access to quality, rights-based, evidence-based, culturally-sensitive, and cost-effective mental healthcare into UHC efforts and existing health services.

INTEGRATING MENTAL HEALTH INTO UHC

When we talk about integrating mental health into UHC we mean:

- Including mental health in all relevant health services and interventions across the life course and throughout the continuum of care. This includes health promotion, disease prevention, treatment and rehabilitation, and in primary, secondary and tertiary care.
- Ensuring that mental health conditions are covered by population-wide financial protection measures, like our annual health budget and the proposed national health insurance (NHI).
- Putting mental health care on par with and – where relevant – accompanying physical health care. Mental health care and related services have hardly ever enjoyed the same resourcing as other types of health services in our country.

THE NHI BILL AND MENTAL HEALTH

The NHI Bill seeks to realise Universal Health Coverage in South Africa.

In the Bill's preamble, we welcomed the reference to mental health within article 12 of the UN Covenant on Economic, Social and Cultural Rights, as well as Article 16 of the African Charter on Human and People`s Rights. This roots the bill in a human-rights based approach to mental health.

We appreciate that there is specific mention to provide school-based services to promote mental health for young people (pg 49; 4.4.4) and, importantly, there is a conditional grant provided to invest in improving the mental health services in the country (pg 58; 8.7) ahead of implementing the NHI.

However, as mental health advocates, we have concerns with

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the NHI Bill. We echo concerns raised by other key stakeholders, like the South African Medical Association and the Hospital Association of South Africa. This includes:

1. The Portfolio Committee for Health passing the bill without any changes or with only minor amendments, thereby largely rejecting the public's concerns
2. The poor track record of our state's duty bearers for policy implementation, accountability, and good governance. Government is trying to assure us that the NHI will be a Schedule 3 Public Entity and so will operate as a 'reputable entity', unlike Eskom, which is a Schedule 2 Entity. As a reminder, the National Lottery Commission and Unemployment Insurance Scheme are also Schedule 3 Public Entities. These are just two of many Schedule 3 Public Entities that have been riddled with looting, corruption and mismanagement, with negligible, meaningful consequences for offenders (see here, here and here). The NHI being a Schedule 3 Public Entity does not equate to implementation, accountability, and good governance.
3. The lack of clarity about what the government is actively doing right now to address the myriad of issues already facing health systems, including poor service delivery. Former Health Ombudsman Professor Malegapuru Makgoba, described our health system as a 'dysfunctional mess'. What is the government currently doing to remedy this so that the NHI – funded by taxpayers – will be founded on and build on a functional public sector; one that inspires trust from the public and delivers quality services to all.

We have mental health specific concerns:

1. The conditional grant budget line item for mental health needs to be revisited (pg. 58; 8.7). This amount is not congruent with the proposed recommendations from a Mental Health Investment Case Report done in 2021 to sufficiently strengthen mental health services and integration. An adequate conditional grant for mental health is necessary to correct the injustices of the past regarding mental health service allocation and investing in scaling up mental health care in the country.
2. There is no commitment to an explicit priority setting exercise for the NHI packages of care. Currently, the Bill states the Health Minister will ultimately determine health care benefits that will be reimbursed through the NHI Fund, as well as the service coverage. This is a serious concern. If the Minister does not see value in quality mental health services, would this mean no coverage? Furthermore, what if, for example, an outgoing Health Minister saw value in mental health and prioritised it adequately, but an incoming one has a drastically different view? Such decisions cannot be made subjectively by a single person. We advocate that the decisions related to the amounts and types of resources to be made available, eligible populations, and specific rules for allocation are informed by an economic analysis to maximise value and achieve social goals. We recommend that the Department of Health and the Portfolio Committee for Health establish a process with key stakeholders, including persons with mental health conditions, where they review and interrogate these packages and the potential benefits, placing equal consideration on both the burden and disability imposed by diagnosable mental illnesses, our human rights obligations and the socio-demographic conditions which place particular groups at heightened risk of deterioration in their mental health, in and across the country.
3. We are unsure what approach will be used to inform priority setting. We advocate that any priority setting should be informed by a needs-based approach rather than a current service use approach. Considerations around burden of disease, our human rights obligations and treatment gaps should drive the prioritisation of health services and associated budgets. These metrics alone provide good evidence for investing in mental health care.

WHAT DOES THIS ALL MEAN?

We want to see the right to health – including mental health – realised for all in South Africa. This means supporting UHC. To achieve UHC we need enabling national laws, policies, planning and regulatory frameworks, monitoring mechanisms and dedicated budgets. Mental health services must be integrated into all the aforementioned areas, including in the basic package of essential services.

However, our concerns with NHI Bill remain, as outlined above.

While debates around the NHI will continue and perhaps even intensify in the lead up to the 2024 elections, this should not stunt the immediate implementation of known, uncontroversial rights-based and evidence-based actions desperately needed to improve health system performance.

We continue to advocate for evidence-based, cost-effective mental health services, like those outlined in the Mental Health Policy Framework, which can be implemented today to improve the mental wellbeing of all in South Africa.

There is currently a call for written submissions and enquiries about the NHI Bill with the deadline for the 15th September. If you would like to raise your concerns or voice your opinion, please make a submission at the link: National Health Insurance (NHI) Bill | PMG (*https://pmg.org.za/call-for-comment/1334/*)

References available on request. MHM

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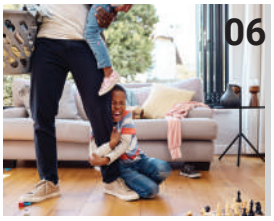


Dr Lerato Dikobe-Kalane
Psychiatrist

ADHD IN RELATIONSHIPS

INTRODUCTION

Adult ADHD, which is diagnosed in early adulthood or childhood, is a neurodevelopmental disorder which affects a person's attentiveness, impulsivity, and hyperactivity. Although the prevalence of ADHD decreases with age, sometimes these symptoms persist into adulthood and lead to functional impairment. A global estimate places the prevalence of adult ADHD at 6,67%.

According to the National Institute of Mental Health, it's estimated that 5,4% of men are diagnosed with ADHD compared to that of 3,2% of women. It's worth noting that the presentation across genders differs, with men tending towards hyperactivity and impulsivity, and women tending towards inattentiveness. Women with ADHD are less likely to be diagnosed and treated, which leads to poor long-term social, educational, and health outcomes.

Although ADHD is easily diagnosed in children, adult ADHD presents a challenge to clinicians, largely due to the overlap of symptoms with those of mood and anxiety disorders. For this reason, many adults aren't even aware they have ADHD, only that they struggle with everyday tasks. Comorbid conditions such as learning disabilities and other psychiatric disorders can also complicate the diagnostic picture.

COMPLICATIONS

ADHD has been linked to a multitude of complications, including, but not limited to:

- Decreased rates of academic completion
- Poor employment records and unemployment
- Financial issues
- Substance misuse
- Difficulties with the law
- Frequent accidents, including car accidents
- Unstable relationships
- Poor mental health in general
- Poor self-image
- Suicide attempts

ADHD AND VIOLENCE

Males with childhood ADHD and conduct problems that persist into adulthood are more likely to be verbally aggressive and even violent with romantic partners. Evidence points to a positive association between adult ADHD and interpersonal and domestic violence. Some researchers argue that hyperactivity in ADHD – which is more commonly seen in men – is an indicator for aggression and violence, as it stems from a deficit in emotional regulation. While we know that within the general population, substance dependence is independently associated with more severe and repetitive forms of violence, we also know that those with ADHD commonly abuse

substances and alcohol once they are young adults. This exacerbates the incidence of interpersonal violence. Aggression in general, both externally and self-directed, is a common feature in adults with ADHD. In fact, adult males with childhood ADHD and exposure to domestic violence as children are more likely to perpetrate interpersonal violence.

SYMPTOMS AFFECTING THE PARTNER

The common symptoms of ADHD have an effect within relationships by impacting partners of those diagnosed with ADHD. These take place within the following ways:

- **Inattention:** those with ADHD can lose focus in conversation, which may leave their partner feeling devalued. They may also commit to issues and later forget, which may result in frustration and resentment from their partners.
- **Forgetfulness:** it's difficult for those with ADHD to sustain focus and they may easily forget discussed information. This may, in turn, lead to their partner feeling they are incapable, unreliable, and untrustworthy.
- **Impulsivity:** those with ADHD may frequently interrupt others during conversations or blurt out what they're thinking without considering another person's feelings. These symptoms may result in a partner's feelings being hurt.
- **Disorganisation:** ADHD makes it difficult to organise, prioritise, and complete household tasks, which lends itself to a disordered environment. Another thing that is more difficult for those with ADHD is holding a job. This has a great effect on household finances and places additional pressure on their partner, which itself lends to feelings of frustration and resentment.
- **Explosive temper:** due to emotional dysregulation and poor stress/frustration tolerance, people with ADHD have a tendency towards anger outbursts and aggression. This naturally could lead to their partner feeling hurt, fearful, and even abused.

RELATIONAL DYNAMICS

Those with ADHD who are in relationships may find themselves in interesting relational dynamics than those of a typical partnership. Commonly, the relational dynamics may present as:

- **Parent/child dynamics:** one partner may feel that they have a child instead of a partner, as those with ADHD struggle to complete tasks that they perceive as boring or that require their full attention, which leads to their partner taking on most of the responsibilities and feeling resentful.
- **The constant critic:** partners of those with ADHD may feel like they are forced to nag, remind, and constantly tell their partner how and when to do things properly. In turn, the person with ADHD may feel as though they are being evaluated, monitored, and corrected, which results in low esteem and demoralisation.
- **The hyper-focus courtship:** because those with ADHD often present with a hyper-focus, their partner may feel like they are special and loved, making their courtship an amazing experience. When this hyper-focus stage ends, however (which often happens quite abruptly), their partner is left feeling alone, confused, and betrayed.

MANAGEMENT

For all the personal and relational implications mentioned above, it's easy to see why effective management of adult ADHD is a necessity. Management that is both combination and holistic has been found to be most effective. A starting point would be to exclude any possible organic causes.

Following this, medications such as stimulant (methylphenidate or dexamphetamine being the first line), non-stimulants like atomoxetine (for those who struggle with stimulants), antidepressants like bupropion, and other medications targeting the co-occurring disorders are indicated. Psychotherapy as an adjunct is also indicated. Types of suggested therapies for those with ADHD and their families or partners include:

- Cognitive behavioural therapy (CBT) focusing on challenging thinking and managing behaviour
- Dialectical behavioural therapy (DBT) focusing largely on emotional regulation, distress tolerance, and interpersonal effectiveness
- Family and couples therapy which focuses on familial relationships, communication, and problem-solving skills within relationships
- ADHD coaching which assists with improving time management, goal-setting, and organisational skills

Occupational therapy is also an essential key in ADHD management, with occupational therapists providing the tools to assist those with ADHD to organise their environments, enhance their social interactions and awareness, optimise time management, monitor and regulate sensory stimulation, and develop stress-management techniques.

For those with ADHD and those in relationships with them, many options are available. It's up to us to set the tone for treatment and prevent further fall-out resulting from the illness.

References available on request. MHM

Dr Terri Henderson
Psychiatrist

ODD AND CONDUCT DISORDER

Oppositional Defiant Disorder (ODD) is described as a severe and persistent, recurrent pattern of negativistic, defiant, disobedient and hostile behavior beginning in childhood or adolescence with a duration of six months or more. Symptoms that are specific to ODD are: irritable or angry mood, argumentative and defiant behaviour, being easily annoyed by others, aggression and vindictiveness, a refusal to comply with rules, the deliberate annoyance of others and blaming others for their own mistakes. It is well established that ODD is a precursor for Conduct Disorder.

Conduct Disorder (CD) occurs predominantly amongst male youths. They display at least four of the following behaviours:

- Aggression towards others including physical altercations and physical cruelty to animals
- The use of a weapon to harm others
- The perpetration of a forced sexual act on another
- Property destruction by arson or any other means
- Criminal acts such as breaking into a property or theft or shoplifting or mugging
- Truancy, running away from home and a refusal to comply with the rules set by parents and/or other adults.

These individuals also show a lack of remorse, no empathy towards others and seem callous and unconcerned by the nature of their behavior. Callous and unemotional behaviour strongly suggests the potential progression towards Antisocial Personality Disorder or habitual adult criminality. The rate of this progression is as high as fifty percent.

For both conditions there is well established co-morbidity and pre-morbidity with Attention Deficit Hyperactivity Disorder (ADHD). ODD is a comorbid diagnosis in 60% of minors with ADHD. The combination of the diagnoses indicates a worse prognosis, earlier age of onset with more functional impairment, increased risk of developing anxiety, depression and progression to conduct disorder and more delinquency than either disorder alone. ADHD is a treatable condition. Therefore, diagnosis and successful treatment of ADHD is critical factor in reducing the potential progression to ODD and CD.

Risk factors for the development of ADHD, ODD and CD include:

- Antenatal maternal smoking and postnatal adversities
- Family history of ADHD, ODD or CD
- High levels of family conflict
- Parental psychopathology, substance abuse and maladaptive parenting styles including harsh parenting
- The absence of fathers/positive male role models
- The experience of any form of abuse

Specific risk factors contributing towards CD are:

- The inability to self-regulate combined with rapid activation of the fear and anger centres as a result of neurological malfunction in the amygdala and the orbito-frontal cortex
- Low verbal IQ
- Lack of economic opportunity
- Frequent unoccupied and unsupervised time
- Rejection by more prosocial peers and an association with delinquent peers and the gang system

Fifty to seventy percent of referrals to Child and Family units in the Western Cape are for male minors presenting with unmanageable behaviour, extreme impairment in functioning and the creation of significant distress in both patient and family, as a result of this diagnostic combination. This combination of diagnoses tells the sad tale of family structures that have collapsed. Fathers are usually absent; mothers are overwhelmed or are abusing substances and

grandmothers are left to try and raise their grandchildren - a momentous task.

Attending school can be an opportunity for these children to experience structure, leadership, encouragement and healthy outlets like sport. However, our schools are overburdened and under-resourced. Most schools don't provide after-school programmes which leaves youths unsupervised and less likely to make pro-social choices. Communities offer another opportunity to provide support to youths. Community cohesion and prioritisation of the needs of youth (exposure to positive role models, access to sports coaching, extramural activities, leadership programmes) would help this precious developmental phase to realise a successful outcome.

Diagnosis of these conditions requires an in-depth assessment of disruptive behaviour symptom profiles. A focus on family history of possible ADHD, ODD and CD as well as antenatal and postnatal events is necessary. Family functioning, family challenges, family substance abuse and parenting practices must be assessed. The minor's schooling history, level of academic functioning or cognitive ability and behaviour in the school environment provide essential information. Screening for mood, anxiety and trauma related psychopathology is necessary. An assessment of risk factors with regards to the patient and the family members should also be done.

The occurrence of ODD, left untreated, which progresses to CD is a tragic development of disorders that carries significant negative consequences.

The cost to the individual includes sexually transmitted diseases, risk of serious injury, failure of education, isolation from family and friends and involvement with the juvenile justice system. Consequences for parents include self-blame, shame, anxiety, social embarrassment, interruption of work, escalation of family discord and theft of their property. Cost to communities and society are significant. Often these youths are drawn into the gang system and a cycle of criminality with significant risk to self and others begins. Substance abuse is a frequent comorbid disorder, further aggravating dysfunctional behavior and criminality. The economic cost per individual per annum, runs into the hundreds of thousands of rands.

Treatment of this symptom dimension includes early intervention, maximising the pharmacological management of ADHD, augmentation with other pharmacological options and psychological or behavioural interventions. Successful treatment and behavioural change are possible where interventions are implemented before the age of eight years. The primary form of intervention is parental guidance. Parents are guided to encourage the use of house rules, problem-solving, structure in the home environment, sympathy and empathy. Working solely with the individual child is ineffective without the additional parenting interventions.

Prevention programmes are typically initiated in grade one or two of the school years. The fundamental purpose is to teach prosocial behavior and correct antisocial behavior. The components of the programmes are communication of clear expectations of behaviour and limit setting, modelling appropriate behaviour, ignoring offensive behaviour, the use of quality time, practice and feedback and specific praise and rewards to reinforce correct behaviour. Well-resourced countries implement targeted programmes including psychosocial interventions such as parent-training, family therapy and child social skills training. More intensive interventions include a nurse-family partnership where parent training is done in the home environment over a period of six to nine months. Adolescents presenting with ODD and CD require a multidimensional approach including social services intervention, social skills training, parent training, family therapy, educational support and the involvement of the juvenile justice system. Minimal preventative or targeted programmes are currently active within South Africa.

Among the medications used for the treatment of ADHD, psychostimulants have the most efficacy in the treatment of oppositional behavior. The use of polypharmacy to stabilise disruptive behavior is restricted for highly problematic behaviour. The approach should always be step wise. A time frame should be used to trial medications and careful management of the side effects of medication is crucial. The combination of stimulant and risperidone is beneficial. The combination of atomoxetine and olanzapine is beneficial. The combination of stimulant and citalopram, aripiprazole or fluoxetine is effective in the reduction of irritability, anxiety and depression.

Early intervention is the cornerstone of treatment for a good outcome. The prognosis is poor in patients presenting over the age of eight years. Adolescents with problematic behaviour often require placement in long-term, highly structured, inpatient behaviour modification programmes. Application for placement in these programmes is done through state social workers. Within the private sector, referral for behaviour modification is done to the adolescent programme of the 'Healing Wings' organisation. The Department of Social Development has created a six week ROAR programme as a targeted intervention for ODD.

Criminal activity will eventually lead to the involvement of the juvenile justice system. Parents are often hesitant to report violence, destructive acts and theft but should be encouraged to do so for their own safety and the possibility of earlier intervention, even if that means involving the criminal justice system.

Other avenues for intervention come through sport focused organisations like 'Waves for Change' which use the positive and healthy benefits of sport activity to enhance confidence, self-belief and prosocial behavior. The youths of today are the adults of the future. Valuing their talents, providing structure and opportunities, nurturing their education, allowing them to develop surrounded by support and healthy boundaries ensures healthy adult functioning. Ignoring these needs and abandoning our youths to the chaos of broken families, communities and society is an oversight with tragic and appalling consequences.

References available on request. MHM

Marita Rademeyer
Clinical Psychologist

CYBERPSYCHOLOGY AND PORNOGRAPHY

INTRODUCTION

Cyberpsychology is a construct that examines the ways in which the internet is providing the backdrop for our communication patterns, interactions, and even our identities. Studies conducted in this field so far have concerned themselves with constructs such as emotional functioning, behavioural responses, gaming, virtual reality, personality variables, perceptual processes, online behaviour and personality, and artificial intelligence. While the virtual world provides us with wonderful opportunities and information, there are numerous risks involved. Some of these risks include online gambling, pornography, and threats to the identity and safety and wellbeing of the individual.

Common types of stress in the digital age include always needing to be available, connection overload and a fear of missing out which in turns leads to increased usage. One of the more pressing concerns in the digital age is the displaced pathway from traditional victimisation to cyber-bullying that is perpetuated by anonymity. Children especially, are vulnerable in this digital age, specifically to the use of pornography and its effects. The internet allows for the global impact of pornography to be disseminated via a Quadruple-A Engine, being Availability, Accessibility, Affordability and Anonymity. MRI results have shown that the brain activity of those with a pornography addiction is comparable to substance dependence.

CHILDREN'S PORNOGRAPHY USES AND ITS EFFECTS

ADHD has been linked to a multitude ossive and even violent with romantic partners. Evidhin relationships by impacting partners of those diagnnd relational implications mentioned above, it's easy to see why effective management of adult ADHD is a necessity. Management that is both combination and holistic has been found to be most effective. A starting point would be to exclude any possible organic causes.

Following this, medications such as stimulant (methylphenidate or dexamphetamine being the first line), non-stimulants like atomoxetine (for those who struggle with stimulants), antidepressants like bupropion, and other medications targeting the co-occurring disorders are indicated. Psychotherapy as an adjunct is also indicated. Types of suggested theraccupational therapists providing the tools to assist those with ADHD to organise their environments, enhance their social interactions and awareness, optimise time management, monitor and regulate sensory stimulation, and develop stress-management techniques.

Unfortunately, pornography continues to be the main source of sex education for many children and lends itself to permissiveness around topics like casual sex and sex with multiple partners. Because of the way in which pornography sends toxic messaging about sexuality to children, they learn distorted lessons and internalise these toxic messages surrounding sex and sexuality. In fact, children who use pornography are more likely to engage in unhealthy and damaging sexual behaviours. Studies show that girls who are 16 who used pornography were twice as likely to be sexually active at this age than girls who did not. Youngsters who engage with pornography engage in riskier sexual acts, such as having multiple sex partners, failure to use contraception, and using substances during sex. Alarmingly, they are also more likely to abuse their siblings sexually. They also internalise the belief that violence is a normal part of sex, even generalising this to beliefs around rape and sexual exploitation.

Pornography use in children has even been implicated in social deficits, such as a decline in social bonding, social interaction, and social integration in different contexts of the child's life. Gender stereotypes, too, are affected, with children coming to believe that the value of being a girl lies in sexually pleasing men, and even the belief that violent sexual encounters are pleasurable for the girl. Intimate relationships in those who use pornography are negatively impacted, with gender-based violence seeing an increase based on the messages conveyed in pornography consumed.

HOW DO CHILDREN START WATCHING PORNOGRAPHY?

The pornography industry is a profitable one and concerns itself with making money at all costs. With this comes increased accessibility, and children being shown pornography by other people as a form of sexual grooming. Additionally, children may be unintentionally exposed to pornography via unsolicited messages, mistaken searches on search engines, pop-up images, advertisements, and more. Some children are exposed to pornography through unintentional web searches, or by using another person's device which contains pornographic material on it. Older siblings and other school children can also pique a child's interest in pornography. Children may engage with each other to source pornography, specifically when they have limited access to the internet. Group chats can also lead to exposure, when someone in the group shares pornographic content. Additionally, video games which overemphasise sexuality have posed a great threat to exposure to pornography in young people.

HOW CHILDREN REACT TO PORNOGRAPHY

Not all children react the same way to pornography, with some choosing to ignore it, and others passing the content along. Most children don't seek help or support from the adults in their lives on this issue. This leads to them becoming secretive and isolating themselves, as they view pornography use as shameful and a secret. Some children are open about pornography and share it among others or begin to act out sexually. Because pornography has special addictive qualities that are not shared by other activities or substances, it's considered both an "upper" and a "downer". Thus children use pornography when bored to feel stimulated and when anxious or agitated as a means of self-soothing. Pornography has a short delivery pathway, with brain stimulation from consuming it being almost instantaneous, unlike with other substances.

The main problem with children viewing pornography under the age of 12 years is that they tend to develop problematic sexualised behaviours, as they're exposed to sexual knowledge beyond their developmental capacity. There is a continuum of sexual behaviours, ranging from typical, which is developmentally appropriate, to inappropriate, which may be contextually inappropriate, to problematic, which generally lacks consent and is contextually inappropriate, to the other end of the spectrum being harmful, which involves victimisation and violence towards others.

Children in the modern digital age are falling further along the most harmful side of the spectrum, with 30% believing that girls do not have a right to say no to sex, 50% believing that forcing sex on someone you know is not defined as rape, and 26% believing that girls enjoy being raped. Because sexuality is a sensitive developmental process, caregivers often under or overreact to children's experimentation or sexual acting out.

Children don't automatically understand the boundaries of sexual content – they need to be taught this. There are clear boundaries regarding what is developmentally appropriate concerning childhood sexual behaviour, with a fixation on sexual behaviour and pornography being highly problematic. It's therefore important for us to be aware of the potential risks of digital pornography on children, and to act in accordance with the developmentally appropriate bounds, ensuring our children are safe from harm – both within themselves and from a perspective of harming others. Keeping children safe in the digital age is of paramount importance to circumvent harmful sexual behaviours.

References available on request. MHM

By Charlene Sunkel
Founder/ Chief Executive Officer
Global Mental Health Peer Network

EXPERTS BY EXPERIENCE IN POLICY AND PRACTICE

To begin, it's important to define what is meant by an "Expert by Experience" in the context of mental health – it's someone who has or had experience of a mental health condition, who, through their journey of recovery, have navigated systems to access services, and/or faced and dealt with adversity that goes along with a diagnosis. Experts by Experience therefore have unique insights, awareness and are able to provide practical solutions, through personal and collective experiences in mental health.

The phrases 'Experts by Experience' and 'People with Lived Experience' have started to become prominent in global discussion and decision-making platforms that steer through processes of research, mental health service development, delivery, and policy. However, in some (mostly low-and-middle income) countries the concept of people with lived experience playing an integral role in mental health and its various domains, has yet to make a significant shift towards meaningful and authentic inclusion of experts by experience in policy and practice.

One of the key functions of policy is to respond to the needs of people and protect human rights. Therefore, if policy and practices fail to integrate the perspectives and recommendations of service users in its development, implementation and monitoring and evaluation phases, interventions would then result in wasteful expenditure resources and a non-alignment of service user needs. Without the elements of good practices in policy and strategic plans, we sit merely with paperwork and less effective engagement.

International human rights instruments and mental health related reports and guidelines explicitly call for equality and recognition of the value of all people, including people with lived experience of mental health conditions, towards advancing socio-economic and sustainable development.

The WHO World Mental Health Report: Transforming mental health for all (2022) notes that "People with lived experience are crucial stakeholders in mental health. Their participation is vital to improve mental health systems, services and outcomes. Such participation

includes full empowerment and involvement in mental health advocacy, policy, planning, legislation, programme design, service provision, monitoring, research and evaluation".

The UN Convention on the Rights of Persons with Disabilities states the commitment to "recognising the valued existing and potential contributions made by persons with disabilities to the overall well-being and diversity of their communities, and that the promotion of the full enjoyment by persons with disabilities of their human rights and fundamental freedoms and of full participation by persons with disabilities will result in their enhanced sense of belonging and in significant advances in the human, social and economic development of society and the eradication of poverty".

The International Covenant on Economic, Social and Cultural Rights speaks of the right to work and remuneration to be fair and equal "for work of equal value".

Elements of good practices in policy and service development will ensure that people with lived experience are included as key partners, right from the outset and be fairly and equally remunerated for their contributions and expertise. Inclusion of people with lived experience goes beyond mere development and implementation, but extends to monitoring and evaluation of service delivery. Measuring impact should not merely be about clinical outcomes but about achieving quality of life and should be set as a key indicator of mental healthcare services and interventions.

Including people with lived experience in turn results in positive outcomes whereby policy and services form the foundation for respecting and protecting human rights; establishing quality services and support to communities that are aligned with their contextual needs; building trust and confidence in the system that improves engagement with care; and most importantly, it's cost-effective in the sense that outcomes are invested to benefit the people.

In reality, despite the emphasis and evidence of the value of meaningful and authentic inclusion of lived experience partners in mental health research, policy and service delivery, there are obstacles hindering the realisation of the ideal of experts by experience integration across these sectors.

Stigma and discrimination has been one of the biggest barriers to inclusion of people with lived experience and has led to devaluing the personal and collective experiences of people with mental health conditions as significant to transformation of mental healthcare systems. Stigma and discrimination has further resulted in persistent misperceptions that people with lived experience are unable to contribute towards discussion and decision-making processes, due to perceived limitations resulting from a mental health condition, and that such individuals are presumably unable to make decisions.

Paternalistic approaches, often with good intentions, have created power-imbalances whereby people with mental health conditions are solely seen as 'patients' who are objects of mental healthcare and not partners in creating suitable conditions to access appropriate mental healthcare.

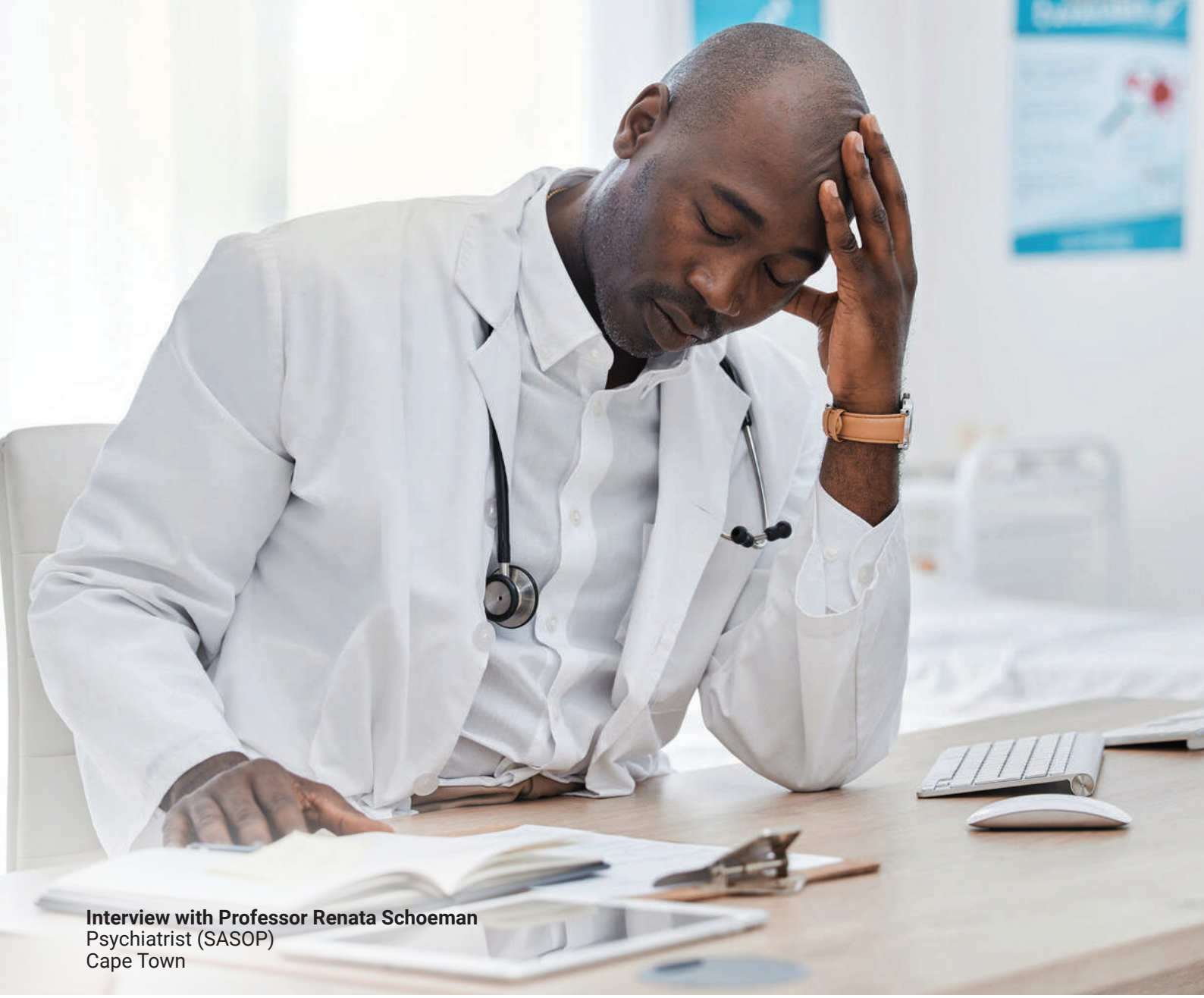
As an international lived experience organisation, the Global Mental Health Peer Network (GMHPN) has focused its work and advocacy initiatives on promoting the experiential and monetary value of experts by experience as catalysts for change.

Through our experiences as an organisation we have found that stakeholders have expressed significant interest in establishing partnerships with people with lived experience and their representative organisations, however, often do not know "how to" involve lived experience meaningfully and authentically. Despite efforts, stakeholders at times do not understand the role of lived experience throughout all phases of a set project or piece of work, and fail to ensure that people with lived experience are embedded from the start and to the end. Some stakeholders may also have concerns about the relevance of the expertise of people with lived experience and base their understanding of inclusion on a requirement to possess professional qualifications, instead of the expertise derived from concrete experiences that bring practical solutions.

In instances where experts by experience had been included in discussion and decision-making processes, most often remuneration for their involvement has been left out of the budget planning, or remuneration has been inadequately budgeted for. This directly devalues the experiential and monetary worth of people with lived experience's expertise. The assumption made is that people with lived experience should participate in a voluntary capacity; not considering the cost to the person or representative organisation in terms of own resources used to participate or the contributions towards the ultimate outcomes itself.

GMHPN developed CONSULT Guidelines to policymakers and other stakeholders as a resource to strengthen their partnerships with people with lived experience and peer-led organisations. GMHPN appreciates governments and policymakers that are open to including our voices and therefore we would like to provide support and guidance on how best to work together and create the change we all envision. Our guidelines provides practical elements of meaningful and effective engagement, including: creating an engaging, safe and supportive space for quality contributions; obtaining diverse representation of persons with lived experience to enhance equality and inclusion; commitment to eliminate power imbalances, paternalistic approaches, tokenism, discrimination, and stigmatisation; sustaining a mutually respected partnership; upholding the principles of effective engagement and consultation; leveraging lived experience expertise through meaningful and authentic inclusion; and transforming policy and practice that is an accurate reflection of lived experience voices.

References available on request. MHM



Interview with Professor Renata Schoeman
Psychiatrist (SASOP)
Cape Town

THE COST OF UNTREATED MENTAL ILLNESS IN SOUTH AFRICA

Health economists estimate that unaddressed mental health conditions cost the South African economy R161 billion per year due to lost days of work, presenteeism (being at work but unwell), and premature mortality.

In the Mental State of the World 2022 report, South Africa scored the lowest average on the mental health wellbeing scale, measured across 34 countries, and the World Mental Health Report 2022 estimated the rise in both anxiety and depressive disorders at more than 25% during the first year of the pandemic.

Today, three years post-COVID 19, burnout, anxiety and depression are at a record high creating a highly stressed, anxious and mentally unwell workforce with a detrimental impact on companies bottom line.

During Corporate Mental Health Week (4-8 July 2023) Prof Renata Schoeman, Head of Healthcare Leadership at Stellenbosch Business School, said that although COVID-19 had raised the need amongst organisations to protect their employees' mental health and well-being, very few are succeeding in making a concerted and relevant effort as part of their attraction and retention programmes.

"Employees are seeking workplace environments where management cares as much about their productivity as they do about their emotional well-being. Emotionally well supported employees are happier, less stressed and anxious, more creative, productive and have higher levels of job satisfaction which leads to low staff turn-overs and less conflict."

"The pandemic forced us all to adapt to working from home

overnight and left hybrid working in its wake as a new model for doing business. Combining both working remotely and in-office has given rise to several benefits but also risks to mental health. If the risks are left unaddressed it could have serious consequences for organisations if they don't actively adapt their Employee Assistance Programmes (EAPs) to support their workforce through these changing times."

Hybrid work provides flexibility with more freedom for employees to manage their work and personal schedules, and less time spent in traffic, reducing stress levels and enhancing work-life balance - essential components of maintaining good mental health.

However, Prof Schoeman says that the risks of hybrid working, if not proactively managed well by organisations, outweigh the positive impact.

"Hybrid working blurs the boundaries between the office and one's personal life. It can become a daily challenge for employees to disconnect and recharge and separate work-related stressors from personal time, leading to burnout especially if the organisation's culture promotes being 'always on', expecting employees to always be available and responsive to work demands."

"Working remotely can also lead to social isolation and reduced interpersonal connections, causing a disconnection from colleagues, increased stress levels and poor decision making. It can jeopardise career progression, in that promotions are not only evaluated based on work performance but also their people and management skills, how they collaborate within a team, and their attitudes and values. These are character traits that are difficult to judge remotely, which slow down and reduce growth opportunities."

Prof Schoeman says with hybrid work models likely to continue and evolve, organisations need to re-evaluate their EAPs and proactively prioritise mental health support to include hybrid working environments to reduce the impact and prevalence of mental health illnesses.

"EAPs have certainly come a long way in the past years where organisations have realised that a healthy workforce equals a healthy company. However, most programmes have been designed as a short-term measure to deal with issues that have already occurred and are largely reactive responses to an individual's wellbeing.

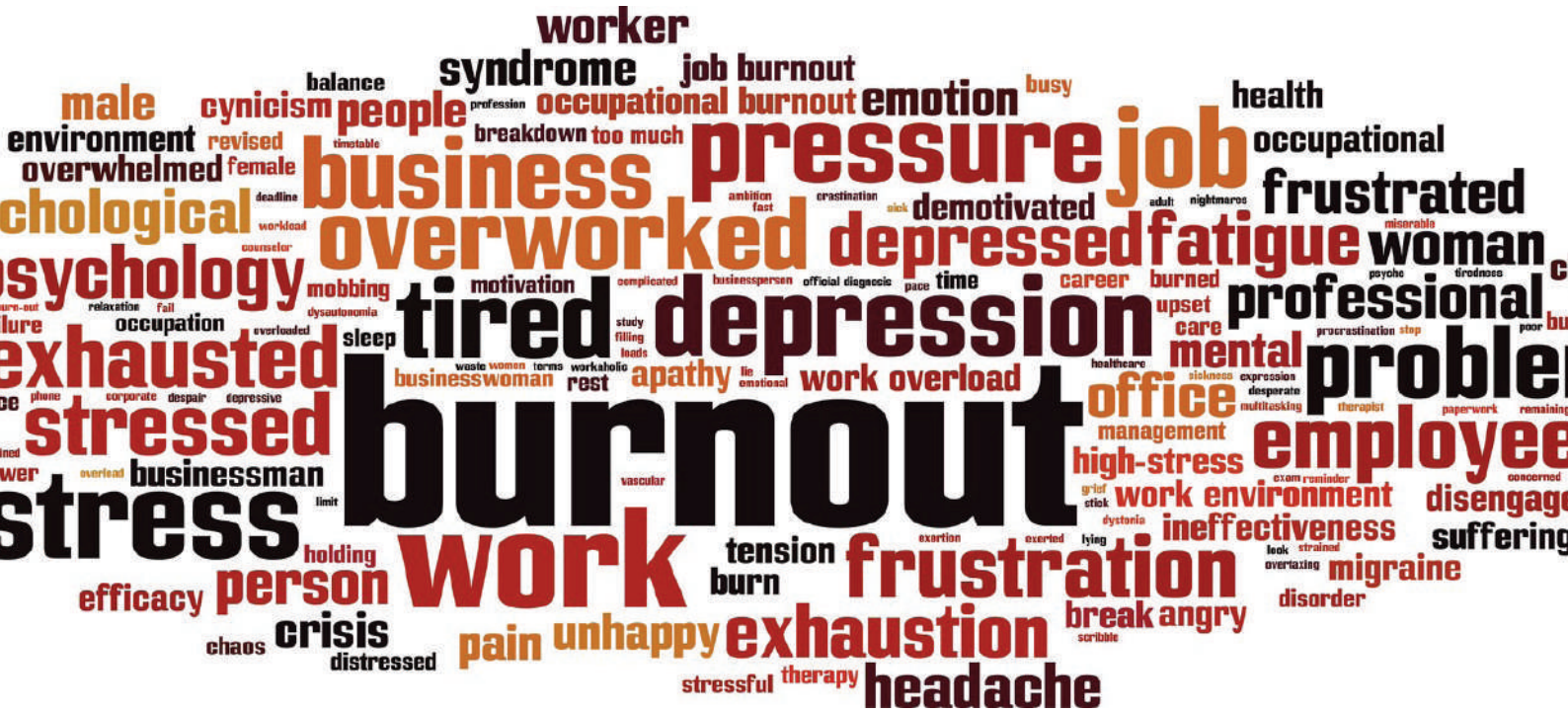
"Organisations need to adapt their EAPs service with additional focus on preventative education, changing the company culture to avoid burnout and adopt a holistic approach to wellbeing that equips employees to manage the challenges of post pandemic work."

In addition to the wellness and financial support offered EPAs should include the following:

- Changing the organisation culture to promote work/life balance
- Expanding mental health benefits
- Access to health tech apps
- Online therapy and remote mental health appointments
- Live, instructor-led skills training
- Collaborative care models
- Reduce stigma
- Burnout prevention
- Cultivate resilience
- Lead by example
- Advocate self-care
- Include in-person gatherings such as team-building and regular face-to-face interactions and time in the office
- Guarantee anonymity and confidentiality

Mental health illness has significant personal, organisational and societal costs, and unless organisations make mental health issues a strategic priority, these costs are set to increase. Prevention is the best strategy to follow and avoids the downward spiral into potential disability, and promoted a happier, healthier society.

References available on request. MHM



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WORKING WITH WHISTLEBLOWERS

PEOPLE WHO RISK SPEAKING OUT

Many of us are familiar with the names of whistle blowers like Babita Deokaran, who was gunned down in her driveway in 2021 after she'd uncovered massive fraud at Tembisa Hospital. Cynthia Stimpel is another well-known person who blew the whistle at South African Airways. She is one of the founders of The Whistleblower House (TWH) which provides shelter, protection, and support to whistleblowers (www.whistleblowerhouse.org).

Then there are the people we don't hear about, who speak out about wrongdoing whether it's at local, municipal, regional, provincial, or national level. Many of these people weren't looking for evidence of corruption, they stumbled upon it while just doing their job, or someone drew their attention to it. Sometimes, they find it is their superiors who are the perpetrators of corruption and other criminal acts, making it difficult to know who to turn to for help.

Research commissioned by the Transparency, Integrity, and Accountability Programme (TIP) and conducted by the Foundation for Human Rights focussed on the whistleblower journey to ascertain trends. Most whistleblowers have been subjected to various forms of retaliation by their employers such as demotions, suspensions, dismissals etc., all of which have had devastating effects on their livelihoods and lives. Psychosocial support was found to be key in enhancing whistleblower support. The recently formed Whistleblower Support Platform for Reform (WSPR) seeks to increase the number of healthcare professionals dealing with whistleblowers.

WHISTLEBLOWER SUPPORT PLATFORM FOR REFORM

In 2022, various organisations met to identify ways of supporting and empowering whistleblowers. In 2023, these meetings led to the establishment of WSPR. It consists of civil society organisations working collectively with statutory bodies within government, business, and the media. WSPR aims to contribute to building a coordinated and comprehensive whistleblower support system that will ultimately lead to increased accountability, transparency, and the fight against corruption.

WSPR also seeks to equip whistleblowers with the knowledge necessary both before and after they blow the whistle so they can make informed decisions and mitigate negative consequences during the whistleblowing journey. It's also working on initiatives to inform and educate the public about whistleblowing, changes to current whistleblower legislation, and the support that WSPR offers whistleblowers.

Whistleblower researcher Mthabisi Moyo of the Southern African Institute for Responsive and Accountable Governance (SAIRAG) said:

"Corruption, being abuse of entrusted power for private gain, thrives under cover of darkness with dire consequences which violate human rights within workspaces and society in general. Whistleblowing is crucial in shedding light where malfeasance

occurs and is regarded as the most effective organisational fraud detection tool. …

Support and empowerment of whistleblowers should prioritise free access to wellness services to provide ongoing psychological counselling, career rehabilitation to victims of employer retaliation, and access to justice and financial aid."

KEY AREAS OF INTERVENTION IDENTIFIED BY WSPR ARE:

- Promoting awareness of whistleblowing and undertaking research on whistleblowers
- Providing psychosocial interventions, including psychotherapy, career counselling and coaching
- Offering interventions focused on personal security, legal support, legislative reform, financial assistance, and policy.

TREATING WHISTLEBLOWERS

What does this have to do with mental health and other healthcare workers? And what risks do they face when they encounter whistleblowers?

Many, if not all psychologists, psychiatrists, and others in the mental health field, are not new to hearing about whistleblowers, be they high-level executives in multinational corporations, or ordinary citizens. Both whistleblowers and wrongdoers are engaged in civil society groupings, in public organisations like the police, the judiciary, and academia, or they may work in State Owned Enterprises.

I asked Cynthia Stimpel what she thinks whistleblowers experience and what they need after they've exposed corruption and unethical practices. Her thoughts below:

"Whistleblowers suffer extreme loss for doing the right things and for speaking up. The loss is unquantifiable. The loss of current and future income, whereby one is unable to get any meaningful work with a reasonable income, the impact of going into debt and losing your home and your possessions which you have worked hard for, and then the knock-on effect of trauma – which impacts family and people close to you.

We as citizens of South Africa need to speak out; we also need to protect our identities in order not to lose our livelihoods and suffer the extreme consequences we know whistleblowers suffer. Hence, we encourage safe reporting through reputable organisations in order to protect the whistleblower."

MYTHS ABOUT WORKING WITH WHISTLEBLOWERS

1. It's dangerous to work with whistleblowers.
   We often feel anxious when we meet new patients. Meeting whistleblowers, in my experience, is no different. Whistleblowers who have received advice before they expose corruption are often more prepared for the repercussions that Stimpel and Moyo have described. Others find themselves alone in the deep end.
   It isn't unusual for us to see deeply affected, frightened patients who are psychically unravelling. That is what we do. While I've felt anxious and very concerned about whistleblowers, at no time have I felt afraid for myself or for those around me.
2. Whistleblowers are high-profile people.
   The Zondo Commission into Allegations of State Capture, Corruption, and Fraud in the Public Sector details this in its recently released report. While many of those named and exposed in the report are high-profile people, there are many more ordinary citizens who find dishonesty in their workplaces. We know that corruption is rife, that it occurs across the board in schools, small businesses, in municipalities as well as in government and non-governmental organisations nationally and that it extends to international and multinational corporations doing business in South Africa.
3. We don't personally know whistleblowers.
   It would be surprising if we haven't all had one or more whistleblowers in our consulting rooms. We've treated teachers who've questioned spending at their schools, people who've heard reports about organisations, businesses, and government departments where unethical practices are common. As healthcare workers, we've also had to struggle with situations involving colleagues who are out of bounds. Organisations are rife with both blue- and white-collar crimes. Who hasn't heard of policemen or policewomen, traffic officers and others abusing their positions of power and authority for their own gain? This bullying behaviour occurs in many "regular" work, community, and domestic situations in which people, young and old, have been compromised in one way or another. Whistleblowers are ordinary people like you and me.

WE ALL WORK WITH WHISTLEBLOWERS

However, we are doing the therapeutic work. We have established study, supervision, and other groups to share technical and clinical know-how and to support each other, especially as each case we deal with is unique. We know about confidentiality, supportive psychotherapy, ethics, empathy, and compassion. And if we feel out of our depth with patients, we can seek help from colleagues, professional protection organisations, and from our boards at the HPCSA.

What whistleblowers need from us is acceptance, kindness, psychological containment, and reassurance that they're not crazy and that they can get through their life-shattering situations.

Organisations that make up WSPR include Corruption Watch, the Platform to Protect Whistleblowers in Africa (PPLAAF), the Southern African Institute for Responsive and Accountable Governance (SAIRAG), TWH and TIP. The initiative implemented by the Deutsche Gesellschaft für Internationale Zusammenarbeit (GIZ). WSPR is committed to making sustainable changes in the whistleblower environment through "collaboration, agility, innovation, and compassion."

A CALL TO ACTION

Contact me for more information on how you can help. TWH pays R1000 per psychotherapy session and therapists doing this work can join a whistleblower supervision and study group that I'm setting up. Cynthia Stimpel will be advising the group.

References available on request. MHM

By Marion Scher
Author of Big Bully: An Epidemic of Unkindness

BIG BULLY

AN EPIDEMIC OF UNKINDNESS

The first question I get asked as the author of this book is why bullying? Quite simply, after writing my previous book which highlighted 11 people's lived experiences with various mental health issues, the one topic which reoccurred during interviews was bullying. Whether at school, home, the workplace and of course online, I realised this needed more research and exposure.

With Lundbeck's encouragement and backing I was able to spend valuable time researching this topic which we decided to break into four categories: teen/school bullying; relationship bullying; workplace bullying and social media bullying. This latter category, given how it's insidiously woven into the very fabric of our society, runs through every chapter of the book.

Perhaps the hardest part of writing this book was actually getting people to open up to me on their bullying experiences, insisting on anonymity to protect themselves – against further bullying! When I did interview people I could sense just how tough it was for them to relate their experiences to me. They felt ashamed that they'd allowed themselves to be bullied.

Another question I'm asked is what do I think is the worst area of bullying? There is no one area, but social media definitely has seen this scourge increase with a powerful, subsequent impact. In my previous book 'Surfacing' a number of the interviewees related how when they were bullied at school at least when they went home and closed the door on the outside world they felt 'safe'. These days that doesn't exist, as social media follows you wherever you are. It also makes bullying easier because the bully is able to hide behind a screen.

Teen bullying

This is where social media plays a massive role and where bullying rather than being an 'in your face' experience takes on a whole new look. For instance a teen goes online over a weekend and immediately sees a group of their school mates having fun at a party. A party they weren't invited to! This type of exclusion is just as bad as a slap in the face as that child has to go back to school the next day aware of being left out...

One of the most horrific, but I discovered not uncommon features of teen bullying, is when sexting goes horribly wrong. Imagine discovering your 11 year old daughter has texted nude photos of herself to her 'boyfriend', who when they break up then proceeds to send these out to his social media group, which could be vast. This girl, at 11 years old may well feel her life is over – and as we're seeing more and more, decides life is no longer worth living. A growing factor in the rise of teen suicide.

The role of schools

The first thing I did when I began my research was to email various well-known high schools to ask permission to speak to teachers and pupils. I received one reply only – from the wonderful Westerford High School in Cape Town, who were enormously helpful in this regard. The rest – as far as they were concerned didn't have a problem. What I came to realise was that it was all about their protecting their brand. They felt if they participated in this project it would look as though they had a problem with bullying, which of course all schools have.

After speaking to schools, parents and teachers the main issues are: lack of willingness to take real responsibility for bullying; communication between all parties; understanding just where teens are with social media.

Relationship bullying

This has been going on since the first caveman grabbed his spouse by her

hair and dragged her out of the cave. The difference again is the subtlety of the bullying. Whether it's financial, emotional, physical or all of these factors, I discovered a common thread was the difficulty in walking away. It's almost easier to stay and battle on, particularly where there were children involved. Again there was almost a shame in admitting abuse had taken place. What surprised me here were colleagues who I'd known for many years and thought were in good relationships, who told me their gruelling stories. The bottom line is that very few people have someone they feel they can trust to open up to and feel supported by. Going to therapy in this country still carries a stigma, which hopefully this book may help disappear.

Workplace bullying

Several key issues came out of my research here. The main one being that human resources is there for the employer not the employee, who generally felt pretty hopeless when it came to reporting any bullying incidents. The other factor being simple economics - if you're lucky enough to have a job, you must shut up and carry on rather than make any waves.

Social media bullying

As social media and AI grow each day, so their effect on people's lives, especially teens becomes part of this phenomenon. So many young people in particular told me that even though they were aware of the damage social media can inflict, they couldn't stop themselves going online – sometimes up to seven hours a day. This impacts their lives not just when it comes to interacting with those they know, but being exposed to what is seen as the perfect life, with the perfect people, which they simply can't aspire to. They then see themselves as less and this is often a fast track to depression, but that as they say is another whole story – perhaps my next book...

Be kind

And what about the bully? Where and when does bullying begin? For me, this can be any time between birth and death, caused by imitation or circumstance. In the case of a child are they just replicating what they see at home? In the workplace will they seem weak if they don't take a firm stance, particular for women bosses? There are many scenarios and very few answers here. Perhaps what we need now more than ever is simply a reminder to be kind. Setting a good example with a simple 'please and thank you' to supermarket staff, waiting staff at restaurants, the cleaner at the office. Anyone and everyone we meet on a daily basis. Showing empathy and understanding goes a long way towards a better, happier society.

BIG BULLY – An epidemic of unkindness (Bookstorm) is available at all good book stores.

References available on request. MHM

Marion Scher
Author of Big Bully:
An Epidemic of Unkindness

SADAG's Ask the Expert with:
Dr Lavinia Lumu, Psychiatrist
Dr Rethabile Khalema, Obstetrician & Gynaecologist

NAVIGATING MENOPAUSAL TRANSITION & MENTAL HEALTH

Menopause is a natural phase of life which comes with many challenges, including mental health issues. Menopause, when a woman stops menstruating for a year at least and experiences a drop in oestrogen, often has symptoms such as hot flushes, night sweats, painful sexual contact, vaginal dryness, and a decreased libido. Menopause can be accompanied by cardiovascular complications and even psychiatric symptoms. This can be challenging for the individual. Because oestrogen decreases during menopause, common mental health issues in those facing menopause are mood instability and conditions such as depression and anxiety.

Women are twice as vulnerable to mental illness due to the fluctuating hormones involved with pregnancy and the menstrual cycle. Most women start menopause from their late 40s into their 50s and the mood changes may be quite distressing for those experiencing it. The emotional impact can carry through to external factors such as relationships, especially seeing as intimacy is impacted during this period. Even the way in which food is metabolised during this period, often leading to weight gain, can have implications on mental and relational health.

Oestrogen has also been researched in its implication in neurocognitive disorders such as dementia, as it is protective in terms of memory. Due to the decrease in oestrogen, there is research indicating that a higher risk of dementia is possible. Every medical condition has ways for preparation, and menopause is no different. This might entail a woman taking calcium for bone brittleness and vitamin D as well as regular exercise and good nutrition as preventative steps.

Perimenopause is often accompanied by the biggest mood swings and symptoms such as hot flushes and night sweats. During the postmenopausal era, the risk of all symptoms, including osteoporosis, is greatest, and can be treated with hormone replacement therapy.

Women with preexisting mental health conditions often see an exacerbation during menopause if they are not on medication or are not already stable. Although mild mood swings are to expected during menopause, many women describe a feeling of their emotions being "out of control" or "going crazy", feeling irritable and angry, and experiencing symptoms that impact their functioning.

Even in those on medication, there can be a mild exacerbation in symptoms. This makes ongoing psychiatric care relevant to make necessary adjustments to their psychiatric medication. Women with undiagnosed or untreated mental

illnesses may still be managed with treatment started during menopause. While menopause can't be treated, management is crucial. Outside of hormone replacement therapy, treatment includes antidepressants, anticonvulsants, contraceptive medications, hypnosis, and psychotherapies such as cognitive behavioural therapy to help support the person during this period. Although herbal remedies may be effective, these have not been tested in randomised control trials, which makes their reliability questionable.

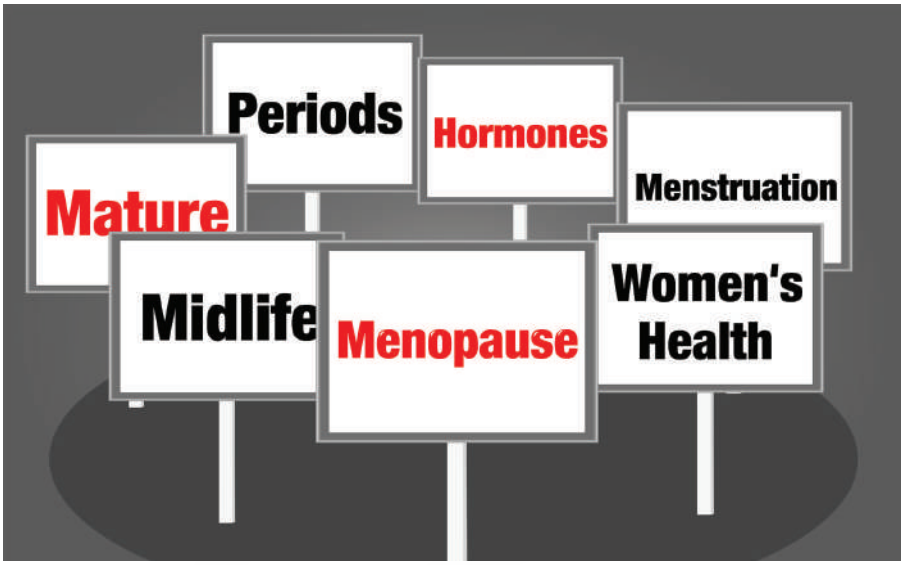
Helpful resources for women going through menopause include the South African Menopause Society (https://www.menopause.co.za/), online forums, and discussions with treating doctors.

Non-medical interventions that women may find useful are changes in eating, limiting alcohol and smoking to a minimum, and exercise, which is research-backed in combating the release of stress hormones which aggravate mental illnesses and the physical symptoms of menopause.

A common myth about menopause is that women should withstand whatever difficulties they go through. However, there are primary healthcare practitioners and mental health care practitioners that can assist with all the resulting symptoms to improve women's quality of life. It's important to emphasise to patients that there is a lot of help available in the form of health and mental health professionals, and to assist in breaking the stigma that blocks those from accessing assistance, particularly for mental health.

Help is available even in the public sector, which offers health and mental health services for those in need at a low or no cost. Loved ones of those going through menopause can also help their family member or friend by allowing them the space to ask for help and support, and to break barriers to intervention inflicted by stigma by facilitating conversation with individuals as well as in communities.

References available on request. MHM



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MEXICO

"The cases of extreme violence and torture that we handle are the tip of the iceberg"


©Yesika Ocampo

"I have never cared for so many people with suicidal ideation as I have here. Just in the month of August there were three cases," says Miguel Gil, a Doctors Without Borders (MSF) psychologist in Tapachula (Chiapas), a city on Mexico's southern border. Miguel has 10 years of experience working with migrants, many of whom are survivors of torture and extreme violence.

Around 30,000 people endure lengthy journeys in harsh conditions to reach Tapachula daily, most of them emigrating from countries in Central and South America. Access to healthcare is not guaranteed for migrants – much less when it's mental health.

"At first, our mental health team visited places like shelters. Our goal was to reach out to people who had survived extreme violence or torture and who might benefit from the treatment that we provide in an MSF centre in Mexico City. Now we also provide mental health care for migrants and care for victims of sexual violence," says Miguel.

The team in charge of offering these services includes six psychologists, two doctors, two social workers, a psychosocial community involvement agent, a mental health supervisor and a team leader.

Surviving extreme violence can have a severe impact on people's mental health. Miguel and his team attend to people who are mainly affected by post-traumatic stress, acute depression, and anxiety. After experiencing horrific trials such as rape, injuries from firearms, mutilation and witnessing the murder of family members, some patients don't want to continue living.

The most complex cases are sent to the Comprehensive Care Centre in Mexico City where a team provides specialised multidisciplinary care to migrants, refugees and Mexicans who have been affected. The team consists of specialists who offer quality services in healthcare, mental health, physiotherapy, and social work.

"We have to educate the local people here and help them to understand the stories of those who have suffered so much. Serving people who have been forgotten makes me feel like I'm doing my bit. What people need from us, as human beings, is empathy,"

- Miguel Gil, Doctors Without Borders (MSF) psychologist

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VISIT: MSF.ORG.ZA/WORK-WITH-US

MEDECINS SANS FRONTIERES
DOCTORS WITHOUT BORDERS

FROM GRIEF TO GRACE

FINDING HEALING AND REDEMPTION AFTER SURVIVING SUICIDE

By Sipho Simelane

It was early morning and I was sitting with my wife after dropping the kids at school. The phone rang and it was my older sister on the other side saying, "Dad is gone, he hung himself at home." Immediately the phone went silent. I knew my sister was not playing because of her tone and the brief message. Usually she'd ask about the weather, the kids and life when calling, but not today. I called her back a few seconds later and she confirmed that indeed our father had successfully taken his life by hanging himself in the kitchen at home.

That started my endless free fall through grief. That morning, my father Enoch Mzikayifani Simelane died not a natural death but a "shameful death" at the ripe age of 73 years through suicide. A shock wave went through our entire family and community. And as loved ones we struggled to understand what had happened, with everyone asking the question: How could something like this happen? How could a *73 year old man hang himself?*

That was a question I didn't need to ask, though. Because a few years earlier, I too, had attempted suicide over a four day period when I was about 40 years and survived.

This didn't make my grief any less painful. I still had numerous moments of confusion, self-blame and loss of hope and faith in God. But it wasn't difficult to understand as it was to everyone else, because it was a struggle I knew only too well.

My experience on 'both sides' then became a curse and a blessing in disguise. When my family, those who had the guts to ask how a suicide attempt could happen, I was able to answer. And when I answered their questions, I saw something wonderful happen - we both could heal and empathise with our family just a little bit more. We were even able as a family to openly disclose the nature of our father's death without shame or stigma, but sadly not all the family and community felt that way.

I can't speak for every person who has struggled with suicidal thoughts but I've spoken to enough survivors to know there are commonalities in how we felt about the experience. I even wrote about it in my book 'A Killer in My Head."

If your loved one could reach you now, these could be some of the things they would want you to know, and you might be able to find some comfort in hearing from someone who's been there.

- Suicide is more complex than a decision.

People who attempt suicide aren't always convinced it's the only option. It's more often that they have exhausted their emotional reserves to continue pursuing those options. It is, in many ways, the ultimate burnout. That state of burnout doesn't happen overnight either. In order to attempt suicide, a person has to be in a mental state where they can override their own survival instincts.

A person like my father, had to have reached a point when they felt their capacity for emotional pain outweighed the amount of time they're able to wait for relief, at the same moment when they have access to the means to end their life.

The fact that someone can progress that far is a much stronger reflection of the state of mental health in our communities and families. We didn't fail, and neither did you. There is a time when someone in crisis has to expend the most energy in order to keep themselves alive. To ignore the internal thoughts, the impulses, and the despair, is often when they have the very last and least available to do so.

Suicide is a tragic, lonely and painful outcome of extraordinary circumstances that, in reality, few of us have control over.

- Suicide is rarely that simple.

Being suicidal is such a confusing state to be in. I tried and survived three times. It's a window of opportunity that disrupts the delicate balance that allows us to survive. That to and fro is exhausting, and it clouds our judgment.

Suicidal thoughts, once they snowball, can become an avalanche that drowns out the part of us that would otherwise choose differently.

This might also be a reason

why some of us suicide survivors sabotage our own attempts. We might choose a method that isn't reliable. We might drop hints about our mental state that are almost undetectable to others. We might choose a time or place when it's possible we'll be discovered in time. The longer we take to plan our suicide mission, the more we leave open the possibility of a slipup or an intervention. A suicide attempt doesn't reflect how we felt about our potential, our life, or about you.

- Suicide is not about hurting you. When I attempted suicide, there were multiple moments when I thought about my family and loved ones. In our minds, we lessen our loved ones suffering and pain. When I speak to other attempt survivors, many of us share the same feeling. In those moments we are so far removed and have such tunnel vision that everything else is blacked out. And that singular vision can override our judgment.

A suicide attempt doesn't necessary mean someone didn't believe they were loved. It doesn't mean your loved one didn't know you cared or believed they wouldn't get unconditional acceptance and care.

Love alone is not enough to keep someone alive.

If love were enough, we would see much fewer deaths by suicide. My father's death by suicide at the age of 73 years says nothing about how much we loved him, or how much he loved us as his family.

I have blamed myself many times over the years for my father's suicide, but I have accepted that it was not my fault. Wouldn't the world feel so much safer if it were possible to save everyone we loved?

Every day since my father took his life and that day I received the call that he was gone, I've found myself wondering, "Why did he die, and yet I'm still here?"

Grief is a powerful teacher; I've learned to live alongside my grief, to let it transform me positively. I find the strength to do what's right, to be relentless and brave.

You're still here and you still have a chance to be extraordinary.

Both as a survivor of loss and of an attempt, life is without doubt precious and worth fighting for.

Fight for your life the way you wish you could've fought for your loved one.

References available on request. MHM

SADAG SUPPORT GROUPS

SADAG Launches a FREE Online Support Group for Issues Faced by Transgender People

The South African Depression and Anxiety Group (SADAG) is proud to announce the launch of a new Support Group aimed at providing emotional support on Issues Faced by Transgender People. The FREE Support Group starting on Monday, 11 September at 7 p.m., is designed to create a safe and nurturing environment where individuals can connect, share their experiences, and find comfort among others facing similar challenges for young adults between the ages of 18-35. The Support Group will meet virtually every second Monday at 7 p.m. after the first launch.

Young Transgender People face a lot of challenges, and they need a safe space of support to express their feelings and emotions. Coping with the emotional, psychological, and practical aspects of transitioning can be overwhelming, often leaving trans people feeling isolated and stressed. SADAG recognises the crucial need for a platform where they can come together, share their stories, and lean on one another for strength.

Pranav Odyan, the Support Group Leader, says "I am a trans man and I know the z and issues faced coming out or being transgender. By creating this Support Group I'll be able to create a safe space where other Transgender People can talk about their problems and get advice or information on transitioning and coming out."

If you have patients you believe could benefit by joining this Support Group, please ask them to WhatsApp Pranav on 081 215 3334 for more details. For more information about our other Mental Health Support Groups, visit SADAG's website for details at www.sadag.org, call 0800 21 22 23, or SMS 31393 to speak to a counsellor. MHM