

brainwaves



South African Clinical Neuropsychological Association

President's
report

Screening vs
Comprehensive
Assessment

State of
Neuropsych
in SA

More
billing
dilemmas



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Dear SACNA member,

Welcome to the first issue of Brainwaves for 2018 and also the first issue that I edit. As you will read in the Presidents report later on in this issue, our previous editor and SACNA president, Elton Bloye, is about to emigrate to New Zealand shortly and subsequently I have taken over the responsibility as editor of the newsletter. I would like to thank Elton for his effort in ensuring the continuity of this publication and his guidance in assisting me in taking over the responsibility. I would also like to thank the editorial board for their guidance and assistance in compiling this issue.

The theme for this issue of Brainwaves may be summarised as "issues" in the field of South African neuropsychology. The first article is the president's end of term report documenting the efforts to which SACNA has gone to build capacity and quality service delivery the field of neuropsychology South Africa.

This is followed by the findings of a survey conducted by Sharon Truter and Menachem Mazabow, both SACNA full members and members of the editorial board, documenting the status quo of neuropsychology in South Africa.

Thereafter, Urvashi Maganlal, HPCSA and Ethics representative for SACNA, provides an update on the neuropsychological billing dilemma that she wrote about in the last issue and shares her experiences of being audited by medical aid for deviating from what is perceived as the norm in psychological billing practices.

Finally, Ann Shuttleworth-Edwards, also a SACNA full member and member of the editorial board, shares an insightful piece outlining the differences between a brief cognitive screening and a comprehensive neurocognitive assessment.

We hope you enjoy reading these articles and we welcome your input and suggestions for future articles.



Christi Gadd
Editor

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President's End-of-Term Report

by Elton Bloye

As we forge headlong into 2018, we are nearly at the end of the current SACNA term, which began in August 2016. The last Annual General Meeting was held at the Riverside Club, Cape Town, in conjunction with the highly successful Paediatric Neuropsychology Mini-conference. With SACNA's next AGM coming up in a few short months (May 2018), it therefore seems pertinent for me at this point to outline some of SACNA's activities over the last two years, and especially to appreciate the development and the broadening of the association's impact in the world of South African neuropsychology.

I will however admit upfront that there is another motive for me writing this report earlier than usual. I have been offered an opportunity to "ply the trade" abroad, where I will be working in New Zealand for the next few years, starting in March 2018. While I foster a great love for South Africa and its people, and remain excited about the future of our beloved country with the recent changes in the political climate, this is an exciting opportunity for my family and I to "climb some different mountains" (both literally and figuratively) for a time. Regrettably, I will not be in attendance of our next AGM to give the outgoing President's address. Annelies Cramer (President-Elect) will be standing in for me in the last few months of my term as President. It is therefore with very mixed feelings that I write this report.

1. Executive Committee

The executive committee for the term consisted of Mr Elton Bloye (President), Ms Annelies Cramer (President-Elect; Treasurer), Dr Menachem Mazabow (Past-President), Dr Frances Hemp (Secretary), Prof Ann Edwards (Elected member), and Dr Sharon Truter (Elected member). A big thank you to all of the members of the exec team, as well as our Administrator, Ms Nicky Botha, for the enormous

effort that went into running SACNA for another 2 years.

2. Goals and objectives for the term

One of the core goals for the executive over the term was to make SACNA activities more accessible to a broad range of individuals interested in the neurosciences, while maintaining our high standard of entry for registered psychologists to enter into Full Membership. Other broad aims were to continue to provide more financial support to previously disadvantaged research candidates within the field of neuropsychology, and to expand our advocacy activities beyond that of the HPCSA professional board, by engaging with other stakeholders in the medical insurance fields.

3. Membership

I am very pleased to report a steady increase in membership in all categories over the two years. At time of writing, SACNA's member base has grown to 46 Full Members 3 Life members, 404 Associate members, 112 Student members,, and 58 Subscribers, bringing membership at the end of the term to a total of 623. That's an increase of 68 members over the course of two years, which we can largely attribute to the high standard of our educational initiatives, keeping registration fees as low as possible, as well as making registration easier with the online payment portal.

In 2017, SACNA increased its membership fees for the first time in many years. We are pleased to inform you that there will be no changes in membership fees going into 2018.

4. Educational Initiatives

Talking of educational initiatives, SACNA has continued to place a high emphasis on providing opportunities to upskill and increase learning in the neurosciences in general. The educational initiatives were initially seen as adjuncts to the credentialing process, but have now become very popular

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activities with individuals registered in all categories of membership.

The term started off with a highly successful Paediatric Neuropsychology Mini-conference, where we hosted Dr. Talin Balbikian (USA) and Dr Coenie Hattingh (SA) as experts in the field of paediatric neuropsychology and neuroanatomy/

neurophysiology respectively. Both presenters were very well received, so much so that Dr Hattingh, our local speaker, was asked to present further workshops based on his vast knowledge of the brain and his unique interactional teaching style.

In November 2016, Dr Hattingh presented a nationwide roadshow entitled, "Making Neuropsychological Sense of Brain Scans". This 1-day workshop was held in Cape Town, Johannesburg, Bloemfontein and Durban. It was collectively attended by 160 people, and Dr Hattingh covered some of the technical aspects of neuroimaging techniques, and then reviewed more context specific clinical presentations in neuroimaging.

Such was the success of the road-show amongst the small number of participants in Bloemfontein, that Dr Hattingh offered to present his full set of neuroanatomy and neuropathology lectures to about 15 participants in a two-day workshop in January 2017. Dr Hattingh did this free of charge, and 15 people attended this workshop, which was presented in an informal and participative way. We'd like to once again thank Dr Hattingh for his efforts in this regard.

On the other side of the International Neuropsychology mid-year meeting, SACNA ran another online book course. On this occasion, the topic was on the frontal lobes and executive function. Dr Elkonhon Goldberg's wonderful text, "The New Executive Brain" was selected, and we had 140 people register. All participants passed with above an 80% pass rate, and judging by the comments received by some of the participants, the course was very well received. Thanks to the efforts of Dr Frances Hemp, this course really provided an

opportunity for the participant to become well grounded in the text, as the questions formulated required a full understanding of the information presented, rather than "cut-and-paste" responses. Thank you once again Frances for the enormous effort you put into the course, as well as to Annelies Cramer and Nicky Botha for making sure it ran smoothly.

At the time of writing, the SACNA Executive committee is working on a follow up to the executive functioning course, by hosting Dr Yana Suchy in May 2018. Dr Suchy will be presenting on the Neuropsychology of Executive Functions and Emotional Processing, taking a look at both theory and practical application in this broad and interesting area. As planned a few years ago, this will be presented as a "mini-conference" on the other side of the INS 2017, and will be held at Kleinkoop Boutique Hotel, Centurion. SACNA will in all likelihood revert back to its traditional biennial conference in 2020.

5. Conferences

The 2017 mid-year meeting of the International Neuropsychological Society (INS) was always going to be the highlight of the term, and SACNA was fortunate enough to be co-hosts with PSYSSA of this event. The international neuropsychology community descended on beautiful Cape Town from 5 to 8 July 2017, and was privileged to hear some of the "best minds in the business!".

Topics ranged from ground-breaking neuroimaging studies in behavioural neuroscience, new approaches toward neuro-rehabilitation, and advances in sports concussion management, to name but a few. We were also fortunate enough to hear updates on a number of local issues pertaining to neuropsychological practice. A full report is available from Ms Annelies Cramer in this edition of Brainwaves.

One of the fringe benefits of hosting the 2017 INS was the fostering of relationships with other interest groups and associations working in the neurosciences. A big thank you should go to Dr Ann

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Watts, Fatima Seedat, and Karl Swain (PSYSSA), Prof Michael Kopelman and Dr Gordon Chelune (INS), and our own Annelies Cramer and Prof Ann Edwards (SACNA) for making this event happen.

6. Training and Credentialing

The last two years has seen more people pass the SACNA exam than at any other time, with 22 people having passed from March 2016 at the time of writing. Congratulations to Bronwyn Wood, Michelle Baker, Elmien Butler, Shireen Mohammed, Willem Annandale, Kirsty Carter, Jessica Munday, Jan Hofmeyer, Ronel Nel, Urvashi Maganlal, and Anthony Townsend. Passing the SACNA exam is no small endeavour, and it is a mark of distinction to have succeeded. We would like to encourage all these individuals to go one step further and submit their unsupervised reports for credentialing, so as to enjoy the benefits of the SACNA online referral system, as well as other professional benefits. Congratulations to Aline Ferreira Correira who was admitted as a full member in February 2017.

7. Research bursaries and funding

SACNA awarded the 4th Victor Nell endowment to Ms Adele Munsamy, who has been using her funding to research HIV-Associated Neurocognitive Disorder. While Adele unfortunately needed to adapt to the unforeseen circumstances of losing her primary supervisor and a move to Cape Town, she has been working at adapting her study to run in conjunction with the Cognitive Reserve Study (CR), being supervised by Prof. John Joska at UCT. She will be piloting the CR tool on a subset of HIV infected patients in the Western Cape, which will begin once ethical clearance has been received.

At time of writing, a call for applications for the 5th SACNA-Victor Nel endowment had just been sent out. This is a one time bi-annual grant of R30000, to encourage training and research in neuropsychology, primarily in areas that are relevant to the South African context.

Unlike in the past, SACNA also made two additional research grants of R30000 each, to assist in

developing local normative data in collaboration with South African universities. The grants were awarded to Dr Linda Blokland (University of Pretoria) who is collecting norms on the Bender II, and Dr Doret Kirsten (North West University) who is collecting norms on the NEPSY-2 and Tower of London. Both of these projects are still in their early phases.

8. Statutory Matters

At the beginning of the term in August 2016, SACNA had just concluded its activities in the HPCSA Neuropsychology tasks team (via our elected representative, Mr Trevor Reynolds). The task team ran for two years from 2014. At this point the task team had officially been disbanded, and we were informed that the procedures required to populate the register for the training of Neuropsychologists had been sent to the Minister of Health. SACNA at this point offered to be of further assistance in the process, and Dr Menachem Mazabow was elected as the HPCSA representative for the new term.

Despite numerous attempts at contacting the Professional Board of Psychology to obtain an update on the process, no new information has been forthcoming. As most will be aware, there has been a draft court order by representatives of the University of Cape Town and University of Witwatersrand against the HPCSA, in order to have graduates of the MA Neuropsychology degrees (on or before 2012) "grandfathered" (This is the appropriate legal term, I am told). It would seem as though any progress on the task team activities has been "frozen" at present, pending the outcome of this court order and other political factors which are at play. SACNA has again written to the HPCSA PBP in January 2018, asking for clarity of the situation, and again offers its support toward resolution of the impasse, in order to get the process back on track. We will continue to keep members informed of any developments.

I was also in attendance at the workshop held by PSYSSA at WITS, entitled, "Reimagining the Scope of Practice", which yielded fruitful discussion about

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different ways to approach the problems surrounding the SOP. Following this, and the call by the HPCSA for comment, SACNA sent a proposal to the HPCSA in May 2017. The Executive Committee proposed that there be no changes to scope for the Neuropsychology category, but that the nomenclature be changed to "Clinical Neuropsychology", in order to convey that the category is a practitioner/clinician based, rather than research oriented.

SACNA also endeavoured to engage in new advocacy activity in 2017, with Urvashi Maganlal (Gauteng Regional Chair) and myself meeting with various medical insurances, in order to advise them of problems neuropsychological practitioners are facing when dealing with an outdated tariff system. The central message given at the meetings with Discovery Health, GEMS, and Metropolitan Health was that the amount of time that goes into a neuropsychological assessment is extensive, and that the amount paid by the funders according to an outdated tariff system is not commensurate with the efforts of the practitioner.

9. Media and Communication

SACNA has continued to produce its newsletter Brainwaves, albeit with one less edition in 2017 due to a future change in the editorial team. Unfortunately, with my other duties as President, I could not keep up with producing a second edition in 2017. However, I am pleased to inform you that the capable and enthusiastic Ms. Christi Gadd (Clinical Psychologist), who has been a regular attendee of our Gauteng regional meetings over many years, has now been co-opted to step up to the plate as the Editor. We would like to formally welcome Christi to the SACNA exec team, and wish her every bit of success as she brings a fresh face to the newsletter.

Christi has also done a fantastic job managing the SACNA LinkedIn page. One of the changes that were made in 2017 is that we moved from a "personal" page to a "Company" page, which allows greater flexibility in terms of posting updates on courses, as

well as interesting articles. This is a work in progress, and SACNA hopes to be more active in the social media environment going forward, particularly as it pertains to keeping members updated on cores issues and events in the South African neurosciences. Our website, which was overhauled in 2014, continues to bear fruit in terms of its ease of use for members. We have found that membership has increased due to the positive effects of the online payment portal, making it easier for people to pay their subs.

10. Regional branches

SACNA regional meetings have long been the core of networking opportunities for the association throughout the year. Our regional chairs have worked hard at trying to ensure that presentations are of a high standard, and in comfortable and accessible settings. Unfortunately, in 2017, we have had a number of disruptions due to student protests in Cape Town and Durban, with some of the meetings cancelled as a result. The regional chairs have not rested on their laurels however, and are brainstorming ways to overcome these obstacles, possibly with new venues for 2018.

On the positive side, the new North-West Province branch was opened in February 2017, and although a smaller centre, they have managed to have 3 meetings during the year. The formation of this branch is just one of the ways that SACNA is trying to foster the development of neuropsychology practice in some of the smaller centres.

With this in mind, I would like to welcome Ms Muneera Mohamed as the Eastern Cape regional chair for 2018. The Eastern Cape meetings will in all probability start again this year, with venues in either Grahamstown or Port Elizabeth. Under Muneera's leadership, we are looking forward to seeing steady growth in this region as well.

A big thank you to Urvashi Maganlal (Gauteng), Frances Hemp (Western Cape), Julianne Hardman (KwaZulu-Natal), Ben Janecke (Free State), and Doret Kirsten (North West) who have worked hard to

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maintain a good level of attendance at the regional meetings.

11. Final acknowledgements

Lastly, I would like to again thank the entire exec team for working very hard over the course of the two years. As SACNA continues to grow in its activity and membership base, the amount of time and exertion toward attaining the organisations goals increases. Courses, conferences and credentialing does not happen by itself - It involves the efforts of those that have been elected, as they fit SACNA activities into busy family life and practice schedules,

often sacrificing personal activities, like sitting down with a good book, or playing a game of tennis. Nevertheless, it always amazes me how the exec manages to get things done with the limited time they have available. I would like to welcome the incoming Executive Committee, which will run from 2018 to 2020, and wish them all the best for the term ahead.

Yours sincerely
Elton Bloye

REGIONAL NEWS

GAUTENG

Urvashi Maganlal has handed over the role of Gauteng Regional Chair to Bronwyn Wood. Urvashi will move to the position of HPCSA & Ethics representative for SACNA.

Before she handed over, Urvashi arranged the first SACNA Gauteng meeting for 2018, on the 26th of February - An Update from APRAV (Association for the Protection of Road Accident Victims) with respect to the RAF/RABS dilemma. The speaker will be Mr Pieter De Bruyn (Co-ordinator at APRAV). The Association for the Protection of Road Accident Victims (APRAV) is a non-profit organisation that aims to protect the rights of South African citizens affected by accidents on our roads.

WESTERN CAPE

Western Cape will kick off 2018 on 28 February 2018 with Tania Pomario presenting her research on Assessing Executive functions in the context of low SES in a Wellington sample.

Their next meetings are planned for:

28 February: Assessing Executive functions in the context of low SES in a Wellington sample. Tania Pomario

28 March: Amazing recoveries. (Persistent vegetative state and West's syndrome). Dr Susan Malcolm Smith.

25 April: Localising language for pre-surgical planning using fMRI and functional connectivity analysis. Dr Vicki Ives-Deliperi

30 May: Neuropsychological profile of HIV+ children referred to the Red Cross Pediatric Neuropsychology Service. Limpho Mokoena.

Venue: Seminar Room 2, UCT Psychology Department, PD Hahn building, UCT upper campus. Time: 17.00 for 17.15 pm, last Wednesday of each month.

Contact Frances Hemp, Western Cape Regional Chair for more info franhemp@yebo.co.za

SACNA PRESENTS

The Neuropsychology of Executive Functions and Emotional Processing Theory and Practical



Yana Suchy is a Full Professor
at the Department of
Psychology, University of Utah.

GAUTENG

9 & 10 MAY 2018

Kleinkaap Boutique Hotel, Centurion
87 Jim van der Merwe Road, Clubview, Centurion

DAY 1

Clinical neuropsychology of emotion: Integrating theory and practice

ABSTRACT: The first half of this workshop (approximately 3 hours) will be spent on a detailed review of five domains of emotional processing that are relevant for neuropsychological (as well as general psychological) practice, including (a) the emotional trigger mechanism, (b) the reflexive emotional response, (c) the awareness and understanding of an emotional response, (d) emotional communication, and (e) emotion regulation/coping. The basis for the theoretical framework for each domain will be presented, consisting of an integration of functional and structural imaging, lesion, animal, and neuropsychological research, with a particular focus on neuroanatomic underpinnings and interface with cognition. Next, the workshop will examine ramifications for clinical practice, including ways in which deficits in each domain affect test performance, descriptions of relevant syndromes, as well as an overview of typical clinical populations characterized by deficiencies in a given domain. The second half of this workshop (approximately 3 hours) will review how emotions motivate complex behavior via interface with temperament, personality, mood, and cognition. Important implications of these processes for coping with stress will be examined, with a particular focus on how deficiencies in stress coping mediate physical, psychologic, and neurocognitive dysfunction, principally via dysregulation of the HPA axis.

LEARNING OBJECTIVES:

This workshop will help you to

1. Be able to name the five primary domains of emotional processing and their neuroanatomic substrates
2. Be able to name clinical populations that exhibit deficits in emotional processing
3. Understand how neurocognitive abilities and test performance are affected by strengths and weaknesses in individual domains of emotional processing
4. Understand how emotions motivate complex behaviors via interface with temperament, personality, mood, and cognition
5. Understand how and why deficiencies in coping with stress translate into poor physical, psychologic, and neurocognitive health

DAY 2

Executive functioning: A comprehensive guide for clinical practice

ABSTRACT: The first half (approximately 3 hours) of this workshop will be spent on a conceptual overview of five clinically relevant subdomains of executive functioning, including executive cognitive functions, meta-tasking, response selection/inhibition, initiation/maintenance, and social cognition. For each subdomain, elemental neurocognitive processes, neuroanatomic underpinnings, and relevance to daily life will be detailed. Following a thorough exploration of the executive construct, typical clinical syndromes characterized by discrete patterns of EF dysfunction will be reviewed, highlighting associated etiologies, behavioral and personality changes in daily life, as well as patient presentations during formal evaluations. The second half (approximately 3 hours) of this workshop will be spent on a review of assessment methods for each subdomain of EF, as well as assessment challenges and hindrances to ecologically valid interpretation of standardized tests of EF. Clinically useful recommendations for overcoming those challenges and hindrances will be offered, including the introduction of the Contextually Valid Executive Assessment (ConVExA) model and the first steps toward the application of the model in every-day clinical practice.

LEARNING OBJECTIVES:

This workshop is designed to help you

1. Gain a thorough and clinically useful understanding of the construct of executive functioning (EF) and be able to name the subdomains and elemental processes that comprise the EF construct.
2. Describe individual neurobehavioral syndromes characterized by discrete patterns of executive function measures, as well as the associated etiologies.
3. List the limitations of typical executive measures, as well as available methods for overcoming those limitations.



Gordon J. Chelune, Ph.D.
Professor, Department of Neurology
University of Utah School of Medicine

Specialist Talk

Title: Key Elements of Evidence-based Practice and their Application
in Clinical Practice: Using the five A's

The primary goal of any diagnostic evaluation is to reduce clinical uncertainty regarding a patient in an empirical manner. To achieve this goal, evidence-based practice involves a value-driven pattern of clinical practice that attempts to integrate the 'best research' derived from the study of populations to inform clinical decisions about individuals. This presentation will discuss the five key steps (five A's) in evidence-based practice

While neuropsychology has a robust research literature, many research studies fail to provide key details that can inform the clinician as to the quality and applicability of the investigational findings for individual clinical decision making. Likewise, even when present, practitioners often have difficulty applying the information that is available in an evidence-based manner.

Neuropsychology in South Africa:

Results from a nation-wide survey

by Sharon Truter & Menachem Mazabow

The results of a survey, conducted between July and November 2015, addressing various aspects of the practice of neuropsychology in South Africa, were published in the journal *Applied Neuropsychology: Adult* in August, 2017¹. The study was a component of a broader international project, and some of the findings, pertaining to the South African component, are presented below:

138 Participants responded to the survey, of which 95 were included in the final analysis. These participants were South African psychologists who considered themselves to have expertise in neuropsychology and/or who had performed at least some of the activities related to neuropsychology (such as assessment, diagnosis, treatment, teaching or research) within the year prior to the survey. Of these, 84.2% were female and the age-range of the participants was 25 – 73 years, with a mean age of 46.97 years. 24.2% of the participants had a doctoral degree. The participants' years of experience in neuropsychology ranged from 1-35 years, with a mean of 10.85 years of experience.

Professional Training, Teaching and Research

76.8% of the participants reported that their training in neuropsychology had taken place through continuing education as independent professionals. 20% of the professionals reported that they had not received any clinical supervision during their training.

All of the participants indicated willingness to seek official certification, should this become available in South Africa.

The most frequently perceived barriers to the development of neuropsychology in South Africa were identified as a lack of academic training



programmes, a lack of clinical training opportunities, and a perceived absence of willingness to collaborate between professionals.

Most of those participants who reported being involved in the teaching of neuropsychology, operated in public institutions, in which most of their teaching duties involved supervising neuropsychological-related theses/dissertations at Master's degree level.

Regarding research training, only 11 participants reported receiving specific training in neuropsychological research during their clinical education or training, 9 reported having received grant funding for research, and 11 reported insufficient resources and material to conduct neuropsychological research.

Work Situation

Approximately half of the participants reported that



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Results from a nation-wide survey

they work as private practitioners. Just over half of the practitioners reported that they work full-time while approximately one third reported that they work part-time, with the remainder being either unemployed or retired. Most of the participants reported satisfaction with their work-situation.

Most of the participants reported working 24.8 hours a week in the field of neuropsychology, with a reported average monthly income, specifically from neuropsychological work, being R17 256,94.

Assessments

Of those participants who had performed neuropsychological assessments in the year prior to the survey, 64.7% reported assessing an average of 9 patients per month (which equates to approximately two per week). The number of hours spent on testing, scoring, interpreting test results and report-writing averaged 10.5 hours per patient, but the amount of time varied significantly, with a range of 2 – 48 hours spent per patient.

Most of the respondents used flexible batteries of neuropsychological tests, i.e. test batteries that are tailored to the needs of individual cases, rather than using uniform test batteries. Of the 60 tests listed in the survey, the 19 most popular tests, listed in descending order of popularity (most-to-least), were: the Wechsler Adult Intelligence Scale (WAIS), the Rey Auditory Verbal Learning Test (RAVLT) and the Bender Visual-Motor Gestalt Test, the Rey–Osterrieth Complex Figure Test (ROCF), Finger Tapping (Finger Tapping/Finger Oscillation Test), Trail Making Test A & B, Wechsler Memory Scale (WMS), Controlled Oral Word Association Test (COWA/FAS), Stroop Test, Clock Drawing Test, Wechsler Intelligence Scale for Children (WISC), Symbol Digit Modalities Test (SDMT), Mini-Mental State Examination (MMSE), Delis–Kaplan Executive Function System (D-KEFS), NEPSY, Wisconsin Card

Sorting Test (WCST), Test of Memory Malingering (TOMM), Boston Naming Test (BNT) and Wechsler Preschool and Primary Scale of Intelligence (WIPPSI).

When participants were asked to identify



difficulties experienced with test material, they identified a lack of local normative data and an absence of measures adapted to their culture, as being the most problematic.

The most-frequently evaluated neuropsychological patient-populations were individuals with ADHD (54.2%), Traumatic Brain Injury (53.1%), and learning disabilities (45.8%), and, less frequently, individuals with dementia, depression and stroke. Referrals for neuropsychological assessments came primarily from the legal profession, followed by other psychologists and then psychiatrists. To a lesser extent, referrals from school systems, neurology, general medical practitioners and paediatricians were reported. Self-referrals, and referrals from insurance companies and rehabilitation sources were least frequently reported.

Rehabilitation

25.6% of the participants reported working in neuropsychological rehabilitation in the year prior to the survey, where on average a range of 1-50 patients were seen per participant, per month (with an average of 8.5 per month). The majority of rehabilitation services were directed to persons with

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traumatic brain injury and stroke. The most common treatment provided in the rehabilitation setting was individual therapy.

Implications

The authors, in their discussion of the implications of this study, emphasise the necessity for formal professional training programs, and highlight the ongoing need for continuing efforts to compile local normative data, and to adapt test instruments to the local context. Also apparent from the survey results is a requirement for greater emphasis on rehabilitation efforts, which appear from the survey results to

constitute only a minor portion of general neuropsychological activity currently. Finally, the authors point to the pressing need for the allocation of greater resources towards neuropsychological rehabilitation and local research.

¹Reference: Truter, S, Mazabow, M, Paredes, AM, Rivera, D & Arango-Lasprilla, JC (2017). Neuropsychology in South Africa. Applied Neuropsychology:Adult. DOI:10.1080/23279095.2017.1301453
To link to this article: <http://dx.doi.org/10.1080/23279095.2017.1301453>

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The Neuropsychological Billing Dilemma – An update

by Urvashi Maganlal

To practitioners of neuropsychology, the lack of recognition of the clinical value of neuropsychology combined with the outdated tariff system continues to be a source of distress for anyone undertaking neuropsychology for clinical purposes. The work is time and resource intensive, and a thorough neuropsychological investigation cannot be done by a computer alone.

If you do so, you do so at great professional risk. The current tariff system works on a sliding scale, such that the longer one spends on an assessment, the less one is remunerated. I know, this sounds like you've heard it all before. Indeed, you have (this was an issue in last year's Brainwaves and the same was presented at INS 2017 in Cape Town), yet the status



quo remains unchanged almost a year after that conference and in the forty plus years of recordable history of Neuropsychology in South Africa.

At present, there has been no change and in the minds of the funders and until a category has been created there is nothing to distinguish whether a Psychologist is practicing neuropsychology or not. This is their argument. There is also nothing to distinguish whether an appropriately trained practitioner of neuropsychology is doing a neuropsychological, psychological or clinical assessment based on the current procedure codes or their professional registration and practice numbers. All the funders align to the BHF which issue a practice number to all psychologists which identifies the specific category you are authorised to practice in.

So, based on my own experience, and as a follow-up to the last article, I thought it worthwhile to present some of my own learnings in the hope that until the register for the category has officially been opened, that appropriately trained practitioners of neuropsychology be mindful of the following.

Firstly, be aware that if you are routinely undertaking assessments, whether in hospitals, or in private practice and whether you are a cash practice or not, if the client submits a claim to their funder, and the funder pays (either you as the practitioner directly or refunds the client), that funders have the right to

The Neuropsychological Billing

Dilemma – An update

request all the clinical records (every single clinical paper, document, transcript or electronic material) from the assessing practitioner.

One may argue that this goes against what practitioners are taught - that confidentiality with a client is of paramount importance and it is essential that right at the outset of any intervention (therapy, assessment or otherwise) that the issues regarding confidentiality be outlined and that the client be informed of the limits to confidentiality. Most practitioners make their clients aware that if there is risk to self or others that confidentiality will not be guaranteed. Indeed, as a new practitioner I was ignorant to the fact that confidentiality does not extend to the client's funder, nor do I recall studying this as part of my board exam!

Indeed, confidentiality regarding the patient's treatment is prescribed by section 14 of the National Health Act and is further entrenched by HPCSA's National Patient Rights Charter (Booklet 3), with specific regard to Guideline 2.7 which stipulates that information regarding a patient's health and treatment may only be disclosed when informed consent had been provided by the patient (save for a couple of exceptions which are not of issue for this article). In general, it is noted that it is only under the conditions of a subpoena that psychologists divulge their records and that too, with reservation. In my conversations with other therapists who have been asked to open up their files, they have simply disclosed the information or presented a summary – neither, I emphasise, would be acceptable if you are abiding to the HPSCA ethical guidelines for practitioners.

So while this is what is stipulated by the HPCSA, I am not sure how many psychologists are aware that the funders have the right to that material – despite the confidentiality agreements one might have in place with their clients and HPCSA

regulations. It almost seems like a case of the “devil or the dark blue sea” – ethically you have a confidentiality agreement with your client, but the schemes can also demand that material?

According to many of the medical schemes, part of the scheme rules require that the client grant permission to full disclosure of their medical records. With the introduction of the Regulation 15J(2)(c) of the Medical Schemes Act Regulations, "subject to the provisions of any other legislation, a medical scheme



is entitled to access any treatment record held by a managed health care organisation or health care provider and other information pertaining to the diagnosis, treatment and health status of the beneficiary in terms of a contract entered into pursuant to regulation 15A, but such information may not be disclosed to any other person without the express consent of the beneficiary." Most medical aids indicate to their clients that this may be the case, whether the client actually understands what this means is a different story. Regardless, you will need to get that proof from the funder prior to releasing any data.

The Neuropsychological Billing Dilemma – An update

For whatever the reason may be, the funders are known to routinely conduct forensic audits. These audits, are aimed at ensuring that the service rendered by the health practitioner was legitimate and that if the health care practitioner saw a patient for a said amount of time, that there are adequate records of what was done and whether the work done justified the time and money spent on that service. Because psychology procedure codes are based on time – there is no real distinguishing criterion as to whether the session is for a consultation, psychotherapy or assessment. Thus, if a clinical psychologist (for example) uses an 86211 procedure code or an 86205 procedure code, there is insufficient information to advise what the objective of the session was. Statistically, most psychologists use a 86205 procedure code – since most therapies are usually 50 -60mins long, so if you are routinely billing a client for seeing them for anything longer than 1 hour (as would typically happen when one is routinely doing neuropsychology assessments) then you would be flagged by their computer system as an outlier and stand the risk of being audited.

While audits are a fact of life, it is a hinderance and the burden of proof lies with the practitioner to prove that what they have done is legitimate. Most practitioners won't be happy about this, so I am not surprised why there are so few people doing in-hospital neuropsychological assessments or neuropsychological assessments for clinical purposes. As I said right at the outset, not only is it far more resource intensive, but the time and effort

spent on a case is not adequately remunerated and even if you have a cash practice, you are immediately at risk of being flagged as an outlier and audit-worthy. Who wants this headache?

At the moment, there are no easy solutions to the problem. If you decide to focus your practice on neuropsychological assessments for clinical purposes (where there is a huge need), you stand the risk of being an outlier, and hence you stand the risk of being audited. Regardless of where or what direction you choose to practice, make sure that you adjust your informed consent to make the client aware that their medical aid may request their records for their own forensic auditing purposes and that permission is granted for them to view your files should this be the case. Secondly, keep copious records of everything you do – this is easy if you are doing an assessment as there will inevitably be stacks of material of what was done. Finally, state the times next to the dates on every invoice as well as in the client's file i.e. what time did they start and what time did they end. Be vocal – if it took four hours – say so. Reports are not covered by medical aids, so you charge for this – make this clear to the client from the very onset. State it in writing and point it out to them. In conclusion, I wish there were better answers. The ideal is to revise the current tariff system and have procedure codes that are not just time based also provide a better definition on what was done – be it therapy, a psychological assessment (such as projective tests or inventories), neuropsychological, IQ tests or psychometric – career tests and/or educational assessments or a combination. I sigh as I end this article, because I wonder if this will ever change. In the meantime, we learn as we go along, we do the best we can with what we have. The issue remains unresolved, and until we see positive signs of change or a willingness to engage with us on the issue, we carry on knocking on those doors and we carry on speaking to whoever will listen.



Brief Screening Techniques versus Comprehensive Neurocognitive Testing

by Ann B. Shuttleworth-Edwards

The aim of this report is to address the question of how to differentiate between a "brief screening technique" and "comprehensive testing" in the neuropsychological assessment arena. The explication of this terminology, and correct application of the separate types of assessment, requires careful scholarly consideration, and is not as simple as it may seem. For instance, as will be described below, there is a hybrid version of the two modes that prevails quite routinely in the assessment arena, that can best be described as a "comprehensive test screening" approach. Such an approach is insupportable when evaluated against the assessment principles of modern clinical neuropsychology.

For the purposes of this report, the term "screening technique" is used with reference to a cursory, brief assessment approach, probably taking not much more than 15 to 20 minutes. In contrast, "comprehensive testing" refers to the use of a wide spectrum of tests, sometimes including a test of intellectual ability such as one of the Wechsler IQ tests, and a series of more specific cognitive tests, that taken together cover multiple core functional modalities examined in some depth, and may take several hours to complete.

Taken on their own, neither "screening techniques" nor "comprehensive testing" can be seen to be all

good or all bad. Both are subject to success or failure if poorly conceptualized from a neuropsychological standpoint, and ineptly used from a psychometric perspective. For clarity on the issue, it is necessary to



return to basics.

Conceptual underpinnings underlying screening versus comprehensive testing

In modern clinical neuropsychology (Lezak, Howieson, Bigler & Tranel, 2012), assessment is based on a hypothesis testing model in terms of brain-behaviour relationships, and not a psychometric testing model. The orientation, therefore, is functional rather than test-based, and what this means is that there is no single screening test, and no set comprehensive test battery that exists for the identification of brain-related sequelae in a de-contextualized manner. In other words, in order for either of these approaches to have utility, whether

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brief screening, or comprehensive testing, the assessment will always require a focus in terms of



the neuropathological condition being targeted for evaluation. Long gone are the days of the single brain injury screening test premised on the false assumption that brain damage is a single, rather than multifaceted entity.

Further, whether conducting screening or comprehensive testing, there is always the chance of false negative findings: i.e., the failure to identify the presence of brain pathology when it is present; or false positive findings: i.e. the identification of brain injury when it is absent. The probability of false negative findings (i.e., the failure to identify the presence of brain pathology when it is present) is normally much greater on a brief screening technique because the net is not spread as wide. However, the comprehensive assessment is not exempt from a false negative finding, and regardless of how extensive the evaluation, it is never possible to "rule out" the presence of brain pathology. It can only be said that on the basis of the present testing there is no evidence to support its existence, which appears unlikely at the present time. Both modes (screening test or comprehensive evaluation) are subject to false positive findings (i.e., the identification of brain injury when it is absent), particularly if westernized tests and norms are used on educationally disadvantaged individuals.

In the final analysis, a focused brief screening assessment in terms of the expected pathology, used in an applicable setting, is more likely to identify the presence of brain pathology if it exists, than a poorly designed multiple test evaluation that claims to be comprehensive, but has omitted a core function in terms of the targeted pathology, and/or used demographically inappropriate norms for the individual under examination.

Decision process when embarking on screening or comprehensive testing

Step 1. Decide whether testing is necessary. The starting point for undertaking neuropsychological assessment (whether screening or comprehensive) is because there is the known, or hypothesized presence of a neuropathological condition or conditions, accompanied by likely functional sequelae (available from presenting complaints, prior medical investigations, etc.). On that basis a decision should be taken as to whether or not psychometric testing is indicated, to evaluate the presence of the proposed possible cognitive sequelae.

A primary error which is to be avoided, is to do routine psychometric testing, with a pre-packaged toolkit (whether screening or comprehensive), that is without any due motivation. Reasons for not doing testing might be because the brain injury signs are pronounced and clearly in evidence on clinical examination or on a relative's report, and/or that appropriate evaluation has already been completed, and/or that cognitive testing will not answer the question as well as another type of evaluation such as a home visit, or visit to the occupational setting.

This argument may seem self-evident. However, I have seen individuals criticized and embarrassed in court for producing voluminous test results used for "comprehensive psychometric test screening" that is applied routinely in the practice to all clients, even in advance of any clinical interview, whether for custody or disability or criminal referral. Such testing might

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include IQ testing, so-called "brain injury" tests, projective tests, etc. when there is no reason to believe the individual has brain injury, and in the absence of conducting the necessary clinical investigation, family visits, home, school or occupational evaluations. The exposure of clients to a barrage of psychometric tests in advance of a probing clinical interview, and without due motivation, is both un scholarly and might be considered malpractice. It is this type of approach that causes psychometric testing to be demeaned and fall into disrepute.

Step 2. Decide on the type of assessment. Once an adequately motivated decision has been taken that more information is required on the basis of cognitive testing, to establish the presence or absence of actual or suspected brain pathology, the next step is to decide on the most appropriate TYPE of assessment to apply in terms of: (i) the use of a brief screening assessment, or (ii) the use of a time-consuming comprehensive assessment. Given that the conceptual underpinnings of these two



approaches are the same in terms of brain-behaviour principles, the critical proviso here is to give careful consideration as to what constitutes an appropriate setting for their valid application in each case.

Appropriate application of screening versus comprehensive techniques



There are two broad contexts within which screening or comprehensive techniques might be employed.

1. Individualized clinical assessment. In the individualized clinical situation, quick screening tests can be used to formalize the presence of pathology when it is already clearly evident on the basis of behavioural reports and clinical examination, and comprehensive psychometric evaluation is redundant. However, for the identification of uncertain brain impairment and its sequelae, screening tests have application as an early warning system only (Lezak et al. 2012, page 174), following which patients normally require more comprehensive neuropsychological investigation, possibly in conjunction with neurological follow up.

Screening tests are not a fair and comprehensive basis on which to design a rehabilitation programme, to make educational recommendations, or to evaluate the full extent of disability in the case of a compensation claim. For these applications, the limitation of any screening device used must be acknowledged, and referral made for a suitably focused comprehensive neuropsychological investigation.

The comprehensive examination will usually be made up of tests of old acquired knowledge, often including a vocabulary test, to provide an indication of premorbid ability, and a spectrum of tests covering functions that are likely to be impaired due to the

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neuropathological event that is suspected or known to have occurred. For any condition involving diffuse brain damage, tests of memory, and tests of processing speed should routinely be included, in that these functions are regularly impaired in association with such pathology. It would be unusual not to include memory tests or tests of processing speed in a comprehensive battery since the majority of neuropathological



conditions are of a diffuse nature, and even if focal will frequently result in associated diffuse pathology due to infection, brain swelling and pressure effects. Where there is knowledge of relatively focal damage, such as in the case of a cerebrovascular accident, or the site of impact in a traumatic brain injury, or the position of a tumour demonstrated on a scan, tests will be chosen to tap the functions associated with the area of the brain affected. However, it is still useful to include tests tapping a brain area that is not presumed to be affected by the targeted pathology (such as tests of left hemisphere function in the case of suspected right hemisphere pathology), in that preserved function in the unaffected area, at the expected premorbid level, serves to endorse the extent of the disability arising from the damaged area.

2. Group research contexts. Screening tests have tended to move out of popular use in clinical

settings, alongside recognition of the multifaceted nature of brain pathology, and increasing awareness about the limitations of their diagnostic accuracy in the individual case (Lezak et al., 2012). However, they do have substantial utility in research settings in order to evaluate large numbers of participants in group studies efficiently where there are usually time restrictions and the need to work with limited financial resources. Examples of such research contexts would be studies on the effectiveness of treatment interventions, or the identification of cognitive sequelae of a particular condition such as HIV/AIDS, or studies of normal aging where older individuals with dementia need to be excluded. In these situations, it is expected that the inevitable false negative and false positive results on screening tests will be averaged out in the group analyses, and will not have deleterious individual consequences.

It is important to be aware that many of our well-known screening tests such as the Mini-Mental State Examination (MMSE), and other dementia screening instruments have been developed within such research contexts. Tests of this type typically cover a spectrum of functions that might be depressed in the presence of a progressive dementia. However, the tasks are not very challenging or probing, and the cut-off points are normally quite lenient. If used blindly such a test might easily produce a false negative (i.e., indicating the absence of brain impairment when it is present), especially if the pathological condition is at an early stage, and/or administered to a formerly intellectually superior individual with a high level of advantaged education. Therefore, they should be applied very cautiously if used as the only instrument in an individualized clinical setting, and even if producing a positive result, should be recognized as being merely preliminary.

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Examples of specific screening versus comprehensive applications

Two specific examples of how screening versus comprehensive evaluations apply, are isolated here for illustrative purposes.

1. Testing for a level of intellectual ability. For the assessment of a level of intellectual ability, screening may be done by using a Vocabulary test or Reading test in isolation, and some tests have been developed specifically with this purpose in mind. However, such screening relies on an estimate of verbal intellectual ability only, and operates on the broad assumption that all other functions will be on a similar level. A more sophisticated screening for intellectual ability is to use a test of both verbal and non-verbal ability, such as the Wechsler Vocabulary subtest in conjunction with the Wechsler Matrix Reasoning subtest, so that both verbal and nonverbal parameters are brought into the estimate. Screening for the level of intellectual ability on this basis (i.e., the use of a single, or limited number of relatively stable functions), occurs mainly in research contexts (such as establishing the equivalence of intellectual ability between comparative groups). Again such screening would normally not be used in a clinical context except for quick ratification of a clearly apparent situation on clinical grounds, or for a preliminary opinion requiring more in depth follow up.

In contrast to these screening mechanisms, a comprehensive evaluation of intellectual ability involves the time-consuming use of a costly instrument such as the Wechsler IQ test, covering multiple functions, and thereby allowing for a much more secure and differentiated indication about ability. The assessment will allow for comment on areas of relative strength and weakness, and have the necessary scope for making fully informed diagnostic and placement recommendations.

2. Testing within the sports concussion context. Within the sports brain injury context, screening is usually applied to an apparently head injured player on the field or sideline. The screening includes a brief set of relatively simple orientation and memory tests that are likely to flag the presence of a concussion in the acute phase. If a concussion is confirmed on that basis, the athlete will be removed from play. Once asymptomatic he/she may be followed up with more comprehensive neuropsychological investigation to ensure that the brain dysfunction has resolved, and for educational and occupational recommendations going forward. The on-field screening test would not be suitable for such follow-up investigation as it is easily passed once the athlete is out of the acute phase. In order to identify lingering residual sequelae, more comprehensive and challenging testing is required.

SUMMARY

Screening and comprehensive psychometric tests are formulated with the same conceptual underpinnings from the perspective of modern clinical neuropsychology. They need to be functionally oriented, focused on the nature of the brain pathology being targeted, and applied according to demographically appropriate principles. Screening tests are applied for flagging problems, or in group research contexts, but are not normally used in clinical contexts for diagnostic and placement purposes, where instead comprehensive evaluation is called for.

Reference: Lezak, M.D., Howieson D.B., Bigler, E.D., & Tranel, D. (2012). *Neuropsychological Assessment (5th Ed.)*. Oxford: Oxford University Press.



SACNA BURSARIES FOR CROSS-CULTURAL NORMING RESEARCH

The South African Clinical Neuropsychological Association of South Africa (SACNA) is offering a single large bursary, or a series of smaller bursaries, up to the value of R50 000 to support norming studies on commonly employed neurocognitive tests. The aim is to facilitate valid neuropsychological assessment within the multicultural South African context.

In early 2000, a South African norming research initiative was embarked on at Rhodes University in the Eastern Cape, co-ordinated by Professor Ann Edwards. As a result of this project a pool of data for Xhosa speaking individuals from educationally disadvantaged backgrounds has been established, and continues to be collected on tests such as the WISC-IV, WAIS-III and WAIS-IV, and a variety of commonly employed neuropsychological tests, for example the Trail Making Test, the Purdue Pegboard, and the NEPSY-II. For adults, the tests were administered in English on individuals whose first language is other than English, but who have a basic proficiency in English. Various translation options have been employed for norm collections on the child populations, and similarly might be employed on adult populations. There is ample scope for expanding this data base for Xhosa individuals living in the Eastern Cape. Especially, there is a pressing need to broaden the research initiative to include individuals in other South African provinces, and individuals whose first language is other than Xhosa.

For the purposes of this research the variable of 'Educational Disadvantage' applies to schooling achieved exclusively in one of the former Department of Education (DET) township schools that were designated for black learners in the Apartheid era, and that continue to be poorly resourced up to the present day.

In sum, SACNA wishes to support research initiatives that will grow the availability of demographically focused South African data on cognitive tests, specifically with respect to educationally disadvantaged African first language or Afrikaans speaking individuals located in any of the South African provinces.

ELIGIBILITY

The bursaries are aimed at postgraduate students in Psychology (Clinical, Counselling, Educational and Research), and/or University based Psychologists conducting research for publication purposes;

Student research will be conducted under the supervision of a researcher employed in one of the South African universities;



The research may be conducted in collaboration with Professor Ann Edwards, or may be an independently motivated study that does not comply with the methodological parameters of the described earlier research studies;

It is expected that the research will be presented and published in the scientific forum, with pre-arranged contractual arrangements being made about authorship prior to commencement of the research study;

The norms, cited with respect to authorship as per the previous point, will be made available pre-publication to all SACNA members for their clinical use;

SACNA will receive due acknowledgement of funding provided to facilitate a particular norming project.

APPLICATION DETAILS

The application for a bursary should be accompanied by:

- (i) An outline of the proposed norming project;
- (ii) A detailed educational history, including any proof of a background interest in the field of neuropsychology.

The closing date for submissions is 31 May 2018. An extension to this time may be granted if an intended area of research investigation is provided, with a view to submitting a more formal proposal within a reasonable additional period of several weeks.

Interested researchers should submit their applications, or any related inquiries to the SACNA Bursaries Subcommittee Chairperson, Professor Ann Edwards (a.edwards@ru.ac.za).

CALL FOR APPLICATIONS:

THE VICTOR NELL-SACNA ENDOWMENT FOR THE STUDY OF NEUROPSYCHOLOGY IN SOUTH AFRICA



One of SACNA's primary aims is to promote the professional development of clinical neuropsychology in South Africa through encouraging training and research in the field, with particular reference and relevance to the unique circumstances of the South African context.

In line with those aims, the Victor Nell-SACNA Endowment for the Study of Neuropsychology in South Africa was established in 2010. This endowment takes the form of one-time bi-annual grants of R30 000, aimed at providing financial assistance in support of post-graduate studies towards a qualification in psychology, with particular focus on neuropsychological practice.

The endowment aims to honour the memory of the late Prof Victor Nell, who was one of the founding members of SACNA and who, until his death in April, 2007, made significant contributions to the status, development and training of neuropsychology in South Africa. He was the first President of SACNA, established and ran the UNISA Health Psychology Unit, initiated the only epidemiological study into traumatic brain injury in South Africa, authored *Cross-Cultural Neuropsychological Assessment: Theory and Practice*, and, shortly before his passing, was published in *Behavioural and Brain Science*, with his paper on Cruelty reflecting his wide interests within the field of psychology.

Eligibility. Applications will be accepted from students who have entered into an Honours degree or Masters degree in the domains of Clinical or Counselling Psychology in a university in which neuropsychology forms part of the syllabus.

Applicants must provide:

- (a) A full CV, including a detailed educational history, and past and present bursaries/scholarships received;
- (b) Proof of acceptance into the Honours or Master's degree training course;
- (c) Justification of their requirement for financial assistance;
- (d) A brief statement of intent to focus on clinical neuropsychology in their research and practice;
- (e) Proof of background interest in the field of neuropsychology (for example, voluntary work at settings such as Headway);
- (f) A statement undertaking to carry out research for the purposes of the Masters' dissertation in the field of neuropsychology; and
- (g) An undertaking to present the results of that research at the subsequent SACNA Bi-Annual Conference.

Applications should be sent to Dr Menachem Mazabow at info@sacna.co.za

The deadline for applications is March 31, 2018, and the award will be conferred at the SACNA AGM, which is planned for May, 2018.

