“While there is no health without mental health, there is also no complete mental health without psychiatry.”

1. **SASOP Position Statement 1 on national mental health policy**

SASOP has noted the process of formalizing national policy for mental health care in South Africa and extends its strong support for the process, as well as the principles incorporated in this policy framework. SASOP strongly encourages the formalization and implementation of the policy both nationally and at provincial level.

2. **SASOP Position Statement 2 on psychiatry and mental health**

As point of departure, it should be acknowledged that psychiatrists should play a central role, along with the other mental health disciplines, in the strategic and operational planning of mental health services at a local, provincial and national level. Specific time frames, definitions of care at different levels, norms and standards of care, resources to be allocated and the routine monitoring/auditing of mental health care programs all need to be done in conjunction with psychiatrists on all levels.

3. **SASOP Position Statement 3 on infrastructure and resources**

It is essential that, as a matter of urgency, the State takes up its responsibility, according to Chapter 2 of the Mental Health Care Act, no 17 of 2002 (amongst other), to provide adequate structures, systems and funds for the specified services and facilities on national, provincial and facility level, with specific emphasis on district hospital infrastructure capacity. Since the lack of the provision of the above routinely results in poor service conditions, mental health practitioners’ clinical judgment, decisions and practice may, in the mean time, be compromised as a result of existing substandard infrastructure and poor staffing conditions. It is therefore also necessary to adequately protect public sector mental health care practitioners from a medico-legal, professional and labour point of view. Appropriate staffing of facilities and services is also required, acknowledging that in the past, mental health and psychiatric services have been inadequately staffed and many institutions have been allocated no mental health professionals (e.g. tertiary and central hospitals).

4. **SASOP Position Statement 4 on STG and EDL**

Close collaboration and co-ordination should occur between the processes of establishing SASOP and national STGs, and the related decisions on EDLs for different levels. This will also require liaison with private sector practitioners. It can also be suggested that the authors of the SASOP STGs (who followed a formal peer-review process) and the NEDLC should form a standing committee and/or other structures for ongoing liaison to explore procedural issues, as well as the current and ongoing revision of the

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1 The South African Society of Psychiatrists (SASOP) and SASOP State Employed Special Interest Group (SESIG) Position Statements on Psychiatric Care in the Public Sector. SAJP. August 2012, Vol. 18 No. 3: pp133 -148
current different lists of available drugs. If, however, finalising the national EDL would occur in the absence of such close collaboration and co-ordination in the EDL and STG processes, SASOP will have to express its grave concern, as psychiatry as a specialist clinical discipline will be prejudiced against, while the availability of evidence-based medications will be threatened, in particular, within the public sector.

5. **SASOP Position Statement 5(a) on HIV/AIDS in children**

National programmes for HIV also have to promote awareness of the neuro-cognitive problems and psychiatric morbidity associated with HIV in children. It can be suggested that a task team should be set up to focus specifically on the needs of long term survivors of perinatal HIV infection. Specifically, the focus needs to be on the following:

- early anti-retroviral therapy (ART) initiation as a prevention strategy
- effective screening to increase the detection of early HIV encephalopathy, subtle neuro-cognitive deficits and psychopathology
- capacitating at primary level via increased human resources (including increasing subspecialist input at primary care) and intensified training
- mental health to be incorporated into early intervention programmes
- integrated and comprehensive, family based services at primary level
- strengthening of referral pathways from primary to tertiary level CAHMS services
- strengthen HIV prevention and safe sex psycho-education programmes within existing CAHMS services
- strengthen liaison with the Education Department in order to effectively address the educational needs and support of children infected with HIV

**SASOP Position Statement 5(b) on HIV/AIDS in adults**

In addition to increased awareness in national HIV programmes of HIV in children, the need for routine screening of HIV positive individuals (children, adolescents and adults) for mental health and cognitive impairments should also be emphasized. These psychiatric complications of HIV impact on critical issues in HIV/AIDS care, such as adherence. Many adult patients have a mental illness, either before or as a consequence of HIV infection. These patients often live under dismal conditions, often abuse substances and are often poorly compliant with all forms of treatment. They also run the risk of becoming a “reservoir” for resistant strains of HIV and TB. This is a “special needs” group who demand a specific integrated mental health and infections care package under the auspices of specialised primary care teams.

6. **SASOP Position Statement 6 on Substance abuse and addiction**

While the management strategy of substance abuse and addiction involves multi-sectoral responsibility, including social services, justice and education, the role of health and mental health must be regarded as a core component in a collaborative multi-sectoral effort. The adequate diagnosis and clinical management of related substance abuse and addiction problems should therefore also fall in the domain of the health sector and in particular that of mental health and psychiatry. The necessary resources and infrastructure will have to be made available to render these services effectively.

7. **SASOP Position Statement 7 on community psychiatry and referrals**
The ongoing rendering of ambulatory specialist psychiatric services on a community-centred basis should be regarded as a key strategy to make these services more accessible to users closer to where they live. In addition, the establishment of community based day-care centres and residential facilities is regarded as a core component of community-based mental healthcare services, ensuring access to the full range of psychosocial rehabilitation services, including occupational therapy and social services. It is essential that community-centred specialist psychiatric services are established within an appropriate referral system, consisting of: primary mental health and psychiatric (family physician) care; secondary specialist care (in community clinics and regional hospitals); and tertiary and quaternary psychiatric care (in tertiary, central and psychiatric hospitals). In this context, the need for community-based residential, day-care and step-down facilities should also be emphasised.

8. **SASOP Position Statement 8 on recovery and integration**

   Essential steps for the adoption of a recovery framework include:
   - the promotion of recovery awareness in all aspects of services, such that personal recovery outcomes become the universal goals by which service provision is measured
   - the institution of active measures to combat discrimination against individuals with psychosocial disability, within services and on a societal level
   - the institution of progressive programs in all services to establish and further develop consumer involvement in service feedback, planning and delivery
   - steps to improve accessibility to the wide range of treatment and support services required for recovery
   - the strengthening of primary-level and community-based mental health services to improve prevention, rehabilitation and restoration of social roles.

9. **SASOP Position Statement 9 on culture, mental health and psychiatry**

   Culture, religion and spirituality should be considered in the current approach to the local practice and training of specialist psychiatrists. It should however be done within the professional and ethical scope of the discipline, while all faith traditions and belief systems in the heterogenous South African society should be respected and regarded equally. In the public sector domain, no preference for one particular tradition should be given over another, as a result of a practitioner or a dominant group being from the one tradition or the other. To build up relationships of mutual trust and understanding, will require training and health education initiatives aimed at psychiatric practitioners, their patients, carers and students and at cultural and religious practitioners whom patients and their carers may choose to consult. The protection of individuals with psychiatric conditions within traditional and other religious/spiritual healing systems, however, needs to be ensured and all forms of abuse in this context, or neglect and delay with regard to appropriate psychiatric care, should be identified and prevented.

10. **SASOP Position Statement 10 on the specialty status of psychiatry**

   While the main business of SASOP is to promote, maintain and protect the honour and interest of the discipline of psychiatry as a medical specialty, it is strongly advised that:
   - the academic status of psychiatry as 1 of the 5 major clinical disciplines in all schools of clinical medicine in the different SA universities should be restored as a matter of priority
   - appropriate management structures for psychiatrists on all levels be created to ensure that the supervision and management of psychiatric services is rendered by psychiatrists themselves
   - the training of medical interns in psychiatry should be extended to at least 2 months within departments of psychiatry and not as a sub-programme of Family Medicine
- the appropriate structures and posts be created on the appropriate levels for psychiatric sub-specialists (including child and adolescent, old-age, addiction, consultation-liaison, neuro and forensic psychiatry).

11. **SASOP Position Statement 11(a) on Forensic observations; PS 11(b) on State patients; PS 11(c) on Mental ill prisoners**

**SASOP Position Statement 11(a) on forensic observations** - At least one observation unit should be established in each province; within provinces, satellite units should be considered to bring the service closer to the people. Observation units should be upgraded according to the standards set by the national Department of Health. Considering infrastructure, organograms for the adequate staffing of these units should be developed and approved by the provincial departments.

**SASOP Position statement 11(b) on state patients** - The emphasis for the care of this patient group must be rehabilitation. The institutions involved in the treatment of state patients should develop a uniform approach towards a rehabilitation programme. State patients on leave need to be cared for within the clinic system, and primary health care workers need to be alerted to the special needs of this patient population.

**SASOP Position Statement 11(c) on mental ill prisoners** - Attempts should be made to achieve changes to the MHCA to simplify the procedure of referral. Secure detention of this patient group must be assured by adequate infrastructure and staffing. The question of psychiatric services within correctional facilities must be addressed.

12. **SASOP Position Statement 12 on Security in psychiatric hospitals and units**

An integral part of the realisation of the human rights of mental healthcare users, as protected by current mental health legislation, is to ensure that the physical spaces and structure of facilities for mental healthcare are aligned with the needs and functionality of a spectrum of mental healthcare users, including forensic psychiatric care users. It is also necessary to adequately protect public sector mental healthcare practitioners from assault and injury as a result of performing their clinical duties by, among other, ensuring that adequate security procedures are implemented, appropriate for the level of care that is required, and that appointed security staff members are appropriately trained and adequately equipped.