Governance and power in mental health integration processes in South Africa

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by

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Dissertation presented for the degree of Doctor of Philosophy in the Faculty of Political and Social Sciences at Ghent University. This dissertation has also been presented in the Faculty of Arts and Social Sciences at Stellenbosch University in terms of a joint-degree agreement.

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December 2018

Declaration

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This dissertation includes three original papers published in peer-reviewed journals or books and three unpublished publications. The development and writing of the papers (published and unpublished) were the principal responsibility of myself and, for each of the cases where this is not the case, a declaration is included in the dissertation indicating the nature and extent of the contributions of co-authors.

February 2018

Acknowledgements

First, this work would not have been possible without the grace of Jesus Christ, and its completion affirms a perpetual drive to lead “the good life”.

Lize, ek verdien jou nie. Dankie vir liefde, easy-drinking wine, hondekinders, Damien Rice, en geduld met my tydens laat nagte en lang tye weg van die huis.

A great sense of gratitude towards my supervisors. Thank you to Piet and Pieter for their patience, wisdom, insight, generosity and hospitality. Thank you for exposing me to a new world, full of challenges and complexities, and for always being available for a chat.

My Bloem kwaggas, Duard, Chrizaan, Francois, Adeleen – dankie dat julle saam my gegroei het, van Tassenberg tot Kanonkop, van studentehuise tot meenthuise vol kinders.

Thanks to my friends from the Lowlands: Edwin and Caroline for fruitful, critical discussions, incredible hospitality, and for Grouse Mountain; Vera, for always being ready with a strange Dutch story, and for countless efforts in putting together the logistics for the defence; and Joost and Loran, for their enduring friendship, and for helping with translations.

Thanks to my friends based in the Great White North for their love, hospitality and countless adventures: Alex, Angeli, Lyndsay, Rabia – you were instrumental in my career trajectory.

André Rose, thank you for teaching me grace, for supporting me and this work in ways that cannot be adequately articulated.

Mamma, dankie vir beskerming, oneindige liefde en onselfsugtigheid, en dat ons op een of ander manier altyd Legos en boeke gehad het.

Gerrit en Riëtte, dankie vir liefde, lewensveraderende gesprekke en ingryping, en dat julle gesinne bou wat die wêreld `n beter plek maak.

Sussie en Ouma, dankie vir toevlug, goeie musiek, en dat julle altyd seker gemaak het dat ek `n boek voor my gehad het.

The moral, financial, and institutional support from the CHSR&D is gratefully acknowledged. Thank you to Asta, Michelle, Christo, Gladys, Alfi, Belinda, and Bridget for eight years of wonderful support.

Special thanks to Prof. Dingie van Rensburg, for getting the ball rolling, for unlocking a sociological curiosity and a critical stance towards social research, and for significant financial support.

Institutional support from the University of the Free State and Ghent University are much appreciated, especially from Dr Henriette van den Berg, Prof. Lucius Botes, and Korte Meer 5.

To my father, thank you for the knowledge-generation drive I needed for a career in academia.

Thank you to the Free State Department of Health for allowing access to behind-the-scenes areas, a fundamental aspect of social research.

Crucial support and inspiration from Prof. Inge Petersen is gratefully acknowledged.

Participation in doctoral research is a truly altruistic exercise, and the time, willingness and effort of research participants are much appreciated.

Finally, the constructive, thoughtful and engaging (and often, thankless) critique from reviewers and examiners are readily recognised.

Summary

On the back of centuries of scholarship, mental illness remains a deeply political challenge in modern societies. Although much headway has been made in researching mental health service provision in low-to-middle income countries, a distinct gap exists in understanding the crucial roles of governance and power in care provision. Concerning integrated care, understanding the relations among state and non-state entities is paramount. This doctoral study sought to explore how power relations shape the governance of integrated mental health care in South Africa. More specifically, the purpose was to illuminate the dimensions and structure of integrated mental health care; to describe referral and collaborative ties in a service provider network; and to examine the relations between state and non-state mental health service providers. A pragmatic, theory driven case study was undertaken in Mangaung Metropolitan District, Free State province, South Africa, employing multiple methodologies. The macro contexts of integrated mental health care were explored by means of a framework analysis of health policy, while the case study employed social network analysis and semi-structured interviews with key stakeholders. The findings suggested that integrated mental health care is pursued in South Africa in two ways: 1) by integrating mental health care into primary healthcare, and 2) by fostering collaboration between state and non-state role players. The service delivery network exhibited fragmentation, low density, hospital-centrism and suggestions of significant professional power. Key points of state and non-state collaboration included housing and treatment adherence, though proportional interactions between state and non-state services were lower than interstate service collaboration. Governance-related fragmentation emerged in terms of state and non-state service providers, biomedical and social approaches to care, and departments of health and social development. Gaps in state stewardship included weak strategic leadership and poor information systems. Power emerged in both its mainstream and second stream conceptions, rooted in, for example, professional power, and through an apparent commodification of people living with mental illness. The ambiguities of mental illness were concluded to be an important undercurrent to the dynamics of power that play out in service provision processes. Key policy recommendations focused on improving the following: 1) availability of financial resources; 2) relationships between service providers; 3) overly myopic organisation of government departments; and 4) political relationships between state and non-state partners. Ultimately, the study lays a strong foundation for further research into the mechanisms of power in the governance of mental health care in South Africa.

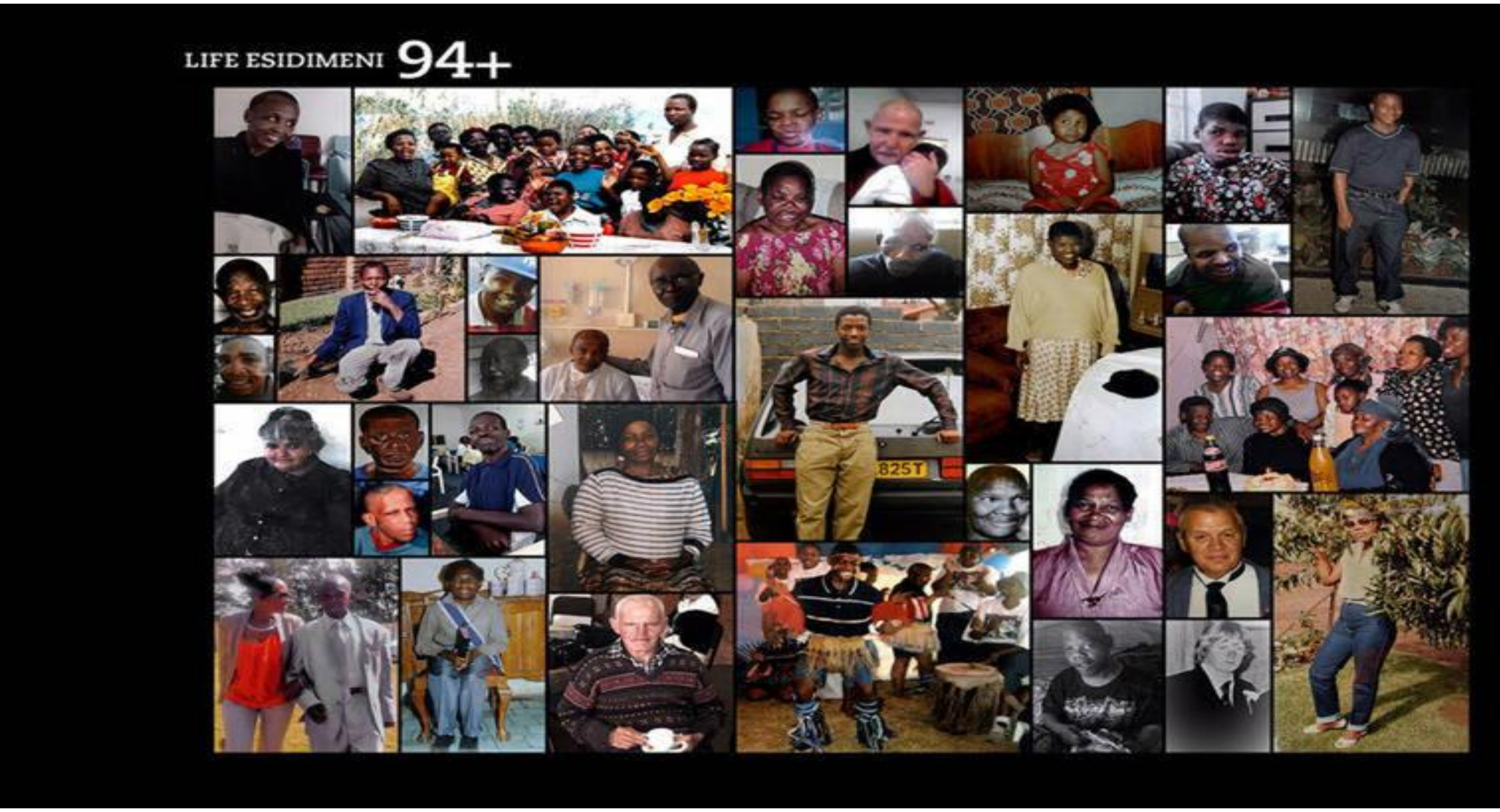
Samenvatting

Na eeuwen van onderzoek blijven geestelijke aandoeningen een grote politieke uitdaging in moderne samenlevingen. Hoewel veel vooruitgang is geboekt in het onderzoek naar het aanbod van geestelijke gezondheidszorg in de lage- en middeninkomenslanden, bestaat een duidelijke kloof in het begrijpen van de cruciale rol van bestuur en macht in de zorgverlening. Met betrekking tot geïntegreerde zorg is het begrijpen van de relatie tussen statelijke en niet-statelijke actoren van het grootste belang. Dit doctoraat onderzocht hoe machtsrelaties het bestuur van geïntegreerde geestelijke hulp in Zuid-Afrika vorm heeft gegeven. Meer specifiek was het doel om de dimensies en structuren van geïntegreerde geestelijke gezondheidszorg te verduidelijken; de doorverwijzings- en samenwerkingsverbanden in een netwerk van een zorgaanbieder te beschrijven; en de relaties tussen statelijke en niet-statelijke geestelijke zorgaanbieders te onderzoeken. Een pragmatische, op literatuurstudie gebaseerde casestudie was uitgevoerd in het grootstedelijke Mangaung district van de provincie Vrijstaat in Zuid-Afrika daarbij gebruik makend van verschillende methodologieën. De macro contexten van geïntegreerde geestelijke gezondheidszorg werden onderzocht door middel van een analytisch kader over geestelijke hulpverlening, terwijl de casestudie gebruik maakte van sociale netwerk analyse en semi-gestructureerde interviews met sleutelactoren. De bevindingen suggereren dat geïntegreerde geestelijke gezondheidszorg in Zuid-Afrika wordt nagestreefd op de volgende twee manieren: 1) door geestelijke hulp te integreren in eerstelijnsgezondheidszorg en 2) door samenwerking te stimuleren tussen statelijke en niet-statelijke actoren. Het aanbod van geestelijke gezondheidszorg was versnipperd, met een lage dichtheid, geconcentreerd op de ziekenhuizen, en met aanwijzingen van significante professionele macht. Belangrijke punten van samenwerking tussen statelijke en niet-statelijke actoren zijn huisvesting en therapietrouw, hoewel proportionele interacties tussen statelijke en niet-statelijke actoren lager zijn dan interstatelijke samenwerking. Bestuurlijke fragmentatie kwam naar boven tussen statelijke en niet-statelijke zorgaanbieders, biomedische en sociale benadering van zorg, en de departementen van gezondheid en sociale ontwikkeling. Lacunes in de rol van de staat zijn zwak strategisch leiderschap en matige informatiesystemen. Macht komt naar boven in zowel zijn gangbare opvatting alsook in zijn tweedelijns opvatting, geworteld in bijvoorbeeld professionele macht of de commodificatie van mensen die leven met geestelijke aandoeningen. De ambiguïteit van psychische aandoeningen worden aangeduid als een belangrijke onderstroming in de dynamieken van macht die spelen in de processen van het aanbieden van zorg. De belangrijkste beleidsaanbevelingen focussen op het volgende: 1) verbeteren van het aanbod van financiële middelen; 2) samenwerking tussen dienstverleners; 3) al te nauwe organisatie van overheidsdiensten; en 4) politieke relaties statelijke en niet-statelijke actoren. Ten slotte legt deze studie een sterke fundering voor verder onderzoek in de mechanismen van macht in de geestelijke gezondheidszorg in Zuid-Afrika.

Opsomming

Ná eeue se navorsing bly geestesongesteldheid ’n diep politiese struikelblok in moderne samelewings. Hoewel heelwat vordering gemaak is in die navorsing van geestesgesondheiddienste-verskaffing in lae- tot middelinkomstelande, bestaan daar ’n duidelike gaping in die manier waarop kritiese rolle van bestuur en mag in die verskaffing van versorgingdienste verstaan word. Wanneer dit by geïntegreerde sorg kom, is dit kardinaal om die verhouding tussen staats- en nie-staat-entiteite te verstaan. Hierdie doktorale studie het beoog om magsverhoudings in die bestuur van geïntegreerde geestesgesondheidsorg in Suid-Afrika beter te verstaan. Die doel was meer spesifiek om die dimensies en struktuur van geïntegreerde geestesgesondheidsorg uit te lig; om die verwysings- en samewerkingsverhoudinge in ’n diensteverskaffersnetwerk te beskryf; en om die verhoudings tussen staats- en nie-staat-geestesgesondheidsdiensteverskaffers te bestudeer. ’n Pragmatiese, teorie-gedrewe gevallestudie is deur middel van verskeie metodologieë in die Mangaung Metropolitaanse Distrik in die Vrystaat-provinsie, Suid-Afrika, gedoen. Die makro-kontekste van geïntegreerde geestesgesondheidsorg is deur middel van ’n raamwerk-analise van gesondheidsbeleid verken, en ’n gevallestudie is met die gebruik van sosiale netwerkanalise en semi-gestruktureerde onderhoude met belanghebbendes voltooi. Die bevindings het voorgestel dat geïntegreerde geestesgesondheidsorg in Suid-Afrika op twee maniere gevolg word: 1) deur geestesgesondheidsorg met primêre gesondheidsorg te integreer, en 2) deur samewerking tussen staats- en nie-staatsrolspelers te bewerkstellig. Die diensteverskaffingsnetwerk was disfunksioneel, met lae digtheid, hospitaal-sentraliteit en tekens van beduidende professionele mag. Belangrike punte van staats- en nie-staatsamewerking het behuising en die nakoming van behandelingsverantwoordelikhede ingesluit, hoewel proporsionele interaksie tussen staats- en nie-staatsdienste swakker was as interstaatsdiens-samewerking. Bestuursverwante verbrokkeling het in staats- en nie-staatdiensteverskaffers, biomediese en sosiale benaderings tot sorg, en die departmente van gesondheid en sosiale ontwikkeling na vore gekom. Gapings in rentmeesterskap het swak strategiese leierskap en onvoldoende inligtingsisteme ingesluit. Mag het in hoofstroom- én sekondêre stroom-vertolkings na vore gekom, en is byvoorbeeld vasgevang in professionele mag, en deur ’n klaarblyklike verandering van mense met geestesongesteldheid in kommoditeite. Daar is tot die slotsom gekom dat die vaaghede van geestesongesteldheid ’n belangrike ondertoon is in die mag-dinamika wat in diensteverskaffingsprosesse voorkom. Belangrike beleidsvoorstelle het gefokus op die verbetering van die volgende: 1) beskikbaarheid van finansïele bronne; 2) verhoudinge tussen diensteverskaffers; 3) die nou organisering van regeringsdepartemente; en 4) politiese verhoudinge tussen staats- en nie-staatsrolspelers. Oplaas lê die studie ’n sterk fondament vir verdere navorsing rondom die meganismes van mag in die bestuur van geestesgesondheidsorg in Suid-Afrika.

Dedicated to those who have suffered and continue to suffer in a society that perpetually fails them.



A photographic collage which non-governmental organisation Section27 presented at public hearings on the patients who had died in the Life Esidimeni tragedy. At the time of writing, 144 deaths had been confirmed, with 62 missing. ***Photo: Section27***

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Abbreviations

ANC	African National Congress
CPS	Cash Paymaster Services
DALYs	Disability-adjusted life years
DoBE	Department of Basic Education
DoH	Department of Health
DoSD	Department of Social Development
DSM	Diagnostic and Statistical Manual of Mental Disorders
FSDoH	Free State Department of Health
GDoH	Gauteng Provincial Department of Health
GEAR	Growth, Employment, and Redistribution
IFC	International Finance Corporation
LMICs	Low-to-middle income countries
MEC	Member of the executive committee
MHCA	Mental Health Care Act
MHPF	Mental Health Policy Framework and Strategic Plan 2013 – 2020
NAWONGO	National Association of Welfare Organisations and Welfare Organisations
NDP	National Development Plan
NGOs	Non-governmental organisations
NHI	National Health Insurance
NIMH	National Institutes for Mental Health
OHSC	Office of Health Standards Compliance

PHC	Primary healthcare
PLWMI	People living with mental illness
PPP	Public-private partnership
RDoC	Research Domain Criteria
RDP	Reconstruction and Development Programme
SADC	South African Development Community
SAPO	South African Post Office
SASHS	South African Stress and Health Study
SASOP	South African Society of Psychiatrists
SASSA	South African Social Security Agency
SNA	Social network analysis
WHO	World Health Organization

Section I: Context

Chapter 1: Background

> *The local press, so lavish of news about the rats, now had nothing to say. For rats died in the street; men in their homes. And newspapers are concerned only with the street. Meanwhile, government and municipal officials were putting their heads together. So long as each individual doctor had come across only two or three cases, no one had thought of taking action. But it was merely a matter of adding up the figures and, once this had been done, the total was startling.*
> ***- Albert Camus, The Plague*** (1991, 32)

Introduction

Mental illness and societal responses to those who are burdened by it have been the subject of centuries of politics and power (Scull 2006, 2015). The present study adds to a truly enormous body of scholarship, the majority of which have been produced in the Western world. The past decade has seen significant growth in filling this gap, though there has been a palpable blind spot in terms of the politics of mental health service provision in low-to-middle income countries (LMICs). The foundation is laid here for scholarship that touches on the complex dynamics of governance and power in the provision of integrated mental health care in post-apartheid South Africa. In this introductory chapter, the purpose, goals and structure of the research are described. More specifically, the study rationale is discussed, outlining in broad terms the necessity for research. Thereafter, the problem focus of the study is described, followed by the research questions that drove the study focus. Theoretical points of departure are described, after which the structure of the dissertation is set out. First and foremost, we need to consider the very meaning of mental illness, as a central argument of the study is rooted in its nebulous nature.

More than perhaps any other set of human afflictions, mental illness has, under the names of “madness,” “insanity,” “lunacy,” and “mental illness”, historically provoked a wide variety of often contradictory reactions (Eghigian 2010). After all, “psychiatric concepts are products of social forces” (Moncrieff 2014, 591). Terms such as “mental illness”, “mental disability”, “mental conditions”, “mental distress” etc. are often used interchangeably, and a comprehensive term remains elusive. As described by Bruce Scott (Scott 2016, np):

> *When one uses the term “mental health”, in a context where it means everything (e.g., concerning mental distress) the concept of health and ill-health subsumes the all of the context. However, the concept has so much slippage when subjected to a detailed critical analysis, it deteriorates into a phantasm that continually haunts in the background, because the concept cannot contain or represent in an ideal way, when it reduces or reifies human experience in such a way*.

Without wading into the murky waters of pinning down mental illness as a concept, and for the sake of pragmatism, we accept that the definition of mental illness is closely intertwined with policy, with the most important consideration being the severity of impairment (Goldman and Grob 2006). The National Mental Health Policy Framework and Strategic Plan 201–2020 defines mental illness as “a positive diagnosis of a mental health related illness in terms of diagnostic criteria made by a mental health care practitioner authorized to make such diagnosis” (South African National Department of Health 2013, 7), which strongly and overtly highlights professional power and diagnosis. The global mainstay for expounding the meaning and diagnosis of mental illness (and related terms) is the Diagnostic and Statistical Manual of Mental Disorders (DSM), now in its fifth edition (American Psychiatric Association 2013). The result of decades of synthesis and effort, the fifth edition was produced after five years of work by a team of 397 participants in 13 working groups, six study groups, and a specialist task team led by the American

Psychological Association, the National Institutes of Health, the National Institute of Drug Abuse, the National Institute of Alcoholism and Alcohol Abuse, the World Health Organization (WHO), and the World Psychiatric Association (Vahia 2013). Despite this impressive effort, the DSM has been the subject of regular critique. It has been noted that it is very much skewed towards Western psychiatry, with high levels of disparities between its content and approach, and individual psychiatric practice (Pickersgill 2012). Concerns were also raised over the "medicalisation" of normality in line with pharmaceutical intervention (Pickersgill 2013). As Ian Hacking (2013) pointed out, our attempts to classify mental illness are inherently flawed due to our conceptualisations (especially the DSM) being based on a botanical model, rather than adequately reflecting the true nature and realities of the varieties of mental illnesses. In short, mental illness cannot be neatly stacked into clear cut boxes. Diagnosis and definition are made all the more difficult given that there are no known biological markers with which to pin down mental conditions (Rose 2013). While this certainly challenges analyses of mental illness, Susan Sontag (1978, 58) highlights the importance of engaging in this project as a political struggle:

> *The notion that a disease can be explained only by a variety of causes is precisely characteristic of thinking about diseases whose causation is* not [italicised in the original text] *understood. And it is diseases thought to be multi-determined (that is, mysterious) that have the widest possibilities as metaphors for what is felt to be socially or morally wrong*.

Study rationale

The burden of mental illness

There is growing consensus that mental illness is a public health priority, especially in LMICs. Results from the South African Stress and Health Study (SASHS, 2002–2004), the first (and to date, only) nationally representative survey of psychiatric disorders in an African country, provided a sobering picture of the burden of mental illness in South Africa – even though its indications are now somewhat dated. Anxiety disorders (15.8%), substance abuse disorders (13.3%) and mood disorders (9.8%) were especially prominent, while 30% of respondents reported a lifetime history of at least one psychiatric disorder (Stein et al. 2008). While these indicators might not be extraordinary in terms of global trends, they do illuminate a population who lack access to quality health services and support. Three out of four adults presenting with a 12-month psychiatric disorder received no treatment in the final year of the SASHS (Williams et al. 2008). Additionally, South Africa's mental health workforce is inadequate, with only 0.3 psychiatrists, 0.3 psychologists, and 0.4 social workers respectively per 100 000 population, heavily concentrated around urban areas (Lund et al. 2010a). Recent indications are that there are high levels of stigma towards people seeking mental health care from district-level health services, thereby inhibiting access (Egbe et al. 2014; Hanlon et al. 2014). In terms of accessing treatment and care, patients must often travel varying distances to outpatient clinics at hospitals or other selected facilities (WHO 2008a). People with serious psychiatric disorders generally access treatment services from public sector facilities (Lund and Flisher 2006), but South Africa's health system is highly skewed towards private care in terms of financial spending, human resources and quality of care (Harris et al. 2011; Harrison 2009; Van Rensburg and Engelbrecht 2012). This inequitable distribution of resources for mental health, combined with the correlation between the social and economic conditions of poverty and common mental disorders in low-to-middle-income countries, creates an especially troubling context for the majority of South Africa's mentally ill population (Lund et al. 2010a; Lund et al. 2010b; Lund et al. 2011).

Integrated care

A current initiative in South Africa – driven both by local and global mental health service experts – is to integrate mental health services on primary health care level, specifically applying a task-shifting approach (Petersen et al. 2012; Breuer et al. 2014; Hanlon et al. 2014; Mendenhall et al. 2014; Petersen et al. 2014; Chisholm et al. 2016; Lund 2016). Integration has become an increasingly popular strategy to address fragmented and uncoordinated health systems (Lamontagne 2013), as well as to increase accessibility to care, especially of disadvantaged communities (Mills, Rasheed, and Tollman 2006). Integration is a social process involving the management and delivery of a continuum of curative and preventative, multi-level health services, according to the needs of clients (WHO 2008b). The conceptualisation of integration has been an onerous task, and has since been readily accepted as a multi-conceptual construct (Kodner and Spreeuwenberg 2002; Blount 2003; England and Lester 2005). Although many definitions have been produced, mental health care integration generally involves collaboration and co-ordination of services, co-location of care, with effective communication (particularly regarding referral and discharge) across the organisational and professional interface (England and Lester 2005). Such aspects of integration – the vertical and horizontal networking and collaboration, both formal and informal, between service providers (Kodner and Spreeuwenberg 2002; Durbin et al. 2006) – is referred to as organisational integration, which has featured prominently in South Africa's government policy response to mental illness (Pillay and Leon 2003; Janse van Rensburg and Fourie 2016; South African National Department of Health 1997, 2000, 2013).

Mental health care integration is heavily contingent on the effective coordination of referral across different levels of care and collaboration among different service providers. An effective referral system is a key component in integrated mental health services provision (WHO 2003; Funk, Saraceno, and Drew 2008). The dearth in research on mental health care referral networks (Hanlon, Wondimagegn, and Alem 2010) is especially pressing in the case of integration processes, given its effects on outcomes such as effectiveness (Provan and Milward 1995, 2001; Provan and Kenis 2008). The referral, support and supervisory relationships between health care facilities, both vertically and horizontally, are key aspects of integrated service provision (Axelsson and Axelsson 2006; Funk et al. 2008; Lund et al. 2008; Petersen et al. 2009). An additional feature of integration is the relationships between government-run health facilities and non-governmental entities (Taylor et al. 2000; Mur-Veeman et al. 2003; Rosen 2006; Saxena et al. 2007;). Little research has explored these particular aspects of integrated care in LMICs. Moreover, although there are suggestions that mental health integration in South African health districts are poor (Petersen 2000; Lund et al. 2010a;), empirical accounts of this are almost non-existent.

While integrated mental health care is envisioned as a model with which to address mental illness in South Africa, the country does not have a strong record in public policy implementation, particularly in the health sector. This has been well-documented, and factors such as human resource constrains, problems caused by an inadequate institutional framework, the pressure on the health system by the HIV/TB co-epidemic, the lack of public health spending, poorly-developed health information systems, poor quality service delivery, and a severe lack of leadership and management capacity have been highlighted (Development Bank of Southern Africa 2008; Coovadia et al. 2009; Harrison 2009; Mayosi et al. 2012; Van Rensburg and Engelbrecht 2012). Lower levels of government in particular has been pointed out to be a key site of contradictions and instability in the democratic era (Hart 2012) – a feature that negates successful policy implementation in communities (Van Zyl Slabbert 2006). Even though the chronic challenges in the governance of health systems at the local level has been suggested to critically contribute to the lack of public policy implementation, empirical research in this area remains sparse.

Finally, it must be noted that the present study's intention is not to necessarily promote or discourage integrated mental health care as a public health policy. Mental health service provision has a contentious history, reaching heights of controversy during the anti-psychiatry movements of the 1960s and 1970s. Clinical and system responses to mental illness have gone through many shifts – not only on a national level, but also globally – with significant unintended consequences (Mechanic and Rochefort 1990; Mechanic 1995; Rochefort 1997; Mechanic 2003; Mechanic and Bilder 2004). While many strong claims are promoted by powerful multinational organisations (which are often readily adopted by governments), the question regarding a "best" approach to the governance of mental health care remains mired in uncertainty. Although shifts toward integrated mental health care has become increasingly popular as part of national health policies, its actual effectiveness in improving clinical outcomes – though promising – is far from definite (Druss et al. 2001; Butler et al. 2008; Butler et al. 2011). Nonetheless, it is not the purpose of this study to explicate this concern. Rather, the overall goal is to illuminate the ways in which relations among key societal role-players influence the processes of furthering a complex public policy, in order to achieve the (apparent) objective of assisting people living with mental illness (PLWMI).

Collaboration

The 2005 WHO Bangkok Charter (WHO 2005, 2) called for the promotion of collaboration "among civil society, the private sector, government and intergovernmental bodies to coordinate public health actions". Collaboration involves voluntary inter-organisational participation – with mutual adjustments – in arrangements that encompass the distribution of responsibilities and rewards among collaborators (Hill and Lynn 2003; Axelsson and Axelsson 2006), resulting in the provision of a multi-organisational service delivery network (May and Winter 2009). Consequentially, collaboration becomes a means with which to address complex public issues that do not render themselves solvable through isolated or singular approaches (Emerson, Nabatchi, and Balogh 2012; Poocharoen and Ting 2015; Vangen 2016). Collaborative relationships inherently involve working across sectors, relationships, and boundaries, towards addressing challenges in the public sphere (Purdy 2012; Poocharoen and Ting 2015). The scope of activities, network structure, and degree of formality of collaborative networks differ widely (May and Winter 2009), depending on a range of factors and contextual considerations. In this respect, the choices of, motivations of, and influences on collaborators emerge (Wanna 2008).

Governance and power

Health care governance principles assume mixed economies in terms of funding and service providers, where strategic interaction and negotiation occur in continuous collaborative processes (Flynn 2002; Touati et al. 2007). Governance here can be referred to as rules and structures that guide roles, responsibilities and interactions among public and private stakeholders, unfolding in micro, meso and macro contexts (Graham, Amos, and Plumptre 2003; Brinkerhoff and Bossert 2008, 2013; Fox and Ward 2008; Janse van Rensburg et al. 2016). Governance processes are far-reaching, as these interactions determine the specific health policies that are pursued, services provided, allocation of resources, cost distribution, service and benefit recipients, and ultimately, health outcomes achieved (Brinkerhoff and Bossert 2008, 2013). Further, mental health care stakeholders often hold different interests and contradictory values; the resulting political processes and interaction among them, along with their network structure and distribution of power might hold significant implications for mental health policy integration (Touati et al. 2007). This is especially relevant in better understanding the relations among government and service providers, which are becoming increasingly complex and non-linear following health system reforms focusing on collaboration (Willem and Gemmel 2013). Despite its apparent relevance, little research has been conducted into the role of governance relations among the local government and service providers, especially in LMICs.

Importantly, collaborative arrangements and governance thereof are heavily influenced by the inherent power-dependence relationships between public and private sectors, who rely on each other for funding and legislative mandate (Schmid 2003). Integrated care as a social policy is significantly shaped by power relations, given the different actors, interests and resources involved (Walt and Gilson 1994). Yet, the influences of power relations among the key health system stakeholders in the negotiation of (especially mental) health policy implementation processes, remains largely unexplored (Erasmus and Gilson 2008; Gilson and Raphaely 2008; Nkosi et al. 2008). This concern becomes especially salient within the contexts of a health system weakened by an extraordinary quadruple burden of disease (Coovadia et al. 2009; Harrison 2009), along with pronounced challenges posed by the decentralisation of governance from national down to local levels with the institutional forms and the implications that it generates (Timothy, Rohini, and Vijayendra 2005). Although much has been written about the role of power in the implementation of public policy within such contexts (Walt and Gilson 1994; Mohan and Stokke 2000; Brock, Cornwall, and Gaventa 2001; Erasmus and Gilson 2008; Gilson and Raphaely 2008; Lehmann and Gilson 2013; Nkosi et al. 2008; Scott et al. 2014), a distinct dearth remains in empirical work.

Problem statement and focus

There is a pressing need to attend to a population of PLWMI who lack access to adequate treatment in South Africa. A strategy to increase treatment access and efficiency is to integrate mental health care with other services in the health system, as reflected by current opinion as well as South African government policy. Mental health services have historically existed on the periphery of the health system and, notwithstanding significant reform processes during the past two decades, still suffer from complex challenges, along micro, meso and macro-levels of analysis. Although increasing research efforts have been launched to better understand these challenges, there remains a significant gap in existing literature on the structural mechanisms that influence mental health care integration. Key among these is the coordination of organisational integration (simply put, referral and collaborative dynamics), the subtleties in the health care provider-health care seeker interface and the governance of these processes. The focus of the research fell on these aspects of mental health care integration in South Africa, centred along an especially neglected social mechanism, namely power relations. For the sake of coherence, these three aspects will in the following sections be delineated by three research questions.

Research questions

The main research question that drove the study is the following: *How do power relations shape the governance of integrated mental health care in South Africa?*

Three key areas of focus fed into the question posed: (1) the dimensions and structure of integrated mental health care in South Africa; (2) referral and collaborative ties in a mental health service provider network; (3) and the relations between state and non-state mental health service providers.

Which dimensions of integrated mental health care are pursued in South Africa? The purpose of this question was to clarify the types of integrated mental health care that are followed in South Africa, as structured by 1) national health policy and 2) district-level mental health service collaboration.

What is the nature and extent of district-level mental health service collaboration among state and non-state mental health service providers? The principal focus of this question was to explore how and to what extent mental health care is organisationally integrated on district level in South Africa, focusing on collaborative relationships between health facilities and between state and non-state service providers.

What power relations emerge in governance processes of district-level collaboration between state and non-state mental health service providers? The research investigated power relations among mental health service providers, especially in governance processes between state and non-state service providers. The purpose of this question was to explore governance-related power relations in organisational-level integrated mental health care.

Theoretical points of departure

Different theoretical points of departure were applied in the research process, given the proposed study's distinct but interrelated areas of focus. However, for the sake of theoretical coherence, it is crucial that the selected theoretical concepts are aligned in some way. The research focused on policy implementation processes involving key actors within the context of established social institutions, and is epistemologically couched in the interaction and institutional orders of society. That is, the areas of co-presence and relationships between people, along with "the world of patterned, organized and symbolically-templated 'ways-of-doing-things'" (Jenkins 2000, 10). This approach follows the call that a central epistemological interest of exploring social processes – such as integration – subsists in better understanding social relationships (Tilly 1984). Following these assumptions, three key theoretical points of departure should be kept in mind: the dimensions, structure and extent of integrated mental health care; the concept of governance; and power as a cross-cutting theme.

The dimensions, structure and extent of integrated mental health care

A useful approach to better understand health system processes is social network theory and analysis, particularly given the putative similarities between a health system and a social network (Blanchet and James 2012). Among the different approaches to study networks, whole network analysis is particularly suitable due to its focus on 1) the relationships between all actors in a network, and 2) organisations as actors rather than individuals (Trotter 1999). Subsequently, within the context of the proposed study, each health facility within the network boundaries is envisaged as a micro-organization (even though all public health facilities form part of the government health organisation). A network is, simply put, “a set of actors connected by a set of ties” (Borgatti and Foster 2003). The interconnected pattern of ties yields a certain structure, hosting actors or nodes (Borgatti and Halgin 2011). Nodes can include individuals, teams, concepts or organisation, which presently will refer to health provider organisations. Ties can be directed or undirected, dichotomous or valued, and presents different options for measurement (Borgatti and Foster 2003). In terms of integrated mental health care, a myriad of social ties can be identified of which referral and collaboration ties are especially prominent (South African National Department of Health 1997, 2000, 2013). Referral relationships between health service provider organisations can be conceptualised as vertical (England and Lester 2005; Petersen et al. 2012a), and due to the flow of information necessary for integrative referral to be successful, it can be posited as flow ties (Borgatti et al. 2009). Horizontal ties can be illustrated through collaboration, which involve relationships between health care facilities, and entities such as faith-based organisations (Taylor et al. 2000), private care (Mur-Veeman et al. 2003), non-governmental organisations (Saxena et al. 2007), and – significantly in the South African context – traditional healers (Freeman, Lee, and Vivian 1999; Rosen 2006; Lund et al. 2008; Petersen et al. 2009; Hanlon et al. 2010). Due to the interaction between network actors necessary to facilitate collaboration, these relationships can be conceptualised as interaction ties. Further, both referral and collaboration relationships can be seen as similarity ties, due to the assumed influences of geographic location (Borgatti et al. 2009).

Governing integrated mental health care

An increasing recognition of the importance of governance in achieving health system outcomes during the past decade has been paralleled by increased efforts to better understand the meaning, focus and measurement of health governance (Kaufmann and

Kraay 2008; WHO 2008a; Lewis and Pettersson 2009; Siddiqi et al. 2009; Savedoff 2011; Mutale et al. 2013). However, the proposed study necessitates the inclusion of different key role players in the integration process, a feature largely amiss in these efforts. Building on earlier work by the World Bank (2004, 2007), Brinkerhoff and Bossert (2008, 2013) put forward a health governance model that identifies key categories of health system actors (state, providers and clients/citizens), as well as the connections between them. These connections create the pathways for the operationalization of governance processes. Such a conceptualisation is squarely in line with a sociological understanding of mental health services, namely that health care providers, health managers and users, along with their relative power resources, interact to determine organisational priorities and the distribution and delivery of services and resources (Rogers and Pilgrim 2005). The understanding of such pathways theoretically informed the understanding of mental health governance in a relational way, focusing on mental health care providers, mental health care users, and the governance structures encapsulating them. However, the study also focused on another conception of governance, one that emphasises the dispersed nature of power in advanced liberal societies. Through a Foucauldian lens, governance in organisations and government institutions can be conceptualised as having undergone a shift from traditional, Weberian, bureaucratic forms of governance, to more indirect, network-type forms, referred to as "governmentality" (Bevir 2010, 2013; Ferlie and McGivern 2014; Ferlie, Mcgivern, and FitzGerald 2012). Governmentality is especially relevant in studying network governance, the diffusion of authority from governments to other actors in advanced liberal states (Triantafillou 2004). In the case of mental health care integration, this elevates the importance of non-state actors, such as NGOs, private carers and traditional healers.

Ultimately, governance and governmentality are entangled with power, a social phenomenon that unfolds in several different ways in mental health service provision.

Power: a cross-cutting theme

Mental health care integration, as a form of cooperation and coordination, is intimately related to the creation and use of power (Rueschemeyer 2009). The nature of health care organisations is a major arena for the exemplification of power processes, due to the manifestation of the hierarchies, interdependence, and goal incompatibilities of social relationships (Tjosvold and Wisse 2009). Further, power is a key theme in health governance. To govern essentially means to coordinate stakeholders in a way that fosters the exercise of pluralistic power, by adopting common representations, rules and structures (Touati et al. 2007). As described by Fox and Ward (Fox and Ward 2008, 534), "[t]he art of governance appears to be to sustain broad consent (and thereby hegemonic power) across the institutions and actors engaging around a practice, but this is achieved not by coercion but by the dissemination of control to these very institutions and actors."

Foucault's contributions in this area remain significant. Power, in his view, is not a substance or mysterious property, but rather refers to specific type of relation between individuals that combine with exchange, production and communication (Foucault 1991). These relations necessarily extend beyond the limits of the state, the state being superstructural to a range of different networks of power throughout society (Foucault 1980). Additionally, "The exercise of power is not simply a relationship between partners, individual or collective; it is a way in which certain actions modify others" (Foucault 1982, 788). For the purposes of the present investigation, power is understood as "an agent's intentional use of causal powers to affect the conduct of other participants in the social relations that connect together" (Scott 2001, 1). A policy such as mental health care integration in itself is also, in its simplest sense, a manifestation of power (Walt and Gilson 1994) in that it aims to produce causal effects (Scott 2007). There remains a pronounced need for the study of the roles and interaction of politics, process and power in health policy implementation (Erasmus and Gilson 2008; Gilson and Raphaely 2008; Nkosi et al. 2008).

Research methods

The study drew from pragmatic underpinnings, and employed a case study approach, with different methodologies. More specifically, the study contained three work packages: a policy analysis, a social network analysis, and qualitative exploration. In the first instance, a framework analysis was used to interrogate national health policies towards clarifying the strategic meaning of integrated mental health care (Chapter 4). Second, a social network analysis was performed in a South African district, illustrating the nature and extent of inter-service collaboration in mental health care. This work package was also combined with semi-structured interviews (Chapter 5). Third, semi-structured interviews were conducted with key stakeholders in the district, and were thematically analysed (Chapter 6). Ethical approval for the study was granted by the Stellenbosch University Research Ethics Committee: Human Research (Humanities) (Reference: HS1156/2015), and institutional permission was granted by the Free State Department of Health. The methods of the study are presented in broad strokes in Chapter 3, while more specific methods are presented in Chapters 4 to 6.

Dissertation structure

The dissertation was written and is presented in the format of peer-reviewed journal articles (see Chapter 3). In total, six articles were produced, three of which constitute the body of the literature review (Chapter 2), and three others make up the empirical chapters of the study (Chapters 4 to 6) (see Addendum A for authorship declarations). It is important that the dissertation forms a single whole, with a narrative linking all the parts together. Accordingly, every article is preceded by a prelude that ties it together within a broad systematic argument. The dissertation is structured as follows:

Section I: Context

Chapter 1: Background

Chapter 2: Literature review

Chapter 3: Overarching research approach

Section II: Empirical investigations

Chapter 4: Health policy and integrated mental health care in the SADC region: Strategic clarification using the Rainbow Model

Chapter 5: State and non-state mental health service collaboration in a South African district: A mixed methods study

Chapter 6: At the coalface of collaborative mental health care: Governance and power in district-level service provision in South Africa

Section III: Synthesis

Chapter 7: Conclusion

Chapter 2: Literature review

> *However, the condemned man looked so submissive and dog-like that it seemed as if one could let him run free on the hillsides, and would only have to whistle at the start of the execution for him to come.*
>
> ***- Franz Kafka, In the Penal Colony*** (2009, 75)

Prelude

The following section sets the stage for empirical explorations in Section 2. The review is structured along three parts: 1) Governance, power, and integrated care, 2) State, non-state, and mental health care collaboration, and 3) A political economy of mental illness in South Africa. First, the complexities of governance and power are discussed in terms of integrated care. The discussion begins by outlining the conceptual dimensions of integrated care and health governance according to micro-, meso- and macro-levels of analysis. Thereafter the concept of power is explored, where the two broad streams of power analysis are summarised: Mainstream and second stream understandings. The lack of second stream explorations of power in integrated care research is highlighted, and governmentality studies is suggested as a key strategy with which to respond to this discrepancy.

Second, the intricacies of "the state" are explored. A brief overview of key movements in mental health care policy in South Africa's post-apartheid period is provided. Then, by drawing from the concept of the bureaucratic field, the post-South African state is positioned as a dynamic space within which power relations emerge between different societal actors. Distinct and important internecine struggles in the bureaucratic field is described by drawing from recent examples in collaboration between state and non-state mental health service providers in South Africa. The argument is a continuation of a second stream lens of power, and sets the context for the study’s approach to collaborative mental health care. Finally, the study highlights a uniquely neglected feature of societal approaches to mental illness in South Africa: the politics involved in the provision of care. By bringing together recent crises of deinstitutionalisation, welfare provision, and shifting responsibilities for care on the one hand, with the conditions and mechanisms of advanced liberalism on the other, the contexts are set for the commodification and the neglect of PLWMI.

Part 1: Governance, power, and integrated care

Article: Janse van Rensburg A, Rau A, Fourie P and Bracke P 2016. Power and integrated health care: shifting from governance to governmentality. *International Journal of Integrated Care*, 16(3):17.

This article was conceptualised by André Janse van Rensburg, who also wrote the first draft. Co-authors provided valuable critique and input. Following critique by anonymous reviewers, André Janse van Rensburg adapted the article for publication.

Abstract

Integrated care occurs within micro-, meso- and macro-levels of governance structures, which are shaped by complex power relations. Yet theoretically-led notions of power, and scrutiny of its meanings and its functioning, are neglected in the literature on integrated care. We explore an alternative approach. Following a discussion on governance, two streams of theorising power are presented: mainstream and second-stream. Mainstream concepts are based on the notion of power-as-capacity, of one agent having the capacity to influence another—so the overall idea is 'power *over*'. Studies on integrated care typically employ mainstream ideas, which yield rather limited analyses. Second-stream concepts focus on strategies and relations of power—how it is channelled, negotiated and (re)produced. These notions align well with the contemporary shift away from the idea that power is centralised, towards more fluid ideas of power as dispersed and (re)negotiated throughout a range of societal structures, networks and actors. Accompanying this shift, the notion of governance is slowly being eclipsed by that of governmentality. We propose governmentality as a valuable perspective for analysing and understanding power in integrated care. Our

contribution aims to address the need for more finely tuned theoretical frameworks that can be used to guide empirical work.

Key words: Governance; power; integrated care; governmentality

Introduction

The study of integrated care, how it is governed and the complex interrelations that constitute it have been the subject of numerous scientific investigations and policy reforms. Integrated care unfolds within distinct governance structures (Pike and Mongan 2014), across micro-, meso- and macro-levels of analysis (Valentijn et al. 2013; Valentijn et al. 2015). Pressures to democratise decision-making processes have led governments globally to place increasing emphasis on partnerships in health care delivery (Lowndes and Skelcher 1998). Health care-related activity is very much subject to politics (Buse, Mays, and Walt 2005), and a clear and comprehensive understanding of power is necessary in order to "build-up rich and nuanced descriptions of the forms, practices and effects of power" in integrated care and its governance (Erasmus and Gilson 2008, 367). This is a paramount step towards clarifying the study's main research question (Chapter 1: *How do power relations shape the governance of integrated mental health care in South Africa?*). The intimate links between integrated care, governance and power require clarification. Studies on integrated care that focus on power rarely base their discussions on properly theorised notions of what power is and how it functions. To begin exploring how this gap can be addressed, a brief outline of two broad trends in theorising power is presented. This article proposes that conceptual applications of governance to integrated care are limited in that they under-emphasise types of governance built on more fluid and subtle (as opposed to more determinist and direct) understandings of power. The article then introduces and explores as an alternative to governance, the notion of governmentality, which incorporates more subtle and contemporary understandings of power. We argue that the shift in emphasis from governance to governmentality could address the need for more finely tuned theoretical frameworks address power and to guide empirical work on integrated care.

Before proceeding to the sections on governance and power, let us briefly clarify what is meant by *integrated care*. *Integrated health care* (or integrated care) in health systems is a collection of strategies encompassing patient-centred, demand-driven, multi-level, and multi-modal (multiple methods/ways of) collaborative processes among various professionals, organisations and sectors towards coordinated patient care (Kodner and Spreeuwenberg 2002; Kodner 2009; Tsasis, Evans, and Owen 2012). Integrated care has become a well-established feature of national, regional and global health policy. It is an increasingly popular strategy to address fragmented and uncoordinated health systems (Lamontagne 2013), as well as to increase accessibility to care (especially of disadvantaged communities) (Mills, Rasheed, and Tollman 2006; Kodner 2009). Its focus on continuity of care, service partnerships and patient-centeredness has been attractive to health reformers, and it is widely-recognised for its attention to patient needs. Research on the topic has grown exponentially, and its development as a public health concept and strategy is underpinned by concerted efforts towards better understanding the complexities and difficulties associated with integrated care (Druss et al. 2001; Ouwens et al. 2005; Butler et al. 2008, 2011). This journal has especially been at the forefront of outlining the meaning and scope of integrated care. Most notably, these efforts culminated in the development of the Rainbow Model of Integrated Care by Valentijn and colleagues (2013; 2015). The Rainbow Model provides a fitting snapshot of the complexity and range of integrated care, describing its forms across micro, meso and macro domains.

The governance of integrated care

Health governance essentially refers to rules that govern the roles, responsibilities and interactions among service users, government decision-makers and the health service providers. These interactions ultimately shape the social organisation of health care, namely public, private and non-profit (Graham, Amos, and Plumptre 2003; Fox and Ward 2008; Brinkerhoff and Bossert 2008, 2013). *In defining health governance*, consideration must be given to the shift from 'government' to 'governance'. This shift denotes a modification from public administration as a homogeneous central state that provides services to a passive public via expert professionals, towards one where the state is but one part of a "mixed economy of funding and provision", which also includes active public consumers and increased managerial control over expert professionals (Flynn 2002, 159). Health governance does not necessarily refer to management, but rather to continuous processes of strategic interaction and negotiation among health care stakeholders at various levels (Touati et al. 2007).

The success of integrated care is significantly tied to the degree of stakeholder collaboration and the extent to which different care components are governed (Mur-Veeman et al. 2003; D'Amour et al. 2008). Governing integrated care can be distilled into three levels. On the micro-level, inter-professional or clinical governance takes place, on the meso-level inter-organisational governance occurs, while on the macro-level the ideal of *good* governance is shaped and pursued by the collective efforts of large multinationals—for instance in the design and application of global indicators to shape and monitor progress towards good governance values (Valentijn et al. 2015).

Micro-level governance

Inter-professional governance focuses on "openness, integrity and accountability between professionals at the operational level (e.g. joint accountability, appeal on pursued policies and responsibilities)" (Valentijn et al. 2015, 8). Inter-professional collaboration is hampered by a range of factors, including poor communication, conflicting power relations and role confusion (Rolls, Davis, and Coupland 2002). Against a backdrop of increasing variability in terms of leadership, culture, participation and professional status, both between and within specialities of professionals that have to align to cater to individual patient needs (Caldwell and Atwal 2003), the burden of collaboration and coordination in clinical settings has been shifted to health professionals (D'Amour et al. 2008). This gave rise to models of shared governance, a key part of collaborative practice among professionals (WHO 2013), and a useful mechanism with which to redistribute traditional clinical authority, responsibility and accountability (Cohen 2015). Many such models exist, and have especially been growing in popularity in North America (Hoying and Allen 2011; WHO 2013; Harper, Vail, and Beechinor 2014; Cohen 2015). An example is the establishment of Inter-professional Practice Councils (IPPCs), a model underpinned by collaborative, multidisciplinary decision-making and shared accountability for care quality and safety by frontline workers (Harper, Vail, and Beechinor 2014).

A related concept is clinical governance, introduced in the United Kingdom's National Health Service during the late 1990s. It surfaced within a broader contexts of the rise of clear financial accountability, the amplification of cost-effectiveness in health care, the crystallisation of service provision needs assessments, and the emergence of the "evidence-based medicine" paradigm (Davies and Mannion 2000). Clinical governance was designed to overcome traditional power struggles in multidisciplinary team-working (Daly 2004), and to "consolidate, codify, and universalise often fragmented and far from clear policies and approaches", shifting final accountability and responsibility for clinical practice to senior clinicians (Scally and Donaldson 1998, 62). It explicitly recognises the centrality of clinicians to the performance and organisation of clinical work and provides clinicians with a medium for integrating the clinical, resource, and organisational aspects of care (Degeling et al. 2004). Clinical governance has been used in the professional integration of mental health care by fostering collaboration between multidisciplinary teams and primary care health professionals by having shared referral, assessment, and management guidelines (Halligan and Donaldson 2001).

Meso-level governance

Certainly one of the most widely studied forms of integrated care is organisational integration, and it is here that the conceptualisation of governance has been most prominent (Valentijn et al. 2013). Principally, three modes of governance have been defined: *hierarchy* (command is the basic mechanism of control and coordination); *market* (price-driven transactions between consumers and providers as the key coordination mechanism); and *network* (coordination by means of mutual, trust-driven contact, negotiation and adjustment). These three modes differ in terms of the positioning and influence of the stakeholders involved, and therefore in terms of the distribution and dynamics of power. In reality, these ideal modes rarely (if ever) occur in isolation; rather, hybrid forms of governance emerge, and this presents an additional level of complexity to understanding the dynamics of power (Lowndes and Skelcher 1998, 35–36). Additionally, collaborative partnerships progress through life cycles, each of which may be characterised by one or more different forms of governance, which implies different power relations over time (Lowndes and Skelcher 1998). Little research has focused on different modes or forms of meso-level governance, power and integrated care. One example suggested that—in terms of integrated care development—England tended to exemplify more hierarchical modes of governance, in contrast to the Netherlands' more network-based forms, each with its own consequences for the different relations and manifestations of power (Mur-Veeman et al. 2003).

Network governance is being paid increasing attention due to the collaborative nature of integrated care. Network governance is defined as the coordination of the collective action of contracted public and private organisations that provide public services (Wiktorowicz et al. 2010). Ahead of our later explorations on the meaning and functioning of power, it needs to be noted here that the idea of collectives and collective action implies social power—in other words power vested in or enacted by groups, or by individuals as group members. Different types of network governance have been identified. These network governance types have been differentiated in terms of coordination and exchange, such as mutual adjustment, alliance and corporate structure (Whetten 1981); in terms of differences in centrality and density, for instance participant, lead organisation and network administrative organisation forms (Provan and Kenis 2008); and in terms of the partners involved and their relative levels of participation, for instance government-led, clustered participatory and hybrid public-private collaborative forms of network governance (Park and Park 2009). Research studies employing theorised network governance types include

Wiktorowicz et al. (2010), who distinguished different forms of social power among different mental health care networks in terms of rural/urban and regionalised/non-regionalised dichotomies, and Fleury et al. (2002), who underlined the consequences of social power as exercised in corporate and alliance governance forms within integrated mental health networks.

Macro-level governance

Systems-level or macro-level governance involves the creation of "trust towards external stakeholders (e.g. municipality and health insurance companies) based on working method, reputation, management, control and/or supervision" (Valentijn et al. 2015, 8). Ultimately, in order to achieve an integrated system of care, "governance needs to be aligned across the various health and social care providers to drive shared interests and accountability in care delivery for people across hospitals, community services, general practice teams and social care" (Goodwin et al. 2012, 9). The body of work on 'good governance' on a systems level has been driven forward by international, regional, and national reports on progress towards good governance—based on globally agreed (if not negotiated) indicators, data collected against those indicators, and analyses.

Influential global bodies have been instrumental in forwarding more normative conceptualisations of 'good governance' (i.e. normative in terms of Western values and aspirations). The WHO's guidelines for better stewardship (Travis et al. 2001) and toolkit for the monitoring of health systems governance (WHO 2008c); World Bank governance guidelines and indicators (Kaufmann, Kraay, and Zoido-Lobaton 1999; Kaufmann, Kraay, and Mastruzzi 2005); and the United Nations Development Programme's principles of good governance (United Nations Development Programme (UNDP) 1997) are examples of influential bases from which subsequent frameworks were developed. Particularly health system governance frameworks geared towards low-to-middle income settings (Siddiqi et al. 2009; Baez-Camargo and Jacobs 2011; Mikkelsen-Lopez et al. 2011; Abimbola et al. 2014) have received focus.

Also building on World Bank conceptions, Brinkerhoff and Bossert (2008, 2013) put forward a health governance model that features key categories of health system actors (state, providers, and clients/citizens); their model differs somewhat from predominantly system-focused frameworks by employing a distinctly relational epistemology that stresses the centrality of the connections among the three groups of actors. This approach is very much tied to the central nodal relationships in health system governance, namely state and market; health ministries and other ministries; public sector, civil society and the private sector; the health system reform spectrum from static to dynamic; and health reform and human rights-based approaches to health (Siddiqi et al. 2009). These normative frameworks, although relatively recent, have proven useful to analyse the role of district health governance on integrated primary mental health care (Marais and Petersen 2015).

The conceptualisations of governance outlined thus far provide us with insight into the ways in which integrated care is strategized and structured. Power is central to the ways in which governance is structured and operates (Rodriguez et al. 2007; Ansell and Gash 2008; Brinkerhoff and Bossert 2008; Bevir 2013; Frenk and Moon 2013). Both governance and integrated care essentially entail relations among diverse actors, with different capacities, agendas and interests. Whether the governance of integrated care occurs at the professional (Hardy et al. 1999; Gilbert 2003; Sheaff et al. 2004), organisational (Hardy et al. 1999; Mur-Veeman et al. 2003; Rodriguez et al. 2007) or system level (Petersen et al. 2011;

Marais and Petersen 2015), power is a central concern. This said, power is poorly defined in studies on governance and integrated care, and the term is often used ambiguously and without due consideration of the potential complexities it contains. The next section will therefore pay attention to theoretical understandings of power, as well as to the ways in which the concept is applied in studies on integrated care.

A brief outline of past and current trends in understanding power

Scott (2007, 25) offers a solid starting point for an exploration of power by pointing out that "power can be understood, at its most basic, as being the production of causal effects." Most power theorists would readily accept this claim, but beyond that their views diverge into many different streams of thought as demonstrated in the extensive accumulated body of knowledge driven by a multitude of disciplines and scholars. As Wrong (2009, viii) aptly notes, power is "an essentially contested" concept. An overview of the many different developments and theories of power is not the aim of this article, and at any rate, is offered elsewhere (Clegg 1989; Scott 2001; Lukes 2005; Wrong 2009). Rather, we set out to map some *main* currents of thought in order to identify those that may best apply to studying governance of integrated care. The literature points to two streams of thought and research on power, namely, *mainstream* and *second stream* interpretations (Clegg 1989; Scott 2001).

Mainstream understandings of power

Mainstream thought focuses on sources of power and is rooted in the idea of power being exercised by one agent over another (Scott 2001). This flows from early ideas developed by Thomas Hobbes, and which focused on *what power essentially is* (Clegg 1989), whether "Originall or Instrumentall" (i.e. natural or instrumental powers of individuals), Social (i.e. collective power), or Sovereign (i.e. created by the transfer of individual rights to one or several people, with the idea that individuals will have their general protection guaranteed) (Hobbes 1909, 66). A major proponent of mainstream tradition was Max Weber, who viewed the state and its related bureaucracies as key sources of power, and defined power (*Macht*) as "the probability that one actor within a social relationship will be in a position to carry out his own will despite resistance, regardless of the basis on which this probability rests" (Weber 1947b, 139). Weber's conception of power was furthered by Robert Dahl (1963; 1957) whose ideas became a common starting point for the study of power during the second half of the 20th century (Ailon 2006) and remains a popular basis from which contemporary scholars launch newer ideas. For instance, Dennis Wrong adds to mainstream understandings by including a focus on 'power *over*' to allow for more subtle and hidden facets of power. Wrong (2009, 2) defined power as "the capacity of some persons to produce intended and foreseen effects on others". He stressed that the conceptualisation of power needs to be posited as something intentional, effective, and include a distinction between latent and manifest forms of power.

One of the first major theorists whose work signalled a shift from Weber's ideas was Steven Lukes (2005). He argued that institutional practices and social forces do not enter politics necessarily through individual action. He proposed three 'faces' of power: decision-making power (political action), non-decision-making power (covert and overt agenda setting), and ideological power (which offsets the predominantly behavioural focus of the first two, and allows for an analysis of latent and observable conflicts in worldviews). Lukes' work is clearly embedded in mainstream concepts, but in later writings we begin to see a growing attention to the role of social structures in power and the exercising of it.

Second-stream understandings of power

Second stream power scholars share some aspects of mainstream thought, but break significantly with the idea of 'power *over'* and mainstream's emphasis on *sources* of power—to focus on processes, techniques and strategies of power (Scott 2001). Deleuze (1988, 70–71) argues that we should not ask "What is power and where does it come from?', but 'How is it practised?", noting that power means "to incite, to induce, to seduce, to make easy or difficult, to enlarge or limit, to make more or less probable". Built on Machiavellian (2001) notions on *what power does* (Clegg 1989), the second-stream tradition centres on how power is established and re-produced within a network of relations in political-strategic ways (Westwood 2002).

Most second-stream scholarship on power originates in, or is a response to, the revolutionary ideas of Michel Foucault—the most influential theorist on power in the late 20th Century. His writings link relations of power to the construction of knowledge and identity. In turn he links these notions to processes of governance and discipline—both of society and of the self (Foucault 1982; Westwood 2002). Foucault's work demonstrated how norms and structures become established and entrenched (institutionalised) throughout history via relations of power, and how these norms and structures shape (construct) the identities of individual and social actors. He also showed how—in a series of slow cyclical processes—the actions of individual and social actors then feed back into those very same norms and structures and in doing so *re*-shape them, sometimes in surprising ways. In these cycles of construction and re-construction, people and groups (subjects) become positioned in specific ways in relation to each other and in relation to dominant norms and structures. Foucault views relations of power as extending well beyond the limits of the state, the state being superstructural to a range of different networks of power that weave throughout society (Foucault 1980).

This interest in the mutually constitutive relationships of power between (a) structures, (b) the norms whereby structures become entrenched and institutionalised, and (c) individual/social actors—is also reflected in the work of sociological giants like Pierre Bourdieu and Anthony Giddens. Compared to Foucault's keen focus on processes and relations of power, however, they place much more emphasis on the structures within which power is enacted. Bourdieu's work centres on four key *sources* of power—economic, cultural, social and symbolic capital. But his is also a 'theory of practice' in that he explores how these sources of power are mobilised and operate via *habitus*—a set of dispositions and meanings that people gain through socialisation—within structured social fields (Bourdieu 1985, 1987, 1994). Giddens, in his structuration theory (Scott 2001) also concentrates on the tension between structure and agency. He sees power as comprising "reproduced relations of autonomy and dependence in social interaction" (Giddens 1982, 39). And he emphasises that social interaction cannot be analysed apart from the social structures within which they take place. In his view people are free to act, but draw upon and tend to replicate structures of power through their own actions.

John Scott (2001; 2007), noting the divergence between mainstream and second stream thinking on power, attempted to systematically bring together elements from both. Scott's conception distinguishes two groups of "elementary forms of power" (Scott 2001, 1): (1) *corrective influence* includes force (negative, physical sanctions that prevent subalterns' actions—subalterns being of subordinate or inferior position) and manipulation (various kinds of both positive and negative sanctions that influence subalterns' intentions), and (2) *persuasive influence* includes signification (persuasion by means of cognitive symbols such as text-based ideas and representations) and legitimisation (persuasion through building value commitments to certain ideas and ideals). Remarking that such a synthesis is a “fundamental priority”, Scott (2001, 12) argues that his theory unifies the two streams of power.

Steward Clegg drew from both mainstream and second stream ideas on power to construct his “circuits of power”, which represents the different ways in which power flows at different levels. Using a metaphor of power moving through an electric circuit board, three multi-level, distinct and interactive circuits through which power must necessarily flow: episodic (micro-level), dispositional (macro-level), and facilitative (macro-level). The episodic circuit represents micro-level and irregular exercises of power by agents in response to everyday interactions. On a macro-level, the dispositional circuit represents socially constructed meanings and rules, while the facilitative circuit signifies technologies, networks and environmental factors that punish or reward episodic circuit agency (Clegg 1989; Clegg, Courpasson, and Phillips 2006).

An important goal of second-stream power theories is to uncover, and by implication help address, structures and processes that disenfranchise some people or groups in favour of empowering others. Essential to this ethic is Antonio Gramsci’s concept of hegemony, which occurs when dominance becomes entrenched via the reproduction of norms favoured and promoted by dominant groups, called elites. In this process dominant classes gain and keep the consent of the (subaltern) majority without relying on any direct forms of compulsion or subjugation (Scott 2001). In this view “force will appear to be based on the consent of the majority, expressed by the so-called organs of public opinion newspapers and associations which, therefore, in certain situations, are artificially multiplied" (Gramsci 1971, 80). An ominous aspect of this artificiality is that people become complicit in the value systems of dominant groups to the extent that they act—knowingly or unknowingly—in the interest of the powerful. Hannah Arendt's contributions to scholarship on power are particularly influential in opposing hegemony. She distinguishes power from violence, strength and force, and views power as the product of collective action of actors bound together in a common political purpose, and based on rational persuasion and consent rather than coercion (Arendt 1972).

The study of power in the literature on integrated care

The importance of understanding the different forms of integrated care governance and its associated dimensions of power has not been ignored by researchers. In fact, several studies have focused on the interplay between governance, integrated care and power. For instance, Fleury et al. (2002) examined the effectiveness of a managerial tool in changing health care, more specifically, the impact of regional planning implementation processes on the creation of integrated mental health service networks. The findings suggested that alliances between organisations are negotiated forms of power, and that certain governance types foster decision-making and influencing powers for certain actors. In studying the influences of the public-private mix in social care systems in the Netherlands and England in the development of integrated care, Mur-Veeman et al. (2003) suggested that centralised, hierarchical governance illustrate different forms of power than more networked, dispersed governance systems. Rodríguez et al. (2007) examined the values, interests, and mobilisation of power within available governance networks of organisational actors in three collaborative initiatives. The authors found power dependencies in inter-organisational relationships in terms of formal authority, control of critical resources, and discursive legitimacy, reproduced over time. Wiktorowicz et al. (2010) explored the governance processes and supporting conditions that foster inter-organisational collaboration in mental health networks. The study theorised forms of power associated with different mental health network governance models, namely, authority, negotiation, and influence.

Studies on integrated care and its associated forms of power have yielded different understandings of power: power as capacity (Ødegård 2006); power as resource (Tousijn 2012); power as strategy (Williams and Sullivan 2009); and what Scott (2001, 16) refers to as “structures of domination” (Mur-Veeman et al. 2003). Some studies (Van Raak et al. 2005; Rodriguez et al. 2007) rely on conceptions of power as wielded by certain actors, who reside in certain positions or have a certain status, which they use in order to further their interests. This predominantly mainstream approach is particularly found in research on collaboration among integration-related role-players, such as medical and non-medical actors. For example, Tousijn (2012, 523) describes the identification of power relations in multi-professional teams as a major barrier to integration, referring to studies that have especially focused on “the dominant position held by the medical profession; the propensity of each profession to defend its own jurisdiction; and the existence of different professional cultures and values, which generate inter-professional tensions”.

Similar tensions have been explored in network research. Essentially, actors’ positions within a network place certain constraints on and provide certain opportunities for their potential to bargain and negotiate, thereby creating different bases of power (Hanneman and Riddle 2005; Raeymaeckers and Dierckx 2012). In network thinking power is inherently relational, in the mainstream sense of ‘power *over*’: a person or organisation has power because they can dominate others (who in turn are dependent on them). However, power can also be systemic, in that power is more easily exercised in more dense networks. Therefore, power in networks can both refer to the relations among individual actors, and to a description of a population. One of the most common social network measures is network centrality. Centrality aims to identify actors who are in a position of privilege (and therefore power) relative to actors in more peripheral positions in a network (Degenne and Forse 1999). Though not always explicitly presented as a measure of power, centrality has been used in studies on integrated care, especially in professional or inter-organisational collaboration (Cook 1977; Boje and Whetten 1981; Provan and Milward 1995; Bruynooghe, Bracke, and Verhaeghe 2003; Lemieux-Charles et al. 2005; Fleury et al. 2014).

In short, studies on power in integrated care have leaned towards its mainstream conceptions. A search of the existing literature yields little research on integrated care conducted with the more subtle, relational, second stream understandings of power. Gilbert (2003) drew from a Foucauldian biopolitics perspective in order to explore the relationships between policy, professional practice and the people who are the subjects of that practice. Using Foucault's notion of governmentality, Ferlie et al. (2012) analysed network organising in the UK cancer field. The idea of governmentality and the ways in which it unfolds in integrated care holds much promise, and is yet to be fully examined. As we hope the discussion on key theories of power has demonstrated, power is a multi-layered, complex construct, which involves far more than relations among key role-players (although this remains a salient part of integration processes) (Clegg 1989; Scott 2001). Adding to this complexity is the different levels and modes of governance that steer integrated health care.

Mainstream perspectives on power in integrated health care (Mur-Veeman et al. 2003; Van Raak et al. 2005; Ødegård 2006; Rodriguez et al. 2007) unfortunately only provide a limited view. We now present a discussion proposing existing models from governmentality studies hold the potential to resolve the lack of second stream power understandings in both integrated health care and its governance.

From governance to governmentality of integrated mental health care

The idea of governmentality is inspired by Foucault's later writings—and firmly embedded in second-stream notions of power. Underlying the idea of governmentality are the ways in which people are influenced to govern themselves, a notion of power that is dispersed throughout a population. Governmentality allows for governing at a distance, by embodying discipline in individuals through the creation of docile agents to be used in modern political and economic institutions. Essentially, when people/ groups embody the norms in which they are embedded, they *self-regulate* their actions, their perceptions and even their values according to those norms—in other words, they self-regulate.

In step with this, governmentality perspectives identify and analyse "the complex of rules, norms, standards, and regulatory practices that extend state rule more deeply into civil society by regulating the ways in which civil society self-regulates" (Bevir 2013, 62). The focus shifts away from state-centred governance, towards self-regulation and reflexivity that are rooted in governance regimes that influence individuals to behave in a certain way (Fox and Ward 2008). A governmentality perspective starts from the standpoint that governance is made up of inter-dependent organisations that together form "semiautonomous and self-governing networks" (Bevir 2013, 62), denoting shifts from traditional, Weberian, bureaucratic forms of governance, to more indirect, network-type forms, relations and processes (Triantafillou 2004; Ferlie and McGivern 2014). The notion of governmentality does not necessarily privilege the state as locus or origin of power, but takes self-governing practices as starting point—this allows a mapping of multiple centres of calculation and authority that traverse and link up personal, social and economic life (Miller and Rose 2008). The focus falls on "power without a centre, or rather with multiple centres" (Miller and Rose 2008, 9). Individual freedom is not an opposing feature of power, but rather a salient part of its operations; power is not about constraining individuals, but rather about creating people who are "capable of bearing a kind of regulated freedom" (Rose and Miller 2010, 174).

Given its conception of power as relationally dispersed rather than focused in the state, governmentality in integrated care highlights the importance of non-state actors such as non-governmental organisations and private practitioners. We concur that the dichotomies through which power has been traditionally characterised—such as state versus civil society, public versus private, public versus private, and coercion and consent—and the mainstream concepts of power that underlie these dichotomies—do not provide an adequate understanding of the ways in which power operates (Rose and Miller 2010). Rather, the focus should fall, as it does in the notion of governmentality, on the "technologies of the self"—the ways in which individuals, or groups, shape the behaviour of others and of themselves. And this includes the "complex of practical processes, instruments, programs, calculations, measures, and apparatuses making it possible to form and control forms of action, structures of preference, and premises for decisions by societal agents in view of certain goals" (Bröckling, Krasmann, and Lemke 2011, 12).

While a governmentality perspective certainly opens up interesting and useful avenues of exploration, it has not been exempted from critique. It has been argued that a governmentality approach ignores lay normativities in everyday routine interactions and is unable to take into account the practical resources through which power operates (Barnett et al. 2008). Others have noted that a governmentality approach foregoes its critical and emancipatory potential in exchange for a theory of social reproduction, in that the approach focuses on a conception of power that externalises and marginalises contradiction and struggle (Kerr 1999). These are valid concerns, and those who pursue the study of integrated care through a governmentality angle should engage with such criticisms. Nonetheless, governmentality as a theoretical construct offers much to integrated care scholarship, as many examples in existing literature highlight.

A governmentality perspective has found great appeal in fostering better understanding the nuances of clinical governance (Flynn 2002; Gilbert 2003; Sheaff et al. 2004). The approach is flexible enough to allow space for other perspectives, for instance, combining governmentality studies with Courpasson's "soft bureaucracy" in the study of clinical governance (Flynn 2002). A governmentality approach can open up the subtler ways in which power work in different settings. It has been used to show how the technology of psychology has been employed as a strategy of government in post-apartheid South Africa (Gentz and Durrheim 2009). It has been shown to be useful in exploring how multidisciplinary mental health outreach teams are managed "at a distance" through subtle "deep management" practices (Brown and Crawford 2003). Further, a governmentality perspective has been used to theorise the ways in which psychiatric nurses govern correctional inmates with mental illness, specifically, by means of sovereign, disciplinary and pastoral power (Holmes 2002). Sending and Neumann (2006, 688) critiqued global governance processes as it is presented in existing literature, namely that state and non-state relations is a zero-sum game concerned with the “triad between sovereignty, authority, and legitimacy”. The authors used a governmentality lens to study the “rationalities of government” and showed that civil society is often made up of political subjects whose autonomy and expertise are crucial elements of governing, that governing occurs through autonomous subjects and not passive objects.

Given its increasing popularity and promise, what can a governmentality approach offer to the study of governance and power in integrated care? Several key areas of investigation emerge, and given the wide array of health system configurations and contextual factors surrounding integrated care, the research possibilities are truly wide-ranging. This said, two areas of interest can especially be fruitful in unpacking the governance of integrated care. Firstly, a governmentality perspective can accentuate the “technologies of the self”, the ways in which the behaviour of those involved in integration processes are normalised, disciplined, empowered and sanctioned. Understanding how the energies of those involved in integrated care are governed – be it clinicians, governors or patients – can potentially emphasise how power operates in different settings. Such an approach also does not position integrated care as a politically neutral project, but as one fraught with processes of both overt and subtle domination. The second suggestion relates to the make-up of health system configurations. Depending on the country context, integrated care unfolds to varying degrees in accordance to the relations between state and non-state entities. For instance, in West European countries such as Belgium and the Netherlands the state has a more facilitating role, leaving the provision of health services to various non-state service organisations. In Southern African countries however, health services are mainly the purview of the state, and is augmented by different non-state organisations. In most contexts however, the state is the main steward of health care, suggesting a dominating, sovereign role in integrated care. However, a governmentality perspective permits us to move beyond traditional governance dichotomies such as state versus civil society, public versus private, public versus private, and coercion and consent (Rose and Miller 2010). A governmentality view allows us to understand the ways in which governance relations between state and non-state service providers play out in integrated care configurations, providing insight into the subtler ways of governing and emergence of power. This is a potentially rich area of investigation, especially in the contexts of wide-spread neoliberal health care reform where power has been reduced to much more indistinct strategic processes (Rose and Miller 2010).

At this point it is important to note that the argument forwarded in this article has not been that the study of conventional forms of governance and power in integrated care should be substituted by a Foucauldian governmentality perspective. Rather, our key argument is that the subtler, second stream of power research has been neglected in integrated care governance research, and that a governmentality perspective can open up helpful avenues of investigation in this sense. In describing the incomplete and fractured nature of our knowledge of integrated care, Kodner (2009, 12) notes that “in some ways, we are like blind men and the proverbial elephant, each aware only of the part of the animal touched and with no experience of the whole”. In line with this metaphor, we stress Scott’s (2001) sentiment that different understandings of power should not be viewed as opposing perspectives, but rather as complementary. In a similar way, governmentality studies should not be seen in opposition to more normative understandings of governance. Rather, it should be seen as complementary, providing us with a diagnostic insight rather than the descriptive leanings of “the sociology of governance” (Rose 1999, 16). Ultimately, we should drive integrated care scholarship forward in a comprehensive, inclusive way, reflexive and open to critique.

Conclusion

The existing and ever-expanding literature on the concepts under scrutiny in this article—integrated care, governance, and power—is diverse and voluminous. From this oeuvre we extracted, and outlined, different modes in the governance of integrated care, alongside two main streams/traditions of power. We then summarised some of the ways in which governance and power have been applied in studying integrated care. We argued for the value of second stream concepts of power over the limitations of mainstream concepts of power. We then show how the notion of governmentality links to second-stream thinking on power and propose governmentality as a useful perspective from which to advance and enhance current understandings of governance and power in integrated care.

The popular appeal of integrated care in health reform agendas has increased scrutiny on its governance, and rightly so. Governance underwrites the outcomes of integrated care in a fundamental way, and provides a gateway through which we can better understand the processes and politics that influence these complex dynamics. Grasping the ways in which power is present in the relations that constitute integrated care and its governance is key to comprehend the reasons why integrated care is often such a challenging ideal to achieve. To this end we argue that there is a need to go beyond traditional governance models and their inherent conceptions of power, towards critically examining the subtle and subvert ways in which integrated care is steered. This, we propose, can be achieved by focusing on the study of governmentality. Ultimately, we add to the construction of a more comprehensive, nuanced and rounded understanding of integrated care and its mechanisms, thereby setting the stage for exploring the ways in which power unfolds in integrated care. In keeping with the study aims (Chapter 1), this article provides a foothold for clarifying state and non-state mental health sectors along with their relations, further described in Part 2 of this Chapter.

Part 2: State, non-state, and mental health care collaboration

Article: Janse van Rensburg A, Fourie P, Bracke P, Wouters E and Van Rensburg D. Collaborative mental health care in the bureaucratic field of post-apartheid South Africa. *Accepted for publication in Health Sociology Review*.

This article was conceptualised by André Janse van Rensburg, who also wrote the first draft. Co-authors provided valuable critique and input. Following critique by anonymous reviewers, André Janse van Rensburg adapted and re-submitted the article.

Abstract

South Africa's long and arduous journey from colonial and apartheid-era care for people with mental illness to more comprehensive, equitable mental health care is well-described. Deeper engagement with the structural power relations involved in providing collaborative mental health services are less-well described, especially in its post-apartheid era. This conceptual article positions state and non-state mental health service providers – along with their relationships and conflicts – within Bourdieu's bureaucratic field. It is suggested that key internecine struggles in South Africa's post-apartheid socio-political arena have influenced the ways in which collaborative mental health care is provided. Drawing from two recent examples of conflict within the bureaucratic field, the article illustrates the ways in which neoliberal forces play out in contemporary South Africa's mental health service delivery. Struggles between the state and private healthcare in the Life Esidimeni tragedy receive focus, as well as the shifting of responsibility onto civil society. A court case between the state and a coalition of non-profit organisations provides further evidence that neoliberal rationalities significantly influences the position and power of non-state service providers.

Unless serious consideration is given to these dynamics, collaborative mental health care in South Africa would remain out of reach.

Keywords: Collaborative mental health care; South Africa; bureaucratic field; power; neoliberalism

Introduction

The complexities of mental illness as a public health challenge are well-known. Despite the common acceptance that mental health requires a continuum of care, extending from biomedical and clinical to social and community-based approaches (Mechanic, Mcalpine, and Rochefort 2014), "the largest room in the house is clearly that of psychiatry, and clinical research dominates the field" (Habibis 2005, 310). Sociological insights into mental health care delivery have provided much-needed perspective, allowing us to "see the forest for the trees" towards understanding of comprehensive service delivery dynamics. Such insights however, have been largely lacking in the South African narrative of mental health care reform – especially during its post-apartheid period. South Africa's long and arduous road from racial and colonial-driven institutionalised mental health care towards more equitable, equal and quality care has received a good deal of attention (Thom 2000, 2004; Petersen and Lund 2011; Gillis 2012; Jones 2012; Sukeri, Betancourt, and Emsley 2014). While not diminishing this valuable, and growing, body of work, the present article shifts from merely describing mental health care provision towards engaging more closely with the politics and power in South Africa's post-apartheid period.

Like any form of social intervention, mental health care is closely tied to politics, and attempting to separate it from its wider socio-political contexts is much like "like trying to separate a dancer from the dance" (Fourie 2006, 82). Health care is after all "a template on which different stakeholders project their values, ambitions, fears and institutional forms" (Light 2001, 1168). Rudolf Virchow's (1983, 125) often-quoted maxim that "Medicine is a social science, and politics nothing else but medicine on a large scale" rings true in this respect. Importantly, it highlights the need for the consideration of power relations in mental health care reform (Janse van Rensburg et al. 2016) and its centrality in health policy implementation processes (Nkosi et al. 2008; Erasmus and Gilson 2008; Gilson 2016). In this conceptual analysis, we hope that – by expanding our understanding of the structural undercurrents of power – we move towards more subtle explanations of mental health care failings, shifting our gaze from the more obvious. This is important in a period of global mental health care reform that stresses the pertinence of collaboration (Hickie and Groom 2002; Fredheim et al. 2011; Unützer and Park 2012; Woltmann et al. 2012), which, in many countries, means partnership working across state and non-state divisions (Janse van Rensburg and Fourie, 2016). Tensions between these two sectors is a stark reality in health care (Obeng-Odoom 2012). Our contribution is particularly salient within the social, economic and political forces that play out in the contemporary era of advanced liberalism (Carvalho 2015), where neoliberal rationalities play out particularly in mental health care (Henderson 2005; Fries 2008; Teghtsoonian 2009). The focus of our article falls on the emergent power struggles in state and non-state mental health care collaboration in post-apartheid South Africa. We approach this task with a conceptual lens underwritten by Bourdieu (1994) and Wacquant's (2010, 2009b) elaboration of field theory. Building on the multidimensional concepts of integrated care, governance and power in Part 1 of this Chapter, the focus is now shifted to provide a review of key terms that illuminate the collaborative ties that constitute integrated care. Importantly, this review feeds into the study's areas of focus, focusing on (1) the dimensions and structure of integrated mental health care in South Africa; and (2) referral and collaborative ties in the mental health service provider network (Chapter 1).

The structure of mental health care in post-apartheid South Africa

Key sectors in service provision

Similar to other low-to-middle income countries (LMICs), South Africa saw a proliferation of non-state health service provider activity following the introduction of neoliberal-inspired reforms during the past two decades (Obeng-Odoom 2012). Before we continue with the main argument of the article, we need to define and delineate what is meant by "state" and "non-state". As discussed below, non-state service providers can further be distinguished in terms of for-profit and non-profit motives. As will become apparent later in the article, the lines drawn between these service providers often become blurry, and the following descriptions are meant to – in broad strokes – anchor the discussion in particular groups of actors.

The state is the steward of health care in South Africa, with the official responsibility for strategic leadership in mental health care provision (Coovadia et al. 2009). State-managed health facilities provide health care to the (uninsured) bulk of the South African population. This responsibility is legally underwritten in section 27 of the Constitution of the Republic of South Africa (South African Government 1996), as well as in the National Health Act (South African Government 2004). The concept of "the state" and state institutions therefore emerge as a central unit of analysis. Weber (1947a) conceived of the state as a political organisation with compulsory association, within a given territory whose administrative staff successfully maintains a monopoly of legitimate use of physical force that is essential to the enforcement of its order. Following this definition, Mann (1993) surmised that the state 1) is territorially centralised; 2) contains two dualities: place and persons, and centre and territory; 3) institutions are differentiated in order to undertake different functions for different interests groups; and 4) engages in geopolitics with other states, due to its delimited territorial nature. The state has further been described as "a relatively unified ensemble of socially embedded, socially regularized, and strategically selective institutions and organizations", which operates in a given territorial area (Jessop 2016, 49). Without wading into the depth and breadth of conceptions of the state – it certainly comprises "whole libraries of historical investigation, and whole bookshops of radical critique" (Rabinow and Rose 2003, 5) – we will indicate a break with more traditional views of the state. Governmentality scholars have critiqued the Weberian notion of the state, arguing that "the state possessed neither the unity nor the functionality ascribed to it; it was a mythical abstraction which has assumed a particular place in the field of government" (Rose and Miller 2010, 175). Analyses of the modern state focused on its inevitable tendency to centralise, control, regulate and manage, an approach rooted in 19th century social theory "which accords 'the state' a quite illusory necessity, functionality and territorialisation" (Rose 1999, 17–18). Taking these considerations into account, the present examination approaches the state in a Bourdieusian fashion, namely that it is not a coordinated and monolithic ensemble, but rather a "splintered space of forces vying over the definition and distribution of public goods" (Wacquant 2010, 200). In Bourdieu's language, we approach the state as a field, more specifically, a bureaucratic field, where the state is a "culmination of a process of concentration of different species of capital" and the power relations that it elicits (Bourdieu 1994, p. 5). Within the bureaucratic field, traditionally non-state institutions operate, and in the South African mental health care context these are private for-profit care and private not-for-profit care.

Private for-profit care can be termed “non-state” in that it does not operate under the direct auspices of the state government, although service providers still operate under the legislative sovereignty of the state. Driven by profit and market forces, these include hospital groups, individual, and group medical practices. Post-apartheid developments saw a significant increase in non-insured use of private medical care (Development Bank of Southern Africa 2008; Harrison 2009). This increase has especially been due to a growing realisation of the effects of the HIV/AIDS epidemic on the workforce, corporate social investment, and an increase in employed, uninsured people (Wolvaardt et al. 2008). These factors, along with a favourable policy environment, led to a rapid expansion of private health providers, especially hospital groups (Van Rensburg 2012).

Private not-for-profit care: As in many LMICs, the non-governmental organisation (NGO) sector in South Africa has been invaluable in providing health care to those not able to access certain services, especially private-for-profit services. Here the term NGO is used as an umbrella term, one which encapsulates a range of different organisations across the social, political and economic spectrum, including faith-based, community-based, welfare or charity, and development organisations (International Labour Organization 2013) – essentially organisations not subsumed under traditional state institutions, with the primary logic of community service over profit-making. Traditional healers – especially prolific in providing mental health care in some areas of South Africa – are also considered as NGOs (Wolvaardt et al. 2008). NGOs have been especially instrumental in the provision of residential/institutionalisation services for people living with mental illness (WHO 2008b).

In the relative absence of psychiatrists, psychologists and mental health nurses generally and particularly in the public sector, NGOs such as professional organisations, religious groups, patient support groups, and traditional healers have significantly contributed to mental, emotional, and spiritual well-being in poor communities (Wolvaardt et al. 2008). NGOs further act as liaison between families and government agencies for grant access, by providing material support to families waiting for grant application processing and catalysing government action in expediting application processes (Rosenberg, Hartwig, and Merson 2008).

South African NGOs have been given a “light touch” by the state compared to other LMIC settings – no doubt as part of a firm move away from an apartheid history of strict NGO control (Batley 2006). By implementing the Non-profit Organisations Act (71 of 1997), instituting a voluntary registration system, and by creating a Directorate for Non-profit Organisations, the post-apartheid government moved swiftly to create a fiscal, legal and political environment conducive to collaboration between the state and NGOs. This environment created new opportunities for NGOs, especially elevating their service delivery role (often to the detriment of their role as activists and government accountability regulators) (Habib 2005). NGOs either became part of business networks or tendered for government and transnational funding (Habib and Taylor 1999). Shifts towards democratisation almost inevitably challenge the legitimacy and capacity of NGOs to serve as “pseudo-democratic representatives of the poor”, undermining broader democratic norms (Mitlin, Hickey, and Bebbington 2007).

The role of NGOs as community stewards has further been challenged by global forces. The Paris Declaration on Aid Effectiveness and the Accra Agenda for Action significantly altered the ways in which global funding flows towards NGOs, importantly funnelling funding through national government infrastructure (Organisation for Economic Cooperation and Development 2008). This development was designed to enhance country ownership, donor priority alignment and harmonisation, impact measurement and improved mutual accountability (a type of global governance of the neoliberal governmentality kind). Nevertheless, the global funding environment of the mid-2000s – spurred on by an intractable AIDS pandemic – restructured the relationship between the state and NGOs, one where NGO independence was curtailed towards a co-option into the role of state service provider (Birdsall and Kelly 2007). This shift has been prominent in NGOs providing mental health services, which receive comparatively less assistance from global health funding and are more dependent on the state for survival.

Expanding neoliberalism in post-apartheid South Africa

To understand the relations between these sectors of mental health service provision, we ought to briefly consider the emergence of neoliberal policy shifts (especially) following the end of apartheid. Neoliberalism is "a transnational political project aiming to remake the nexus of market, state, and citizenship from above", articulating the institutional logics of 1) economic deregulation, 2) welfare state devolution, retraction, and recomposition, 3) an expansive, intrusive, and proactive penal apparatus, 4) and the cultural trope of individual responsibility (Wacquant 2010, 213). In South Africa, following the achievement of democracy, the newly instated African National Congress (ANC) government needed to balance a desperate need for market stability and a demand for social justice (Ncube, Shimeles, and Verdier-Chouchane 2012). A major step in this direction was the introduction of the Reconstruction and Development Programme (RDP) (Republic of South Africa 1994).

It was designed to address the massive social inequalities caused by a colonialism and apartheid, by addressing poverty and social service deficits – ideals which at the time were argued to need a stronger macroeconomic environment. Incorporating both neoliberal and socialist strategies, it adopted mechanisms intended to boost the national economy, including controlled fiscal spending and economic deregulation, alongside pro-poor service provision and infrastructural expansion (Terreblanche 1999). A slew of social policies and legislation followed on the back of the RDP, and health care reforms stood central in this period. Not only were health care reforms part and parcel of wider societal transformations and a reflection of significant state re-creation (Pillay 2001), it also reflected an echoing of social justice-inspired global health care reforms in reaction to rising costs and consumer demands, and more equitable, accessible, effective and responsive health care (Van Rensburg and Engelbrecht, 2012).

The Growth, Employment, and Redistribution (GEAR) policy followed the RDP (Department of Finance 1996) – a strategy that significantly put neoliberal reforms ahead of earlier redistributive goals and undermined the ideal of universal health care (Foster 2005). The shift from the RDP to GEAR was indeed a "quantum leap" rather than an ideological journey in terms of its focus (Terreblanche 1999), and GEAR is widely regarded as symbolic of the entrenchment of neoliberal logic within South Africa's public policy sphere (Nattrass 1996; Terreblanche 1999; Peet 2002; Bond 2005). GEAR in many respects imitated global policies at the time that prioritised market-led principles and privatisation (Van Rensburg and Engelbrecht, 2012), and was a telling influence of the International Monetary Fund and World Bank in the shift from a racial towards an economic apartheid (Harvey 2005). Initial gains by RDP policies were outdone by a failing public-private health care mix along with severe limits on public spending, spurred on by GEAR (Baker 2010). Ultimately, GEAR was part of a broader malaise in young African democracies, underpinned by "a dangerous and destructive delusion…that deregulation and privatization would prove a panacea for African economic stagnation" (Ferguson 2006, 11). How then did these neoliberal shifts influence collaborative mental health care across state and non-state lines? Drawing from Wacquant (2009a, 2009b) we suggest that, in the era of advanced liberalism and neoliberal strategizing, the South African state has attempted to reclaim power and legitimacy in the governance and management of people with mental illness.

The bureaucratic field and its internecine struggles

We draw from Bourdieu's concept of *the field* with which to situate the actors, institutions and their relationships involved in mental health care provision in the post-apartheid South African period. This particular toolkit allows us to – in a relational manner – frame these dynamics within the broader socio-political conditions where they play out (Bourdieu 1985; Müller 2014; Hilgers and Mangez 2015). A social field is "a multi-dimensional space of positions such that every actual position can be defined in terms of a multi-dimensional system of co-ordinates whose values corresponds to the values of the different pertinent variables" (Bourdieu 1985, 724). Agents are distributed within this multidimensional space according to their possession of different forms of capital and the composition of that capital, giving rise to power relations playing out according to the "rules of the game" within that field. Furthermore, a field is conceptualised as relatively autonomous, a domain of activities responding to the rules of functioning and institutions specific to it and the relations among its agents (Hilgers and Mangez 2015). Here, we focus specifically on a particular type of field, namely, the bureaucratic field, which fills out the role of the state, its forms of capital, and the power relations within it (Bourdieu 1994).

In the contemporary period of the bureaucratic field, two internal struggles play out. First, there is an antagonistic cooperation between the *left hand and the right hand of the state*. In this conflicting relation, government agents tasked with the social functions of the state and carry the social struggles of the past (the left hand), stand in oppositional relation to the right hand of the state – i.e. the financial technocrats in charge of the economic locale of a given society (Bourdieu 2000). Second, there is a disjuncture between the *higher and lower state nobility*, where the policymakers stimulating market-led reform (higher state nobility) come in opposition to the collective, made up of executants tasked with carrying out traditional government tasks (lower state nobility) (Wacquant 2010). It is exactly these struggles that permeate the processes of collaborative mental health care, creating complex power struggles which ultimately determine the ways in which different service providers relate to one another. The bureaucratic field allows us to critically examine the ways in which the state interacts with relevant health system actors in collaborative mental health care provision.

Struggles between the left hand and the right hand of the state

In terms of this particular power dynamic, we focus on the recent Life Esidimeni tragedy where – during a botched deinstitutionalisation attempt by the state – more than 100 patients suffering from severe mental conditions died from negligence (Makgoba 2017). The incident was rooted in a public-private mental health care partnership between the state and Life Healthcare. Collaboration between state and private for-profit sectors in South African mental health care mainly focuses on the long-term care of people presenting with serious psychiatric disorders and disabilities. This is not a recent feature; the apartheid government outsourced mental health care between 1963 and 1989 to a private company, Smith Mitchell and Co, to the extent that during the 1980s more than 40 percent of the national number of mental health care beds was controlled by Smith Mitchell and Co (Jones 2012). At present, Life Healthcare – one of South Africa's largest private hospital groups currently operating 60 facilities – provides privately insured mental health services in six facilities throughout the country. It is the largest provider of private mental health care in South Africa, providing acute psychiatric, as well as substance abuse rehabilitation services (Life Healthcare 2013). This capacity has been used towards building the largest public-private partnership (PPP) with the national department of health. The Life Esidimeni (meaning "place of dignity") PPP consists of a national network of 12 mental health facilities (3 987 beds) operated by Life Healthcare, contracted by provincial government departments to provide long-term clinical care to public-sector patients (Life Healthcare 2012).

In a budget speech on 19 June, 2015, the Gauteng Provincial Department of Health (GDoH) announced that their contractual relationship with Life Healthcare would be terminated (Mahlangu 2015a). The termination of a contract that cost the GDoH a significant portion of their annual budget is certainly not out of the ordinary, especially given the well-known financial woes of provincial departments in providing effective and efficient health care. The reasons provided for the termination, however, suggest that more might be at stake here than mere fiscal conservatism. The first reason provided was that this decision falls in line with requirements of Chapter Two of the Mental Health Care Act (17 of 2002): "Persons providing care, treatment and rehabilitation services must provide such services in a manner that facilitates community care of mental health care users" (Subsection Six) (South African

Government 2002). This line of reasoning however presumes the existence of an appropriate community-based “safety net”, something repeatedly highlighted as being woefully inadequate if not completely absent in South African contexts (Janse van Rensburg 2005; Krüger and Lewis 2011; Moosa and Jeenah 2008; 2011). Rochefort (1997, 236) noted that “The severely mentally ill are multiply disadvantaged by poverty, disability, lack of housing and employment opportunities and persistent social stigma”, requiring a public mental health care system that abolishes discriminating structures and repairs “the social ‘safety net’ to make it truly comprehensive and reliable”. It would indeed appear that South Africa has not learnt from international experience of the consequences on deinstitutionalisation without a proper community support system (Habibis 2005; Simpson and Chipps 2012).

A second reason provided was a financial one. The GDoH argued that the amount of $24 million being spent on 2 378 patients during the 2014/2015 financial year was unaffordable, and that that those funds would be reprioritised (Mahlangu 2015b). The reasons outlined by the state for this strategy are quintessentially strategies of the “neoliberal Leviathan”, in its management of a vulnerable population by applying a market-oriented logic and legal tools to that management (Wacquant 2009b, 73). After all, “Economic coercion is often dressed up in juridical reasons” (Bourdieu 2000, 20). There certainly is an argument to be made that the MHCA provides legal power to the right hand of the state by allowing the management of people with severe mental illness by an untrained police force, a key state strategy within neoliberal contexts (Wacquant 2009b, 2010).

Ultimately the narrative forwarded during this event is one of shifting responsibility for people with serious chronic mental illness away from the state (via its private partner) to the community, where NGOs were pointed out as successors in the caring task (Mahlangu

2015b). The people living with mental illness (as well as their families) affected by this episode are governed in a less direct manner, through civil society as an extension of state power into the community. As mentioned, NGOs in South Africa are significantly dependant on the state, as well as on private benefactors and multi-national organisations (Birdsall and Kelly 2007; International Labour Organization 2013). Contrary to private for-profit actors such as Life Healthcare, NGOs are far less independent from the state. Contemporary shifts in aid, along with the conditions set under advanced liberalism, have rendered NGOs as subcontractors of the state; their reliance on external funding agencies have make NGOs increasingly *governmental*, significantly influencing their autonomy and accountability (Habib and Taylor 1999; Habib 2005). As agents of the state, NGOs are woven into the very fabric of the bureaucratic field (Wacquant 2009b). Their activities are funded and facilitated by the state and their organisation and relations with the state should be understood as structured by the neoliberal restructuring of the bureaucratic field (Woolford and Curran 2012). In this way, much attention was paid to the negligent deaths of patients at the hands of NGOs; NGOs which received no financial, human resource or other support from state departments, and were woefully unequipped to offer the most basic care to people suffering from serious mental conditions (Makgoba 2017). The shifting focus on civil society as part and parcel of these tragic events leads us to the second contestation in the bureaucratic field, namely the struggle between higher and lower state nobility.

Struggles between higher and lower state nobility

Tensions have emerged within the relationship between NGOs (as lower state nobility) and state government department (higher state nobility) during the past decade, exemplified by a recent court case between a NGO coalition, and the state. In 2008, the Free State Provincial

Department of Health announced that 48 NGOs were to be funded for a period of three years, at a cost of $65 000, towards strengthening primary health care support (NGO Pulse 2008). Failing to do so, and given that similar instances occurred in other parts of the country, the state was sued in court after two years, by a national coalition of 92 NGOs (Legalbrief 2010). The dispute concerned the amount of funding an NGO can (or rather, should) receive from the provincial government, especially within the limits of budgetary constraints. Many provincial governments rely to a considerable degree on NGOs to provide public services, especially social welfare, to vulnerable populations that include people suffering from debilitating mental conditions. Given the burden of people who were served by the NGOs on behalf of the state, it was argued that the government subsidies should be increased, or the NGOs faced closure. In response, the Free State High Court (2014) noted that NGOs should be encouraged and supported to meet the needs of the population, and stressed the promotion of a "spirit of co-operation and shared responsibility with the government". The Court also stressed that the state's support should not be all-inclusive, that NGOs should operate with a degree of self-sustenance. This particular event should not be chalked down to a mere financial dispute. Rather, for the first time the Court officially underlined that NGOs fulfil constitutional and statutory obligations on the part of the state, and should therefore be compensated accordingly by provincial governments. A clear policy still lacks in this regard, one that highlights state and non-state service provision relationships in provincial budgetary planning (Jagwanth and Soltau 2014).

This particular rift between the South African state and NGOs was certainly not an isolated incident. The infamous Mbeki-era response to HIV/AIDS – preceded by the unilateral development and adoption of GEAR by the government – was met by wide-spread resistance from NGOs, culminating in legal processes to force the implementation of antiretroviral treatment and mother-to-child prevention (Fourie 2006; Nattrass 2008; Kim 2015). The legitimacy of the state in its competency to provide health care (Mackintosh, 2013) was under fire, and in response HIV/AIDS was construed as an attack on the nation's social and political body as well as its ethical well-being (Posel 2008; Fourie 2009). Ultimately then, the "higher state nobility" of South African policy-makers stand in opposition to the "lower state nobility" of NGOs as service providers, in that market-oriented reforms undermine "the traditional missions of government" (Wacquant 2010, 201).

Concluding remarks

The story of mental health care provision has been one rife with contestations, contradictions, and dynamics of power. Due consideration of structural shifts and subtleties of power in narratives of South Africa's post-apartheid mental health care journey has been largely amiss. In an admittedly limited fashion, this article sought to unpack the contestations, contradictions and power relations inherent in collaborative mental health care. Against a growing recognition of the centrality of power in health care and health policy (Nkosi et al. 2008; Erasmus and Gilson 2008; Gilson 2016), we selectively drew from political sociology scholarship. Specifically, we used Bourdieu's (1994) conception of the bureaucratic field – with Wacquant's (2009b; 2010) subsequent elaboration thereof – as a critical lens through which to explicate the ways in which power relations play out in collaborative mental health care in South Africa's post-apartheid period.

South Africa's much-heralded Constitution had the power of altering the bureaucratic field into a "hope generating machine", endowing it with the capacity to conquer public scepticism towards the seemingly indiscriminate and personalised routine practices of the public service “while continually inspiring fantasies, hopes, expectations, and reifications of an impartial public service” (Müller 2014, 41). The values and ideals espoused in the Constitution have nevertheless fallen away to a grave realisation that “Rainbow Nation rhetoric” is little more than a plastering over centuries of brutal conflict (Marais 2010). The neoliberal Janus-faced nature of the ANC government emerged in its approach to the care of people suffering from debilitating mental conditions (Wacquant 2009b), Bond (2005) evoking Bourdieusian language in describing the state as “talking left but walking right”. The metaphorical left and right hand state dynamic gave rise to the rapid expansion of a strong private health sector, which diverge substantially from the public sector in terms of values, resources, and quality of health care provision. Attempts to bridge the two-class character of the state, the “weak, poorly resourced public sector often catering ‘second-class’ services to that majority dependent on the state, and a strong private sector providing abundant ‘first-class’ services to the wealthier and insured minority”, have as yet proven unsuccessful (Van Rensburg and Engelbrecht 2012, 178).

Crucially, it appears as though bureaucratic field conditions significantly shaped the practice of NGOs, who “attach themselves to new procedures designed to meet the disciplinary demands of the neoliberalizing bureaucratic field” (Woolford and Curran 2012, 48). The bureaucratic field acts as a prism that refracts economic neoliberal policy, affecting almost all aspects of society (Wacquant 2009a). The neoliberal market-driven ideology of ‘lower costs, higher efficiency’ that pervaded state power (Žižek 2010), infused South Africa’s post-apartheid bureaucratic field and inevitably permeated the ways in which NGOs were structured (Habib 2005). Further, the global hegemony of “poverty reduction” within international development (Ferguson 2015), with significant resource support from international agencies to NGOs, created a system that insisted on measurement and indicators – reigning in and depoliticising NGOs' strategizing capabilities (Mitlin, Hickey, and Bebbington 2007). Market-led relations and increasing commercialisation may threaten the core values of the NGO sector: corporate human resourcing rather than volunteerism; financial accountability rather than community accountability; and dependence rather that autonomy. The neoliberal influences following the Mandela and Mbeki periods significantly shaped how state and non-state actors collaborate in mental health care. This played out both in the conflicts between the left and right hand of the state, as well as between higher and lower state nobility. Unless we seriously consider the influences of these dynamics, comprehensive, collaborative mental health care in South Africa would remain little more than a pipe dream. In this vein, the study's aimed exposition of (1) the dimensions and structure of integrated mental health care in South Africa; and (2) referral and collaborative ties in mental health service provider networks gains traction, while providing the foundation for Part 3 of this Chapter.

Part 3: A political economy of mental illness in South Africa

Article: Janse van Rensburg A, Khan R, Fourie P, Bracke P. Political dimensions of the governance of mental illness in post-apartheid South Africa. *Submitted to Politikon*.

This article was conceptualised by André Janse van Rensburg, who also wrote the first draft. Co-authors provided valuable critique and input.

Abstract

Despite significant policy shifts toward realising the basic human rights and care of people living with mental illness in post-apartheid South Africa, recent events such as the Life Esidimeni tragedy exposed a decidedly political dimension to mental health care. The contradictory elements of macroeconomic and health policy exposed a neoliberal tendency towards providing public mental health care. This was exemplified in three important cases: the recent grants crisis of the South African Social Security Agency, a court case between the state and non-governmental organisations, and the Life Esidimeni tragedy. Key features emerged: the commodification of people living with mental illness, the pertinence of auditing, accounting practices, and dynamics of globalisation, de- and re-nationalisation. This article speaks to a tangible gap in the discourse on mental health care in South Africa, by highlighting the political dimensions that are involved under an era of neoliberalism.

Key words: Mental health services, policy, SASSA, NAWONGO, Life Esidimeni, power

Introduction

In South Africa's post-apartheid period, mental illness and the management thereof has been rendered profoundly political. This has been illustrated in spectacular fashion by the Life Esidimeni tragedy, where more than 140 people living with severe mental illness (PLWMI) died of negligence in a botched de-institutionalisation process. It exhibited – similar to other tragedies of national significance – a moral miscarriage on the part of the state, a failure to acknowledge the primacy of communal relationships of identity and solidarity, raising the likelihood of reiterations of tragedy (Metz 2016). Tragedies of this nature occur in an age where 'the principle of cost-benefit to choose over competing ends' (Dhar, Chakrabarti, and Banerjee 2013, 586) has triumphed over the incommensurable values of the human rights-based relationships and processes that underwrite mental health care (Lukes 2008). It unfolds in an era where Homo Economicus has triumphed over Homo Sacer (Agamben 1998), where, "in the name of social *and* [emphasis in original] personal wellbeing, a complex apparatus of health and therapeutics has been assembled, concerned with the management of the individual and social body as a vital national resource" (Rose 1996, 37). In low-to-middle income countries such as South Africa, these considerations have been particularly relevant. Rapid socio-political shifts place extraordinary demands on the mental health of populations, and low-to-middle income societies in transition have prioritised economic growth by means of integration with global capitalism and public sector reform over mental health service expansion (Burns 2015; Lee et al. 2015). Despite growing global awareness of the significance of public mental health, increased political lobbying for its prioritisation, and substantial research and development, the political dimensions of mental health care often remain overlooked. In South Africa, the nexus between socio-political and socio-economic change on the one hand and mental health in the other warrant attention (Burns 2015). This has a profound effect on the relations between state and non-state mental health service providers, the third area of focus of this study (Chapter 1).

Accordingly, building on Part 2, in this article we interrogate political dimensions of mental health care in the post-apartheid South Africa, by 1) describing important policy shifts related to mental health; 2) placing focus on three key events that exemplify failing mental health care under advanced liberalism; and 3) positioning these processes within the dimensions of a political economy of mental illness.

Policy shifts in the management of PLWMI in post-apartheid South Africa

Several important shifts in policy and legislation unfolded during the past two decades, significantly influencing the ways in which PLWMI are managed in South Africa's post-apartheid period. We briefly consider a selection of these, as discursive acts that constitute processes that suggest a specific type of governing of PLWMI. The Constitution of the Republic of South Africa (South African Government 1996) has been, in many ways, the lynchpin of post-apartheid re-building and development. Importantly, it presented the new African National Congress (ANC) government with a substantial amount of symbolic capital, rendering the state into "hope generating machine" (Müller 2014, 41). While the human rights ethos of the Constitution acted as a blueprint for succeeding legislation and policy, the ANC had to balance socio-economic transformation in step with the global milieu during the 1990s on the one hand, and social justice and the restoration of entitlements on the other (Sitas 2010; Ncube, Shimeles, and Verdier-Chouchane 2012). In this vein, the Reconstruction and Development Programme (RDP) (Republic of South Africa 1994) was particularly significant, aiming to address colonial and apartheid-era injustices by targeting poverty and unequal social service distribution with a social-democratic approach (Karriem and Hoskins 2016). The expansion of health and social services during this period is significant – health care is a strategic public good, and a key source of contestation: "Health systems frame and either legitimate or de-legitimate the very nature and competence of the state. States that cannot ensure health care, lose their legitimacy" (Mackintosh 2013).

Health and social development were especially prominent in RDP-led gains during the first years of democracy. This included the provision of free PHC to vulnerable groups; the implementation of an essential drugs programme; greater parity in district-level health expenditure; a clinic building and upgrading programme; expanding welfare benefits to those in need; and a revitalisation and construction of public hospitals (Harrison 2009; Van Rensburg and Engelbrecht 2012). Yet, it quickly became apparent that the RDP was in trouble; this became evident in the missing of targets of the first few years of implementation, as well as underspending and allegations of corruption. The RDP also suffered from ambiguity, some perceiving it as a radical socialist transformation, while others seeing it as an anti-poverty programme (Blumenfeld 1997). Weak power and bureaucratic obstructions in implementing the RDP across various national departments further hamstrung its outcomes (Karriem and Hoskins 2016). Ultimately, apart from selected quantitative progress, the RDP did not qualitatively improve the plight of vulnerable populations such as PLWMI. Van Zyl Slabbert (2006, 102) spoke to the core of the RDP's legacy: "In whichever way we look at it, we will measure the success of our transition by the demonstrable improvement in the quality of life at the local level. That is where we live every day".

Following the RDP, the Growth, Employment, and Redistribution (GEAR) policy was introduced in 1996 (Department of Finance 1996). The apparent dramatic shift from a somewhat Keynesian RDP to a neoliberal GEAR has been well described (Nattrass 1996; Terreblanche 1999; Peet 2002; Bond 2005; Visser 2005; Karriem and Hoskins 2016). In many respects, GEAR reflected global neoliberal forces at work during the time (International Monetary Fund and World Bank influences in many developing states), prioritising deregulation, privatisation and market dynamics above redistribution and social justice (Harvey 2005; Van Rensburg and Engelbrecht 2012). Importantly, GEAR provided a fertile environment for the proliferation of private hospital groups and privatisation of mental health services, adding impetus to an already fractured, unequal and dualistic health system. Perhaps the most striking indication of the ideological shift from the RDP to GEAR was the transfer of oversight power from the presidency to the Ministry of Finance, cementing the transformation from "growth through redistribution" to "redistribution through growth" (Karriem and Hoskins 2016).

Against the backdrop of this macroeconomic environment, mental health care reform was driven within several key policies. A particular pressing strategy has been to foster collaboration across the spectrum of different services, including state, non-profit, and private for-profit service providers (Janse van Rensburg and Fourie 2016) – in step with global shifts towards more holistic and balanced care (Mari and Thornicroft 2010; Thornicroft and Tansella 2013). This approach remained a sustained feature of documents aimed to reform mental health services. The ANC's National Health Plan for South Africa (African National Congress 1994) called for "a multisectoral and integrated approach to mental health service", which includes the integration of mental health services into different sectors such as general health care, welfare and education systems. It endorsed the development of multi-level inter-sectoral structures from which mental health care should be coordinated among different government departments as well as all relevant levels of service provision. Community care and support services for PLWMI was a prominent feature, and the document called for the ‘development of non-governmental community-based mental health care services and fostering cooperation between the various mental health service providers’, including increased cooperation with traditional healers.

The tone of the ANC Health Plan was continued in the White Paper for the Transformation of the Health System in South Africa (South African National Department of Health 1997), meant as a roadmap for national, provincial and district health system restructuring. It furthered the directive that health services should be provided in an integrated manner across different sectors, calling for collaboration in care between governmental, non-governmental and private services. A dedicated chapter on mental health care outlined the provision of “a comprehensive and community-based mental health and related services…planned and co-ordinated at national, provincial, district and community levels, and integrated with other health services” (Chapter 12). Inter-sectoral collaboration was to be coordinated at national level, planned and facilitated at provincial level, and maintained at district and community levels. Role players included non-governmental organisations (NGOs), private for-profit practitioners, and traditional healers.

An intention to increase access to mental health care was rooted in The Primary Health Care Package for South Africa (South African National Department of Health 2000) and in A District Hospital Service Package for South Africa (South African National Department of Health 2002). A core overarching standard in both documents relate to collaboration, calling on facilities to collaborate with relevant public entities as well as with civil society and workplaces in catchment areas of health facilities. Regarding mental health care, such facilities should be acquainted with community support and referral organisations, and should seek out collaborative relationships with traditional healers, religious, and non-governmental community services and groups. These initiatives were transferred to a dedicated mental health policy – the Policy Guidelines on Child and Adolescent Mental Health (South African National Department of Health 2008) – calling for coordination of and collaboration with NGOs and the private sector.

Collaboration between government and non-government role-players was adopted in the Ekurhuleni Declaration on Mental Health, which was included in the National Mental Health Policy Framework and Strategic Plan 2013-2020 (South African National Department of Health 2013). This policy provides a roadmap for future mental health system reform, including a focus on inter-sectoral collaboration. More specifically, it provides for the future expansion of community mental health care to formally include NGOs, voluntary groups and consumer organisations. Further, it underlines the responsibility of provincial government to encourage different service collaborations with NGOs. It is important to note that the responsibility for mental health care has been taken up by the Department of Health (DoH); the absence of voice from other state sectors such as the Department of Social Development (DoSD) and Department of Basic Education (DoBE) cast mental illness in a clear biomedical light. This has been profound, since such discursive power trickles down to service delivery level formal health care workers' approaches to mental illness is framed in Western, biomedical ways (Petersen 2000; Campbell-Hall et al. 2010).

Key legislation was also introduced to nurture collaborative and partnership working in mental health care. Financial aspects of state and non-state mental health service collaboration were formalised by the introduction of the Public Finance Management Act No. 1 of 1999 (South African Government 1999). The Mental Health Care Act (17 of 2002) allowed for formal agreements between national and provincial government with "any non-governmental organisation or public or private provider of goods or services" (Section 72) (South African Government 2002). The National Health Act (61 of 2003) further obliges the DoH to establish coordinated relationships between public and private service providers, and allows for formal agreements between government departments and municipalities, and "any private practitioner, private health establishment or non-governmental organisation" (Section 45) (South African Government 2004).

The narrative of collaborations across state and non-state divides, as well as across sectors, has been firmly put in centre stage by the introduction of the ambitious, state-driven National Health Insurance (NHI) scheme. A notable feature of this project has been a combative tone between state and private care sectors. The minister spearheading the NHI, Dr Aaron Motsoaledi, has taken a firm public stance against a perceived frivolous and unjust private sector, describing the state's standoff with the private sector as 'a war', and comparing resistance to the NHI to the introduction of the Affordable Healthcare Act in the USA under Barrack Obama (Koko 2017). Van den Heever (2011) noted that the Green Paper on a Policy on National Health Insurance (South African National Department of Health 2011) contains factually incorrect information that deliberately inflate the public-private health care system discrepancies in South Africa, while the White Paper on National Health Insurance (South African National Department of Health 2015) notes that there is a need to curb private sector labour costs and decrease social inequality. The complex and long-standing debate on health care provisioning is beyond this article, though a degree of private sector regulation can be defended. A high degree of private sector involvement in public services undermines public objectives and curbs social integration (Habermas 1976). Also, the public sector pursuit of values traditionally associated with private sector health care could be problematic, given that "the public sector of health care can play its redistributive and public health role only if its principles of operation differ from those of commercialized services" (Mackintosh and Koivusalo 2007, 2). This is especially telling in the drive towards the "professionalization" of state-provided health services, as reflected in the National Development Plan (South African Government 2013). Such initiatives, along with others aimed at accommodating private sector interests, have significant effects on the behaviour of public sector officials, as well as presenting public resources under the guise of mental health professionals to the private sector (Mackintosh and Koivusalo 2007).

The post-apartheid mental health care policy and legislation journey described thus far speaks to repeated attempts of collaboration in service delivery and support. For a number of reasons, the ideal of unification has not yielded many positive outcomes, and, as will become apparent, it seems as though widening fractures between different service provider sectors have resulted in key political crises in the post-apartheid period. These struggles have played out in a global arena with proliferating neoliberalism that play out in national responses to mental illness. The implications of neoliberalism for health care have been profound. In many countries, neoliberal ideologies aided in the construction of a health policy environment that stresses reduced public responsibility for population health; increased markets and choice; the devolution of national health services to insurance-based systems; privatisation of care; approaching patients as clients and replacing planning with markets; elevating personal responsibility for health improvement; moving from health promotion to behaviour change (Navarro 2009). Much has been written about an apparent unbridled global growth of neoliberalism, and how it has influenced mental health care in different contexts. This is therefore not to say that the neoliberal project is path dependent and followed the same trajectory in South Africa than in the USA. As per Nikolas Rose, that the term neoliberalism has been used for many different ways of governing that obscures its nature in different settings – advanced liberalism, encompassing a family of governing techniques is more appropriate (Carvalho 2015).

Subsequently, in contradiction to the traditional neoliberal trope of decreased state power and involvement in favour of free market forces, South Africa has – especially during the past decade – seen increased statism in the management of mental illness. GEAR was no doubt an instrument of advanced liberal tendencies, and its exclusivity put into motion an internecine struggle when the ANC had to abandon their socialist roots towards creating an environment which inhibit labour (Peet 2002), aligning with domestic and global capital and the black bourgeoisie at the expense of the impoverished majority (Visser 2005). GEAR also exposed increased statism and a nationalist drive under the ANC, that united well-placed black elites with white capital (Baker 2010). At the same time, welfare spending has increased substantially over the past decade. The number of households receiving social assistance rose from 29.9% in 2003 to 45.5% in 2015, while government social protection spending increased by 39% from approximately US$600 million in 2010/2011, to more than US$850 million in 2014/2015 (Statistics South Africa 2016c). The NDP cements the increasingly nationalist and statist features of ANC strategy, through its strong focus on 'nation-building'.

Significant events in the management of PLWMI

The SASSA grants crisis

The South African government re-prioritised values of equity and social development by introducing the South African Social Security Agency (SASSA) – a welfare grant distribution agency – in 2005 (Ncube, Shimeles, and Verdier-Chouchane 2012). Falling under the governance sphere of the Department of Social Development (DoSD), it was tasked to distribute a substantial part of the national budget to millions of people who suffered under poverty, illness and disability. Moving towards outsourcing, on 3 February 2012, SASSA handed a payment system contract for to Cash Paymaster Services (CPS), a subsidiary of Net1, an international company trading on the NASDAQ and Johannesburg Stock Exchange. In 2013, the Constitutional Court declared this arrangement legally invalid, and ordered SASSA to either re-launch the procurement process or to find alternative means of welfare distribution. SASSA submitted a plan to the Constitutional Court in 2014 to take over the payment of grants itself when the CPS contract ends on 31 March 2017. However, as the deadline of 31 March 2017 loomed closer for the transfer, it became apparent that SASSA would be unable to pay the approximately $67 million in welfare grants to 17 million single mothers, people living with disabilities and severe mental illness, pensioners, and war veterans (one-third of the population). In February 2017, SASSA acknowledged its failure to meet this deadline (Maregele 2017). Given the possible catastrophic consequences of non-payment, the Court was forced to – under the emergency procurement conditions of the Public Finance Management Act – order SASSA and CPS to continue the unconstitutional arrangement that was in place before, for another 12 months during which the matter should be resolved. The crisis is on-going, and, at the time of writing, a contract has yet to be formally signed with the South African Post Office (SAPO) as possible partner, five months from the one year deadline set by the Constitutional Court (eNCA 2017). The likelihood of a repetition of the March 2017 crisis seems likely. The SASSA Crisis was scathingly placed into context by Constitutional Court Judge Johan Froneman in the opening lines of his judgement of a case between Black Sash (a NGO and advocacy group) and the DoSD, SASSA and others (Mogoeng et al. 2017):

> *One of the signature achievements of our constitutional democracy is the establishment of an inclusive and effective programme of social assistance. It has had a material impact in reducing poverty and inequality and in mitigating the consequences of high levels of unemployment. In so doing it has given some content to the core constitutional values of dignity, equality and freedom. This judgment is, however, not an occasion to celebrate this achievement. To the contrary, it is necessitated by the extraordinary conduct of the Minister of Social Development (Minister) and of the South African Social Security Agency (SASSA) that have placed that achievement in jeopardy. How did this come about?*

A particularly important feature of this arrangement is the leanings towards building a "techno-financial system" that track and exploit the poor and socially marginalised (Torkelson 2017). Ways to ensure payment fidelity by means of electronic tracking has been a strong consideration of welfare grant processing, ever since its mention in the White Paper for Social Welfare (South African Government 1997). A principal reason for SASSA's outsourcing of the welfare contract was to consolidate systems and authenticate beneficiaries. AllPay, a major competitor for the contract, claimed that SASSA made last-minute changes to the tender criteria, from requiring mandatory to preferential biometric verification – "proof of life" was therefore required (Torkelson 2017). Further, Net1 created a range of subsidiaries that targeted beneficiaries to market loans (MoneyLine), mobile phone cards (EasyPay Everywhere), electricity and airtime (Manje Mobile), and insurance (SmartLife). In all, it has been estimated that Net1 accrued as much as US$420 million profits from the SASSA contract in 2016 alone (Torkelson 2017). At the time of writing, it was announced that the South African Post Office will take over the contract (Herman 2017). Ultimately, it should be kept in mind that social protection policies often become gauze that hides the widening wealth disparities and social costs of neoliberal strategizing (Devereux and Solomon 2011; Harris, Eyles, and Goudge 2016).

The NAWONGO court case

The role of NGOs in illuminating the SASSA crisis was profound, and underlined the importance of their activist role. A section of NGOs have, however, increasingly been subsumed under the state, threatening accountability to the public as well as their autonomy (Habib and Taylor 1999; Habib 2005). It has also significantly influenced their operational abilities and survival, as became apparent in a court case where a national coalition of 92 NGOs (the National Association of Welfare Organisations and Welfare Organisations, NAWONGO) took sued the DoSD for clarification of service agreements. The Court found that the DoSD has underfunded non-profit services that the state is constitutionally obliged to provide. It was estimated that the Free State province requires 2000 child and youth care centre beds; 1085 were available, of which only 320 were provided by state facilities. The DoSD spent between US$354 and US$477 per month per child in state-run child and youth care centres, but subsidised non-profit, non-state child and youth care centres US$242 per child per month. NGOs were essentially expected to provide children in their care with three meals for less than one US dollar a day. A similar trend was found regarding the subsidising of people requiring geriatric care (Free State High Court 2010).

In a significant move, the DoSD contracted the services of KPMG, to assist in calculating the relative costs of financing NGO services. KPMG is one of the ‘Big Four’ global auditors, providing financial auditing, tax and advisory services to the vast majority of public and private companies across multiple countries and multiple stock markets – its global revenues totalled US$25.42 billion for the 2015-2016 financial year (KPMG 2017). During the legal process, the DoSD, with the assistance of KPMG, drafted a policy outlining the costing and prioritising of non-profit service remuneration. The report provided the court with a mechanism with which to determine the annual costs of providing a service to a public beneficiary – including PLWMI. If an NGO provides an essential service, but cannot contribute to its own operational costs in providing this service, the state should supplement the deficit as necessary (Wyngaard 2011).

The KMPG report provided a list of options with which the DoSD can prioritise how funds are prioritised, including prioritisation by programme only (for instance adoptions, substance abuse); by programme and responsibilities (the inclusion of an additional dimension, such as nutrition, medical care, or accommodation); and by programme and expense type (the inclusion of a second dimension, such as beneficiary-related costs). The DoSD decided on a strategy that prioritised by programme as well as necessity level, for instance accommodation along with costs based on necessity level – necessities, partial necessities, and non-necessities. In this way, the relative priority of a programme is determined by the DoSD, after which funds from the annual budget are allocated to programme expenses according to the levels of 1) necessities, 2) partial necessities, and 3) non-necessities. In this way, the DoSD avoided funding whole programmes, rather focusing on necessities within programmes. Two lists are drawn from, 1) a ranked list of 40 priority programmes (consolidated into 34, after combining key programmes in an integrated social work service package), and 2) a list of expenses ranked according to necessity level. It was concluded that the “allocation model…remains a deficit-sharing model. Because the department determines the content of each programme, in that determination it can leave out whatever it regards as non-essential” (Free State High Court 2010). This legal process resulted in the adoption of the KPMG model as a central technique in fund distribution to social services in the province, in which mental illness – a disease whose murky causality and complex treatment render it infinitely malleable (Sontag 1978, 58) – might fall through the cracks of ranked priorities based on economic rationality. It also swayed the power of prioritising towards the state sphere.

The Life Esidimeni tragedy

In what is now widely known as a significant – largely political – series of events, the Life Esidemeni tragedy was put into motion in the public sphere by the Gauteng provincial member of the executive committee (MEC) for Health, Qedani Mahlangu, during the 2015/2016 budget vote (Mahlangu 2015a). In a stroke of arresting irony, the day that the Gauteng Department of Health (GDoH) published the media statement that the Life Esidimeni contract was to be terminated – 21 October 2015 – was also chosen in popular media as “Back to the Future Day”. It was chosen by the screenwriters of the 1989 film “Back to the Future Part 2” as a day on which the USA-based Chicago Cubs baseball team could theoretically win the World Series, selected largely because of the absurdity of their perceived chances of winning (Shontell 2015). To fully appreciate the pertinence of this coincidence, we need to re-visit the first of two reasons provided for the cease of the Life Esidimeni contract. The GDoH claimed that patients suffering from mental illness needed to be deinstitutionalised to community settings, as stipulated in the Mental Health Care Act (17 of 2002) (South African Government 2002). The pertinence of the coincidence lies in the well-known complexity and potential pitfalls of deinstitutionalisation in the context of inadequate community support, having been described with exceptional depth and breadth in existing literature as a feature of mental health care reform in many countries since the 1960s (Goldman and Morrissey 1985; Sawyer 2005; Koyanagi 2007; Morrow, Dagg, and Pederson 2008; Novella 2008; Sheth 2009; Shen and Snowden 2014; Thornicroft, Deb, and Henderson 2016;). The more significant reason for the ending of the contract was a financial one; the annual amount of US$24 million spent on 2 378 patients was argued to be excessive, and it was indicated that these funds were to be re-prioritised (Mahlangu 2015b). This assertion was undercut by later assessments that suggested the costs of US$22.50 per patient per day at Life Esidimeni were below market-related health care costs; average health care costs per patient per day at state-funded Weskoppies, Sterkfontein Cullinan Care and Rehabilitation Centre hospitals were calculated at US$137.82, US$97.45 and US$104.47, respectively (Makgoba 2017). The patients were moved to 27 different NGOs, none of which were regulated by the DoSD. The narrative became one of shifting responsibility for PLWMI from the state to NGOs (Janse van Rensburg et al. n.d.a).

In February 2017 – following an investigation by the Office of Health Standards Compliance (OHSC) initiated by the national minister of health – 94 of the 1371 patients moved to community settings were confirmed to have died due to negligence (Makgoba 2017). MEC Qedani Mahlangu, who initiated the process, resigned (media scrutiny following the report has suggested a death count of more than 100). The unfolding of these events was closely followed in media outlets, countless opinion pieces were produced which universally condemned the events as human rights abused. The United Nations Human Rights Council noted the following (2016):

> *While deinstitutionalisation is the right approach, when implemented without a plan based in human rights that increases community-based services, and provides adequate housing and financial resources, it can have fatal consequences, as this situation illustrates*.

While the OHSC describes the progression of events with a fair amount of detail, for our purposes it will be prudent to revisit the key developments that led to so much avoidable deaths. In June 2015, the MEC communicated her department's deinstitutionalisation plans. During the same month, the South African Society of Psychiatrists (SASOP) warned the GDoH of the likely negative consequences that will results from the Life Esidimeni contract termination. Despite repeated concerns raised from interest groups, the GDoH went ahead with the planned deinstitutionalisation, and by June 2016 all state-funded patients were moved out of the Life Esidimeni facilities. By July 2016 reports started surfacing that patients' families are looking for their loved ones, and many patients were not accounted for in the wake of the transfer process. Further scrutiny built towards August 2016, when a public letter was addressed to the Minister of Health by Christine Nxumalo, the sister of one of the patients who died under negligent circumstances at one of the target NGOs. On 13 September 2016, the MEC announced that 36 patients had died since relocation to NGOs, eliciting wide-spread condemnation and outrage in popular media. Two days later, the national minister of health, Dr Aaron Motsoaledi, requested an official enquiry from the OHSC into the circumstances of the deaths. Following comment from the MEC, the final report was released on 1 February 2017; the total death toll was 94 patients. On the same day MEC Mahlangu resigned.

In the course of the days following the release of the report, both the astounding number and causes of deaths following the re-location process was the subject of public discourse. The full details of the 56-page report cannot be adequately summarised here – readers are encouraged to read the report and its accompanying annexures for better insight into the investigation. Succinctly, clinical and other patient-level records were analysed by an eight-person expert panel; the 26 NGOS involved were investigated by means of on-site visits, inspections and interviews by two OHSC inspectors; the investigation team reviewed popular media coverage, documents, and case presentations with affidavits from civil society group Section 27, and worked with Statistics South Africa to analyse mortality; and the Ombudsman interviewed 73 individuals under oath or affirmation. The findings of the investigation entail a wide-spread condemnation of the Life Esidimeni transfer process, as well as the mental health system as a whole. The rushed manner and consequences of the actual transfer process was described in lurid detail (Makgoba 2017, 2):

> *…frail, disabled and incapacitated patients were transported in inappropriate and inhumane modes of transport, some 'without wheel chairs but tied with bed sheets' to support them; some NGOs rocked up at LE in open 'bakkies' [trucks] to fetch MHCUs [mental healthcare users] while others chose MCHUs like an 'auction cattle market' despite pre-selection by the GDMH [Gauteng Department of Mental Health] staff; some MCHUs were shuttled around several NGOs; during transfer and after deaths several relatives of patients were still not notified or communicated to timeously; some are still looking for relatives; these conducts were most negligent and reckless and showed a total lack of respect for human dignity, care and human life.*

The deaths of the patients received strong focus – both the manner and number – as did the series of poor decisions and flawed argumentation in the GDoH that led to the deaths along with the under-capacity of NGOs to have prevented the deaths (Makgoba 2017). At the time of writing, arbitration proceedings were held between the families who lost loved ones and the state, chaired by Retired Deputy Chief Justice Dikgang Moseneke. During these hearings, it was indicated that the death toll rose to 141, although 59 patients were unaccounted for even though NGOs still drew their monthly welfare grants (Bornman 2017). The focus remains on death – while the plight of PLWMI, both those part of Life Esidimeni and those in other parts of the country – persists.

Towards a political economy of mental illness in South Africa

PLWMI as commodity

Several important themes emerge thus far; speaking to dimensions of a deep malaise associated with the conditions of late capitalist modernity and advanced liberalism. In his popular *Capital in the Twenty-First Century*, Thomas Piketty highlighted the notorious Marikana incident of August 2012 (where 34 striking miners were killed by state police forces) as an example of the immense inequalities in the capital-labour split in the modern era, which often result in violent clashes between workers and their economic masters (Piketty 2013). While the capital-labour split is an undeniable feature of the South African narrative, there are further possibilities left to explore, notably the assertion that, under advanced capitalism, workers become sources of capital themselves: “Labor produces not only commodities; it produces itself and the worker as a commodity” (Marx 1959, 28–29). In the Marikana case, it should be considered that mining companies such as Lonmin (the British company owning the Marikana-based platinum mine where the 2012 events unfolded) invest heavily in private hospitals for their workforce – principally to keep their workforce healthy. This is particularly salient for the management of tuberculosis, a disease rife among the South African mineworker population (Van Halsema et al. 2012; Churchyard et al. 2014), and a well-known "disease of poverty" (Farmer 1999, 2003). AngloGold Ashanti – who operates the Lonmin mine – is in many ways the epitome of the success of global capitalism, operating in eleven countries and listed on five major stock exchange markets. Keeping the workforce healthy is a key concern in the reproduction of capital, and in this way investing in the physical bodies of mine workers is tied to profit. Mental health certainly is not a consideration here; people whose ability to work and take part in the economic system is hampered by an illness which often does not have a good prognosis are not worth investing into within the contexts of advanced liberalism. However, this does not mean that PLWMI are inherently worthless in this system – they become a form of capital themselves.

Responses to mental illness in post-apartheid South Africa have been subject to similar themes as those in the Marikana incident. This includes the commodification of PLWMI; the application of cost-benefit, economistic and accounting rationalities in their management; and the reach of multinational bodies with an associated flow of global capital. It should be emphasized that – under the conditions of advanced liberalism – "the inability of the human to compete in terms of productivity, efficiency, and corporate values become a signal of the failure of his embedded capital or of his ability to adequately create and cultivate capital" (Dhar, Chakrabarti, and Banerjee 2013, 586). Within these contexts, the triumph of Homo Economicus is significant; the championing of individualism, opportunism, and seeking self-serving interests permeated social policy and significantly framed the ways in which PLWMI are "managed" (Davis, Donaldson, and Schoorman 1997). This plays out in conditions 'where the human is itself capital, where capital is embodied not in goods and services but in the human itself" (Dhar, Chakrabarti, and Banerjee 2013, 585). Homo Economicus represents an entrepreneur of oneself with exchange value, deploying cost-benefit analysis in allocating resources, embodying capital in lieu of goods of services, where humans are forms of capital begetting capital in the form of market-driven skills and values (Becker 1976; Foucault 2008; Dhar, Chakrabarti, and Banerjee 2013). Here, PLWMI are cast under a "spectre of uselessness" (Sennett 2006, 83), where their inability to take part in the labour market of advanced liberalist societies have afforded them the status of Homo Sacer, put into context by Giorgio Agamben (1998, 88):

> *It is as if the bare life of homo sacer, whose exclusion founded sovereign power, now became – in assuming itself as a task – explicitly and immediately political. And yet this is precisely what characterizes the biopolitical turn of modernity, that is, the condition in which we still find ourselves*.

While responses to mental illness has featured in significant health policy reforms in post-apartheid South Africa, any real advances in the fostering of a nurturing environment for mental health was undone by macroeconomic shifts that stimulated the commodification of PLWMI. This became apparent in the cases mentioned; PLWMI were left to the devices of the market, where NGOs – the supposed champions of civil society and human rights – are left to compete with each other for the stable capital income generated by caring for this vulnerable population. The monthly SASSA payment system incentivises quantity over quality, and the state and NGOs are embroiled in an enduring and protracted battle for the capital investment associated with the care of people on the peripheries on the social, political, and economic dimensions of the South African landscape. Loic Wacquant (2009a, 2009b, 2010) and Bernard Harcourt (2011) drew our gaze to the double act of widespread divestment in the lives of certain population groups as well as investment in their management, exemplified by the private prison system complex “managing” (especially) black, lower socio-economic class populations for profit. This entails a flow of capital from tax payers to private companies, endorsed and supported by the state apparatus who are the legitimate stewards of population health and well-being. At the minimum, PLWMI are denied basic social and health care, much like many other people in South Africa. However, it no longer is a question about quality of care and human rights, but rather of life and death. We are at a juncture where “necropolitics” have taken hold; where 144 (and counting) people have died as a direct result of an almost extreme expression of biopower, where “death and freedom are irrevocably interwoven” (Mbembe 2003, 38).

Auditing, accounting, and mental illness

A meaningful feature of governance under advanced liberalism, and one that stood central in the cases discussed was the use of accounting and auditing practices in governing PLWMI. The prominent role of KPMG in the court case between the state and NGOs – particularly in influencing the ways in which government welfare spending should be prioritised – speaks to elements of an “audit society”; one where ‘the welfare state is increasingly being displaced by the “regulatory” state, and instruments of audit and inspection are becoming more central to the operational base of government’ (Power 2000, 114). The accounting practices that calculated the costs associated with mental health care provision were key elements of the processes in both the mentioned court case, as well as in the Life Esidimeni tragedy. It should be stressed that this is part of a broader neoliberal project, where accounting, auditing and management techniques enable a marketization of public services that break away from central control and ‘inscripts’ expertise-driven governance (Rose 1996). Here, a calculative technology permeates thought, creates new visibilities of profit and loss, and links private decisions and public objectives through knowledge (Miller and Rose 2008; Rose and Miller 2010), and cuts across government departments, private sectors and NGOs (Miller 2001). The power of calculations that underwrite the costs associated with the care of individuals within a specific population group lies within its ability to “translate diverse and complex processes into a single financial figure” (Miller 2001, 381). The prevalence of an ‘economic machine’ that creates structures that dominate through implanting calculating practices, fiscal regimes and financial regulation (Rose 1996) has then, against the neoliberal turn in post-apartheid South Africa, significantly shaped the governance of mental illness. This cost-benefit economic rationale comes into conflict with core values – referred to by Steven Lukes as incommensurable values – that “resist cost-benefit analysis, where the very idea measuring in order to compare the values of alternative outcomes seem inappropriate” (Lukes 2008, 113).

Globalisation, de- and re-nationalisation

A further feature of liberal governing is the inextricable links between the global and the local, and the influence of powerful multinationals in South Africa’s response to mental illness during the past two decades. The power of accounting practices discussed above make this possible, in part at least, by governance structures that adhere to practices that are “often demanded by outside agencies, and which makes various kinds of internal and external intervention possible” (Power 2000, 114). The 1990s saw an increase in collaborations between powerful global corporations and local companies in LMICs (Smith 2004). There has been a general overall trend towards international financial integration, with global capital flows steadily increasing from less than 7% of the global GDP in 1998, to more than 20% in 2007 – this was led by an expansion of flows from and to more advanced economies (Milesi-Ferretti and Tille 2011). A prime example in this sense has been Net1, the parent company of CPS (the company contracted to manage SASSA grants). In 2015, the company set up a subsidiary in the United Kingdom – Zazoo – with the intention of driving global expansion of mobile payment technologies, specifically geared towards developing countries (Wilson 2015). In 2016, the International Finance Corporation (IFC) bought 18 percent interest in the company for US$107 million. The IFC, a member of the World Bank Group, has invested heavily in the private sector of emerging markets, especially in financial technology – an approximate amount of US$180 has been invested in 26 financial technology companies (Mchunu 2016). Disability grants are a major barrier between PLWMI and abject poverty and homelessness, the correlation of which is well-known (Lund et al. 2010b; Lund et al. 2011b; Cooper, Lund, and Kakuma 2012; Burns 2015). Nonetheless, as the SASSA fiasco demonstrated, social protection of PLWMI is very much linked to global capital flows. Not only in terms of cash, but also in terms of technocratic governing and control of specific populations by means of technologies of surveillance and auditing (Miller and Rose 2008).

A common feature of the global neoliberal project is the power of multinational corporations that benefit from trade liberalisation and reduced state intervention (De Vogli 2011; Moore et al. 2011). There is a correlation between increased health care commercialisation and foreign investment (Smith 2004), and South Africa's strong private health sector certainly provided ample opportunity for the involvement of multinationals. Nonetheless, in contradistinction to "strong" theses of globalisation that underline 'the erosion of state sovereignty and autonomy, and the limitations placed on international and domestic social politics and policies' (Yeates 2002, 70), South Africa has seen increased statism in mental health care during the past decade. Gillian Hart (2014) provides a fitting analytical device with which to make a degree of sense of these apparent contradictory relations. Moving beyond the usual focus on neoliberalism and its internal dynamics, Hart uses the double movement of de- and re-nationalisation to account for the trend of increased statism. De-nationalisation refers to the engagement of South African corporate capital with global capitalist forces following the end of apartheid, with capital flight and wide-spread privatisation and out-sourcing of services. Its dynamics extends to beyond the scope of GEAR, to include forged partnerships between new black elites and white capital and the resulting influence of these partnerships on ANC policy, massive capital flows to the global economy, and denationalisation of conglomerates. This was apparent both in the supportive policy environment as well as in the outsourcing of services by the South African state in the cases described above: the SASSA crisis involved the contracting of biometric social grant management to a global corporation; KPMG was heavily involved in the prioritisation processes in the NAWONGO court case; and, in Life Esidimeni tragedy, mental health services were outsourced to a major private hospital group very much connected to global capital. Employing simultaneous economic, political and cultural practices and processes that generate 'surplus populations', de-nationalisation dynamics have deepened abject inequalities and severely negated livelihoods of the bulk of the black South African population. However, as the Life Esidimeni and SASSA cases suggested, the state attempted to reroute capital back into the state sphere. In the SASSA case, this was especially telling in the awarding of the welfare grant payment contract to the South African Post Office (though the example is rather simplistic); the core functions of the contract include managing a corporate control holding account, a special disbursement account, identity card production and distribution, and enlisting of new beneficiaries – all to be done under the shadow of "cost-effectiveness" (Herman 2017). Further, a backdoor was provided that will allow external companies and banking systems to assist with the delivering of some of these services, thereby facilitating a flow of capital to global networks. The seemingly contradictory movements between statist and globalist standpoints are crucial elements of ANC hegemony. Attempts to "take back services" are processes of re-nationalisation, heavily tied to the ANC's post-apartheid project of "building a new nation", processes that inevitably includes contentions involving race, class, and gender struggles in a post-colonial sense. Re-nationalisation also included the ANC government's immigration policies and practices that fuelled well-documented xenophobic attacks during the past decade, as well as a broader strategy within the ANC that involves the adoption of socialist tendencies after the fall of apartheid. The simultaneous and conflicting processes of de- and re-nationalisation has been a key influence in the ANC's post-apartheid hegemony (Hart 2014).

Conclusion

In this paper, we illuminated – admittedly in a selective fashion – the political dimensions of responses to mental illness in post-apartheid South Africa. We followed the sentiment put forward by McCubbin (1998, 97), that 'a small burning candle may be the most visible object in a closed room, until sunlight pours into the windows. Similarly, particular service delivery structures operate in a much larger environment that remains largely untouched by changes at the local service level'. The focus on agency to the detriment of structure has been telling in the SASSA grant crisis, the NAWONGO court case, as well as in the Life Esidimeni tragedy. By fixing our gaze on the culpability of individuals, government departments and political parties, we have been blinded by the structural subtleties that provide fertile ground for the occurrence of such events. In contradistinction with narratives that involve the de-politicisation of social policy and reform, political struggles permeated different spheres and levels of society (Yeates 2002). Accordingly,

> *…the question is no longer one of accounting for government in terms of 'the power of the State', but one of ascertaining how, and to what extent, the state is articulated into the activity of government: what relations are established between political and other authorities; what funds, forces, persons, knowledge or legitimacy is utilized; and by means of what devices and techniques these different tactics are made operable* (Miller and Rose 2008, 56).

The neoliberal tropes of rational conduct and reasoning, the centrality of auditing and accounting practices, and the setting of specific standards for human capital (Miller 2001; Dhar, Chakrabarti, and Banerjee 2013;) emerge not only in noteworthy events, but also in the daily lived experiences of PLWMI. The South African narrative has deviated somewhat from traditional neoliberal trajectories in lieu of ANC nationalist politics, and the full effects thereof on the most vulnerable of the population remains to be seen. Nonetheless, in Part 3 of this Chapter, we provided a solid base from which to better understand the relations between state and non-state mental health sectors (Chapter 1).

Summary of literature

This literature review aimed to lay the foundation for the empirical explorations that are described in Chapters 4 to 6. Importantly, it served as a clarification of complex constructs that are at the core of the research questions followed. First, it was necessary to make the point that power and governance are multi-layered concepts, and that it occurs in various forms in social reality. While it was suggested that second streams of power analyses are lacking in studies of integrated care, the position taken was one where both streams of power are necessary towards forming more comprehensive descriptions of social reality. Secondly, and building on these elaborations of governance and power, the positioning of state and non-state collaboration in South Africa's post-apartheid period were described in a relational way. The bureaucratic field provided a fitting frame with which to both pay attention to mainstream power conceptions of state and non-state relations in highlighting actors vying for capital, as well as to hint at the salience of second stream power in underlining the strategic elements of state and non-state relations in neoliberal contexts. The internecine struggles in the bureaucratic field sets the stage for the third consideration, namely the political management of mental illness. By drawing from recent, significantly discursive events, it was argued that PLWMI have been rendered both subjects and objects in their governance. The thread of governmentality that was started in the first part of the literature review is illustrated by illustrating how these processes have unfolded in state and non-state collaboration. Significantly, it was argued that PLWMI have been commoditised in these relations under the conditions of neoliberalism, or more accurately, advanced liberalism. These dynamics have not been explored in the post-apartheid South African milieu, and so the stage is set for this study's empirical explorations.

Chapter 3: Overarching research approach

Introduction

In this chapter, the overarching research approach of the study is described. It should be noted that, due to the article format of the dissertation, the research methods of Chapters 4 to 6 are described more comprehensively. Here, the aim is rather to provide – in broad strokes – the general approach that was taken towards generating three distinct articles. In this vein, the nature of the study is described, including briefly considering the nature of doctoral research by publication, the multidisciplinary nature of the research, and its epistemological underpinnings. The broad approach to the research methods are described, including the adoption of a case study design, a description of the case, the methodologies employed, and key aspects of data collection, management and presentation. The ethical considerations of the research are described, followed by an indication of the timeline of the research process.

The nature of the study

Doctoral research by publication

The research was conducted by publication, in line with postgraduate regulations from Ghent University (UGent) and Stellenbosch University (SU) (see Addendum B for the formal co-tutelle agreement). Since the first recorded recognition of a doctoral degree by publication by Cambridge University in 1966, the format has gradually grown in popularity across the globe, across disciplines (Kamler 2008; Frick 2016). A PhD by publication can be defined as "a retrospective examination of an established body of work that has already (apart from the critical appraisal and viva voce) been peer reviewed and published" (Davies and Rolfe 2009, 592). Key drivers behind the shift towards doctoral degrees by publication include increased emphasis on training and skills and supervision quality; calls for improved accountability, quality assurance, effectiveness and efficiency, and the introduction of benchmarking (Park 2005; Frick 2016). An important consideration in doctoral research by publication is coherence, that is, the degree to which the thesis presents a convincing critical narrative and unification of the individual articles (Badley 2009). The thesis should comprise of a significant and cohesive expansion of knowledge, more than the sum of the individual articles (Jackson 2013).

The end product should therefore be a number of articles within a given time period of postgraduate training, as well as additional pieces that bind that project together (Frick 2016). It is generally expected that the study supervisors are co-authors on publications. In this arrangement, co-authorship between the student and supervisors becomes a pedagogical tool to assist the student significantly in obtaining a writing profile in education and science (Kamler 2008), but the candidate has to make the principal contribution to the articles, and be the first author (Jackson 2013). Additional authors can also be added to the writing of articles, which assists in building professional networks and adds critical insight. Co-authorship ultimately helps to build textual confidence and authority, provides an extra layer of support in navigating the practical and political waters of journal submission, and is a conduit to publish international refereed articles (Kamler 2008).

A particular advantage of this format is knowledge production, as articles have the inherent benefit of broader and easier access by the global community than the traditional monograph (Frick 2016). There are pitfalls as well, the most obvious being that there are no guarantees that the articles will be accepted for publication within the time trajectory of the doctoral study, or accepted at all. It should be noted that doctoral research by publication is far from an uncontested norm and flourishes in a context of institutional support along with close engagement of knowledgeable and skilled supervisors (Kamler 2008). Ultimately, this study resulted in five articles that have been submitted for publication to peer-reviewed, accredited scholarly journals, two of which have been published at the time of submission of the thesis for examination. Two articles were rooted in theoretical tenets of the study, while three more were based on empirical work. This satisfied the requirements of both UGent and SU that a minimum of three publishable articles be produced prior to examination.

A multidisciplinary approach

The study was a joint doctoral project between the Department of Sociology, UGent, and the Department of Political Science, SU. The central focus of the study does not adequately lend itself to a single, discrete discipline, but should be approached with a range of perspectives. Accordingly, a brief nod to the compatibility between political science and sociology in studying complex phenomena is warranted. Political science and sociology are intimately intertwined, in that sociology is the study of humans in society, which inherently encompasses politics (Rush 2013). Just as Stanley Cohen and Enrico Ferri stood with feet both in sociology and criminology, many examples of eminent thinkers come to mind that often crossed the borders between sociology and political science, for example Max Weber, Harold Lasswell, Nicos Poulantzas, Claus Offe, and Theda Skocpol. The history of the two disciplines go back together for more than two centuries, and calls for closer collaboration across the two approaches to societal problems can be found as far back as 1906: "Our business is to understand each other as soon as possible, and to help each other all we can in so perfecting our methods that we may make our utmost contribution to knowledge" (Small 1906, 23). In 1921, Harry Elmer Barnes noted: "At present, however, it will probably be conceded in most quarters that the time has arrived when the old lion, political science, may lie down in peace with the young lamb, sociology" (Barnes 1921, 488). The need to consider both approaches in the study of mental health care and its governance processes, stems from the assumption that social phenomena do not exist within a vacuum; rather, like most social processes, it is envisioned to present in an open system, along with a multitude of social mechanisms, structures, cultures and agents that may not always be easily detectable (Archer 1995; Bhaskar 2010; Elder-Vass 2010).

The endless task of human knowledge involves the reconstruction of elements of human experience in a way that promotes understanding beyond mere observation (Small 1906). A central task of social science is to identify and analyse processes "beneath the surface" in order to account for events "on the surface" (Scambler 2007, 298). However, because these processes exist on different levels of analysis, different perspectives are needed in order to provide valid explanations. In order to reach the goals of the study, a "synthetic interdisciplinary integration" of knowledge from sociology and political science was necessary (Bhaskar 2010, 11). The research accordingly drew from both traditions, specifically from the study areas of governance and governmentality, power relations, political economy, health care organisations, and health policy. The multidisciplinary approach is illustrated by the journals where the articles were submitted to, namely in integrated care, health systems, public management, medical sociology, and health policy.

Epistemological underpinnings: Pragmatic, theory-driven research

In line with the multidisciplinary nature of the study, the research was driven by a pragmatic approach. In essence, epistemological pragmatism relates to actions and change, viewing knowledge in terms of humans in constant dynamic interaction (Goldkuhl 2012). Pragmatic approaches do not require the use or exclusion of any particular research methods (Teddlie and Tashakkori 2009), as long as the chosen methods can potentially answer the research questions of the study (Feilzer, 2010). The aim is not to find any form of "truth" or significant causal linkages, but rather to investigate a particular question with the most appropriate research methods (Teddlie and Tashakkori 2009). This does not take away the requirement of robustness, and pragmatic research still needs to adhere to the scientific and systematic rules that render research transparent and replicable. Pragmatic research is therefore not restricted to positivist explanation or interpretivist understanding, and includes prescriptive, normative, and prospective forms of knowledge generation (Goldkuhl 2012). Teddlie and Tashakkori (2009, 93) describe a pragmatic standpoint as "a commitment to uncertainty, an acknowledgement that any knowledge 'produced' through research is relative and not absolute, that even if there are causal relationships they are 'transitory and hard to identify'" (Teddlie and Tashakkori 2009, 93). It affords the researcher the benefit of engaging with the "complexity and messiness of social life and revive a flagging sociological imagination" (Feilzer, 2010, p. 14). A foundational notion of pragmatism is that the idea of a concept is rooted in the practical consequences of the concept (Goldkuhl 2012). Here, theory is central. It means studying the social world through the "mediation of theory", towards fostering an "epistemic and pragmatic relationship with the world" (Salvatore 2016, XXXV). The use of theoretical frameworks has several advantages. It provides a foundation for the formulation of questions and issues (Simons 2014), helps to inform the framing of research problems and ways of understanding its dynamics (Green and Thorogood 2004), aids in the interpretation of processes that otherwise might be missed by researchers (Layder 1998), and ultimately provides "a map for combining the what with the why to gain a multidimensional understanding" of the phenomenon under focus (Evans, Coon, and Ume 2011, 278). A theory-driven approach moves research beyond simplified dichotomies, towards focusing on the complex characteristics of the real world (Maassen and Stensaker 2005). Abductive reasoning is applied, meaning that empirical elements of the research go beyond data retrieval towards producing a version of a social phenomenon in terms of theory; a local version of theoretical concepts are generated in the study's space-temporal setting through empirical investigation (Salvatore 2016). In this way, theory-driven pragmatism attempts to overcome a crucial weakness in social reforms, in that it is often divorced from social scientific understanding of real world problems (Chen and Rossi 1980). Accordingly, the next three chapters all draw from explicit theories. In Chapter 4, the Rainbow Model of Integrated Care (Valentijn et al. 2013) is applied, while in Chapters 5 and 6, the Framework for Assessing Power in Collaborative Governance (Purdy 2012) is used to engage with the power relations of collaborative mental health care.

Research design

Case study research

The study focus fell on organisational levels of integrated mental health care (Valentijn et al. 2013) in South Africa, specifically, collaboration between state and non-state service providers. In order to study these relations empirically, a study site with a relevant population was required which could provide systematised insight into the dynamics of integrated care. Considering the scope and purpose of the study, along with the constraints of postgraduate research, a case study design was deemed appropriate. A case study can be defined as an intensive, in-depth study of a singular instance of a social phenomenon (Gerring 2009; Babbie 2010). It is intended to provide an empirical illustration of a phenomenon, in-depth and within real life contexts, especially when the context/phenomenon boundaries are not clear (Yin 2009). It is important to note that the purpose of a case study is not to generalise its findings to a larger population, but rather to provide insight into the mechanisms at work in a certain social process. It essentially assists the researcher to "shed light onto a larger class of cases" (Gerring 2009, 20). Additionally, case study research is helpful to better grasp the implementation of interventions in real-life contexts, especially in complex environments that lack clear-cut outcomes (Yin 2009). Accordingly, to gain understanding of real-life relations between state and non-state mental health service providers in South Africa, Mangaung Metropolitan District was chosen as a case (Figure 1). Public health services in South Africa are provided on district level, falling under the regulatory oversight of provincial governments and the National Department of Health. District health services include primary services (clinics, community health centres, and district hospitals); secondary services (regional hospitals); and tertiary services (specialist and training hospitals) (Van Rensburg and Engelbrecht 2012).

Figure 1: Mangaung Metropolitan District (highlighted in red)

Source: (Wikimedia Commons 2011)

The case

The geopolitical borders of districts as public service provision spheres are underwritten by district-level government; however, these borders are fuzzy, due to service providers working across district and provincial borders and a lack of district governance capacity and autonomy, leading to increased provincial presence. Mangaung Metropolitan District was deemed appropriate as a case, due to 1) local sites of governance exhibiting key expressions of post-apartheid contradictions and power relations (Van Zyl Slabbert 2006; Hart 2013), and 2) the presence of three distinct areas, namely a city (Bloemfontein, Figure 2 and 3), an industrial town (Botshabelo, Figure 2 and 4) and a small rural town with surrounding villages (Thaba Nchu, Figure 2 and 5).

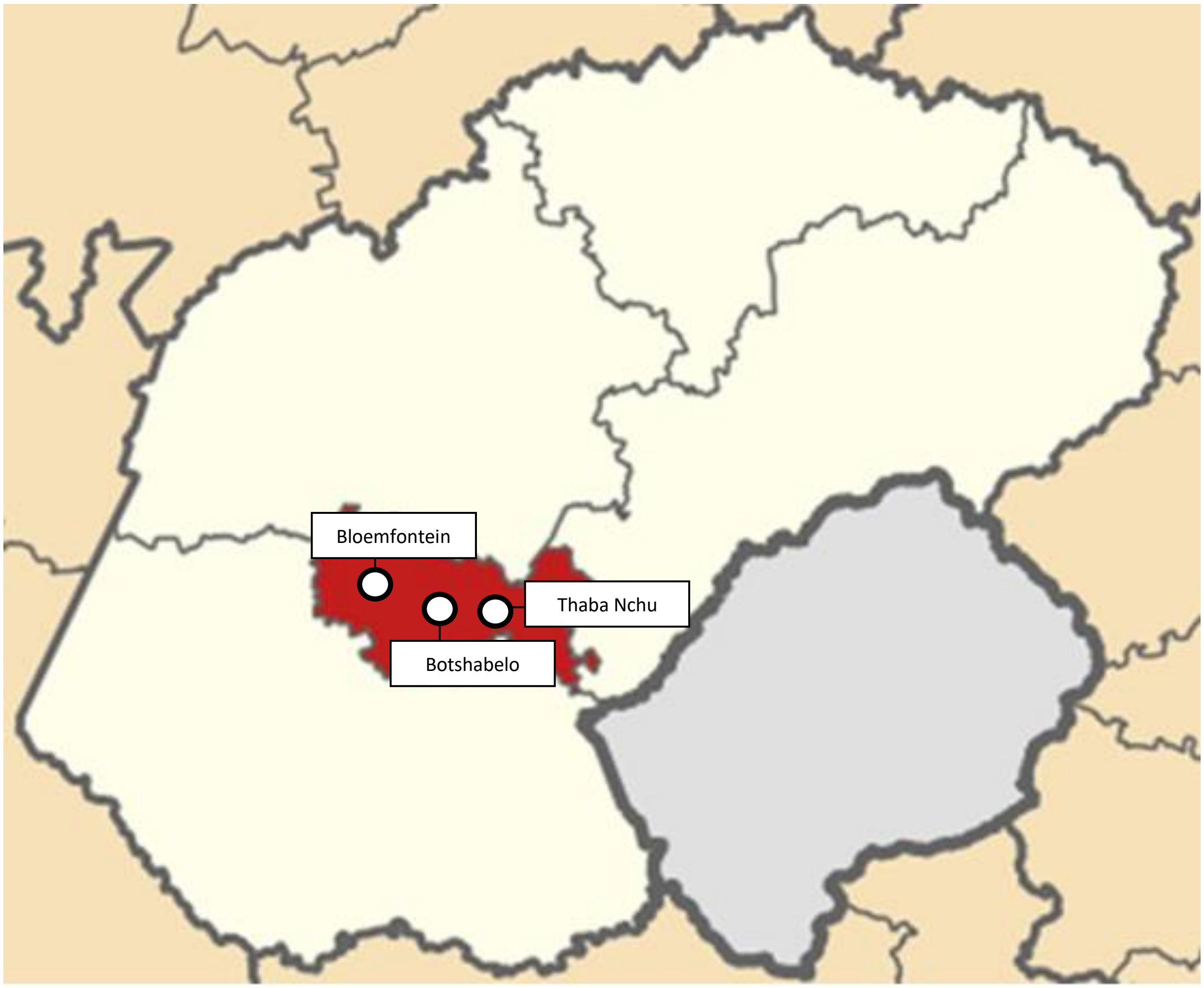

Figure 2: Location of Bloemfontein, Botshabelo and Thaba Nchu

Source: (Wikimedia Commons 2011)

Figure 3: Bloemfontein

(Property24 2017)

Figure 4: Botshabelo

(Maclachlan 2017a)

Figure 5: Thaba Nchu

(Maclachlan 2017b)

Bloemfontein (A Dutch phrase meaning “fountain of flowers”) is the capital city of the Free State Province, and the judicial capital of South Africa, hosting the Supreme Court of Appeal. It was founded by the British Empire as an outpost in 1846, and was grew as a significant Afrikaner city since the 1854 establishment of the Republic of the Orange Free State (Giliomee 2004). Thaba Nchu (a corruption of the seSotho “Thaba Ntsho”, meaning “black mountain”) was established in 1873, and later incorporated into the Bophuthatswana Bantustan under apartheid. Botshabelo (seSotho word meaning "a place of refuge") was established in 1979 as a township for black workers under apartheid. At the last census, the population of Mangaung Metropolitan District was estimated at 747 431; Bloemfontein at 256 185; Botshabelo 181 712; and Thaba Nchu at 70 118 (Statistics South Africa 2011).

The Free State Province has been wrought with a dual HIV and TB epidemic, severe maternal mortality (Massyn et al. 2016), as well as sub-par health system performance and political turmoil, that received wide-spread media scrutiny and civil society reaction (Treatment Action Campaign 2015). As in many other areas of South Africa, the Free State public health system is severely understaffed. In 2016, only 3.6% of fixed PHC facilities being staffed according to workload indicators for staffing needs. In the year 2015/2016, only 9.3% of fixed PHC clinics in Mangaung Metropolitan provided patients with access to a physician, with only 24.8% of the population having medical scheme coverage (Massyn et al. 2016). In 2014, the Free State Province had 22 clinical psychologists and eight psychiatrists working in the public sector, translating into 0.1 public clinical psychologists per 10 000 population and 0.03 public psychiatrists per 10 000 population – both health worker categories strongly concentrated in hospitals and more urbanised areas. These numbers fall significantly short of the national averages of 0.7 for public clinical psychologists and 0.32 public psychiatrists per 10 000 population

(Volmink 2014). Little recent data is available on the prevalence of mental illness and its psychiatric burden on the health system in South Africa, the South African Stress and Health (SASH) survey from 2003-2004 being the best indication available. Accordingly, it was suggested that – along with the Western Cape Province – the Free State Province had significantly higher prevalence rates of mental illness than the rest of the country. Particularly, its prevalence rates of anxiety (21.5%) and mood disorders (14.6%) were significantly higher than other provinces, with higher moderate severity (11.8%) (Herman et al. 2009). In 2016, the disability prevalence (including mental disorders) was highest in the Free State Province, at 11% (Statistics South Africa 2016b). The case under focus in this study was indicative of the broader South African milieu, with a mix of urban, small town and rural areas, suffering under protracted burdens of disease and under-resourced health and social systems, as well as carrying the yoke of colonial and apartheid history (Coovadia et al. 2009; Mayosi et al. 2012).

Methodologies

The borders of the study focus are drawn – not in a strictly clear way – around the district-level health and social system responses to mental illness in South Africa. In terms of social ecology, the emphasis falls on dynamics on the meso-level (Bronfenbrenner 1979), the stratus where organisational service provision subside. This does not mean that the other strata are ignored; social phenomena are the result of fluid and dynamics interaction between individuals, social mechanisms and contexts across micro, meso, exo, and macro systems (Elder-Vass 2010). In real-world terms, "health is a complex notion and it, or its absence, manifests itself under complex conditions" (Cilliers 2013, 27). Health and the societal responses to it have been rendered increasingly complex in the era of late modernity, where we see

> *the dramatic intensification of societal complexity that flows from growing functional differentiation of institutional orders within an increasingly global society with all that this implies for the widening and deepening of systemic interdependencies across various social, spatial, and temporal horizons of action* (Jessop 1997, 111).

In line with the considerations of pragmatism and societal complexity, multiple methodologies were applied in this study. In Chapter 4, a framework analysis was conducted of policy documents; in Chapter 5, mixed methods were applied by combining social network analysis and semi-structured interviews; while in Chapter 6, semi-structured interviews were analysed thematically. In terms of scope, Chapter 4 focuses on the clarification of the meaning of integrated mental health along policy lines in South Africa and its region. In the absence of provincial mental health policy in many South African provinces (Lund et al. 2010b), including the Free State, district-level mental health service provision occurs within the ambit of national policy. This provided a macro landscape of the priorities for integrated mental health care pursued by the state, and Chapter 5 and 6 intensified this focus on meso-level inter-organisational dynamics. These dynamics were studied on two levels.

First, taking the lead from previous studies that exhibited its utility in investigating integrated care and its governance (Mur-Veeman et al. 2003; Fleury 2005; Bruynooghe, Verhaeghe, and Bracke 2008; Wiktorowicz et al. 2010; Lamontagne 2013; Nicaise et al. 2013; Willem and Gemmel 2013; Lorant et al. 2017), these relationships were observed in terms of SNA. SNA is especially appropriate to investigate power relationships on a meso-level, that is, between health facilities and other organisations (Degenne and Forse 1999). It has further been noted to offer innovative methodological and analytical tools that may significantly improve our understanding of key aspects of integration that may not have been conducted before (Goodwin 2010). As a worthwhile, reproducible and viable method, SNA is especially useful to provide a snapshot of existing integration levels within a network (Lamontagne 2013), and has been a proven methodology with which to better interrogate governance and power relations (Savage et al. 1997; Wiktorowicz et al. 2010; Nicaise et al. 2013). Using SNA provided further utility, in that it assisted in the selection of participants for qualitative research, the second face of meso-level dynamics under scrutiny.

Following the complex and slippery nature of the concepts of power (Scott 2001), integrated care (Kodner 2009; Valentijn et al. 2013; Valentijn et al. 2015), and the governance of inter-organisational relationships (Purdy 2012), interviewing key stakeholders in a mental health service delivery network was a crucial element of the broader study. Interviews focus on human experience, attempting to elicit understanding of the world from participants' point of view; it is "an instrumental dialogue", where the conversation between the researcher and the participant is instrumentalised towards reaching the goals of the research (Kvale 2006, 484). In line with the theory-driven approach of the research, semi-structured interviewing were used, that allowed a degree of guidance to the interviews according to theoretical constructs (Brinkmann 2014). Crucially, semi-structured interviews allowed for the interrogation of more subtle forms of power, the second stream of power studies, particularly the processes of governmentality that unfold in mental health service collaboration (Miller and Rose 2008; Ferlie, Mcgivern, and FitzGerald 2012; Ferlie and McGivern 2014).

Data collection, management, presentation

All study instruments (described in more detail in the following chapters) are attached in Addendums D to H. Data collection and management were conducted within three work packages. Firstly, health policy documents relevant to mental health care were obtained from all SADC countries that had such policies in place. Electronic versions of policy documents were categorised according country and type and subjected to framework analysis (described further in Chapter 4). Second, a SNA of Mangaung Metropolitan District was conducted. Key actors involved in mental health service provision and referral were targeted, the non-governmental actors with whom they have a collaborative relationship were identified, and these non-governmental actors were further asked to provide other possible collaborating service providers (described further in Chapter 5). This process resulted in a list of nodes (mental health service providers) and directed links (the nature of relationships), which were subjected to basic descriptive social network analyses. In the third work package, SNA clusters were qualitatively identified, and the actors were targeted for semi-structured interviews. These actors were asked to identify more participants, who they perceived to be influential in district mental health provision (described further in Chapter 6).

All data were rendered electronic and transferred to software programmes for data analysis. The presentation of data generally followed accepted ways of presenting scientific data as well as the requirements and format of the journal where articles were submitted. Data in Chapter 4 were presented in narrative form, bolstered by direct quotations from policy documents. In Chapter 5, SNA statistics were presented in tables, while depictions of networks were illustrated with the assistance of the Gephi SNA programme. In addition, the findings from semi-structured interviews were presented in narrative form, with anonymised quotations from transcribed recordings used to illustrate salient points. Finally, in Chapter 6, themes deduced with the help of a theoretical framework, as well as themes that emerged inductively, were presented in a similar way to Chapter 5. In Chapter 7, the key findings from Chapters 4 to 6 were synthesised with the literature provided in Chapter 2, towards forming logical conclusions.

Ethical considerations

The study adhered to accepted good practice and standards of ethical research. Though the research was by no means medical in nature, it followed the spirit of the ethical principles for medical research involving human subjects in the World Medical Association Declaration of Helsinki (World Medical Association 2013). Subsequently, the goal of knowledge generation did not overshadow the rights and interests of individual participants, and the principles of dignity, integrity, privacy, right to self-determination, and confidentiality of personal information were followed. Participation in the study was contingent on informed consent, that is, respondents and participants were briefed on the study background and its objectives, as well as their role and responsibilities in the research before giving their consent for participation, both in writing and verbally (Bless, Kagee, and Higson-Smith 2006; Denscombe 2007) (see Addendum C for the information and informed consent forms). Respondents and participants were assured that their participation in the study was voluntary and that non-compliance will not result in any sanctions (Babbie 2010). Respondents and participants were assured that all information provided during the course of the study will be kept confidential.

Hard copies of the SNA instrument and semi-structured interview transcriptions were kept in a locked office at the University of the Free State. Electronic copies were stored on a password-protected computer and external memory drive and transferred to a password-protected electronic archive after the completion of the study. Only the doctoral candidate and article co-authors had access to the data. All data were anonymised by giving codes to participants and mental health service providers. These steps were especially important given the potential sensitive information associated with an exploration of power relations. A core principle of ethically sound research is alignment with generally accepted scientific standards and a good degree of knowledge of the field – this should be clearly described in the protocol (World Medical Association 2013). To ensure that the study yielded to acceptable scientific and ethical research standards, the research protocol was submitted to and cleared by the SU Research Ethics Committee: Human Research (Humanities) (Reference: HS1156/2015: See Addendum I). Institutional permission to conduct the research in public health facilities was obtained by the Free State Department of Health (FSDoH) (See Addendum J). These permission documents were diffused by FSDoH top management to district and facility structures, in line with formal provincial lines of authority. Appointments were made with and fieldwork was conducted in respondents' and participants' workplace.

Study timeline

As shown in Table 1, literature relevant to the study was periodically reviewed from the start of the research to the final phase of finalising the dissertation. In total, from writing the proposal and registering the research in February 2015, to defending the study in the first half of 2018, the study took approximately 42 months to complete. The table details different, overlapping, phases of the research process. In addition to the review of literature, the table reflects the preliminary, conceptual and administrative aspects of the study; the underlying empirical work for and finalising of Chapters 4 to 6; the finalising of the remaining dissertation chapters and finalisations of the dissertation for examination; feedback to stakeholders by making a draft report available; and finally, examination and defence (both internal and external, both at SU and UGent).

Table 1: Timeline of the proposed research

Study year	**2015**						**2016**						**2017**						**2018**					
Months	1-4		5-8		9-12		1-4		5-8		9-12		1-4		5-8		9-12		1-4		5-8		9-12	
1. Review of literature	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■					
2. Proposal writing	■	■																						
3. University title registration			■	■																				
4. Ethics clearance process			■	■																				
5. Institutional permission			■	■																				
6. Chapter 4: Document gathering				■																				
7. Chapter 4: Data analysis				■	■																			
8. Chapter 4: Article writing and submission					■			■																
9. Chapter 5: Fieldwork					■	■																		
10. Chapter 5: Data transcription							■	■	■	■														
11. Chapter 5: Data analysis										■	■	■												
12. Chapter 5: Article writing and submission													■	■	■									
13. Chapter 6: Fieldwork						■	■	■																
14. Chapter 6: Data transcription								■	■															
15. Chapter 6: Data analysis										■	■	■	■	■										
16. Chapter 6: Article writing and submission														■	■	■	■	■	■					
17. Writing Chapters 2 and 3									■	■	■	■	■	■	■	■	■	■						
18. Writing Chapter 7																		■	■					
19. Writing Chapter 1																		■	■					
20. Dissertation preparation																		■	■					
21. Feedback to stakeholders																			■					
22. Examination																			■	■				
23. Dissertation defence																								

Summary

In this chapter, the overarching methodological features of the research were described. The study was conducted as part of doctoral research, following the dissertation-by-publication format. Three empirical articles follow in the following chapters. The study was of a multidisciplinary nature and rooted within a pragmatic epistemology. A case study design was followed, and Mangaung Metropolitan District in the Free State province, South Africa, formed the primary focus of the research. In line with its multidisciplinary and pragmatist underpinnings, the study employed different methodologies, specifically framework analysis of policy documents, SNA of mental health service collaboration, and semi-structured interviews with key stakeholders. The data that were generated, were electronically transferred to appropriate software programmes for analysis, and presented in accepted scientific format. Generally accepted ethical standards were applied. Finally, the timeline presented shows a crucial feature of scientific investigation namely systematic investigation. In the next section, the research findings will be presented in article format.

Section II: Empirical Explorations

Chapter 4: Clarifying integrated mental health care in South Africa

Human beings have the right to live in a meaningful world. Respect for this right is a moral imperative for policy.

Peter Berger, Pyramids of Sacrifice: Political Ethics and Social Change (1974, 193)

Prelude

In the first empirical article, the strategies of integrated mental health care employed on a national level are described. Against the background of regional similarities, health policies are analysed according to a framework approach, insofar as policy is assumed to reflect intent and – in a more limited way – real structure. This exercise in clarification is necessary due to the abundance of tacit indications and an absence of empirical work. It lays the foundation for an understanding of integrated mental health care that is complex and highlighting a neglected feature of integrated mental health care in South Africa, namely collaboration among state and non-state counterparts on an organisational level. The pertinence of this step is to provide a macro-level context for the district-level case study that follows in Chapters 5 and 6.

Health Policy and Integrated Mental Health Care in the SADC Region: Strategic clarification using the Rainbow Model

Article: Janse van Rensburg A and Fourie P 2016. Integrated mental health care in the SADC region: Towards strategic clarity 2016. *International Journal of Mental Health Systems*, 10: 49.

This article was conceptualised by André Janse van Rensburg, who also wrote the first draft. The co-author provided valuable critique and input. Following critique by anonymous reviewers, André Janse van Rensburg adapted the article for publication.

Abstract

Background: Mental illness is a well-known challenge to global development, particularly in low-to-middle income countries. A key health systems response to mental illness is different models of integrated health care, especially popular in the South African Development Community (SADC) region. This complex construct is often not well-defined in health policy, hampering implementation efforts. A key development in this vein has been the Rainbow Model of Integrated Care, a comprehensive framework and taxonomy of integrated care based on the integrative functions of primary care. The purpose of this study was to explore the nature and strategic forms of integrated mental health care in selected SADC countries, specifically how integrated care is outlined in state-driven policies.

Methods: Health policies from five SADC countries were analysed using the Rainbow Model as framework. Electronic copies of policy documents were transferred into NVivo

10, which aided in the framework analysis on the different types of integrated mental health care promoted in the countries assessed.

Results: Several Rainbow Model components were emphasised. Clinical integration strategies (coordination of person-focused care) such as centrality of client needs, case management and continuity were central considerations, while others such as patient education and client satisfaction were largely lacking. Professional integration (inter-professional partnerships) was mentioned in terms of agreements on interdisciplinary collaboration and performance management, while organisational integration (inter-organisational relationships) emerged under the guise of inter-organisational governance, population needs and interest management. Among others, available resources, population management and stakeholder management fed into system integration strategies (horizontally and vertically integrated systems), while functional integration strategies (financial, management and information system functions) included human resource, information and resource management. Normative integration (a common frame of reference) included collective attitude, sense of urgency, and linking cultures, though aspects such as conflict management, quality features of the informal collaboration, and trust were largely lacking.

Conclusions: Most countries stressed the importance of integrating mental health on primary healthcare level, though an absence of supporting strategies could prove to bar implementation. Inter-service collaboration emerged as a significant goal, though a lack of (especially) normative integration dimensions could prove to be a key omission. Despite the usefulness of the Rainbow Model, it failed to adequately frame regional governance aspects of integration, as the SADC Secretariat could play an important role in coordinating and supporting the development and strengthening of better mental health systems.

Keywords: Integrated health care; mental health systems; SADC; Rainbow Model; health policy

Background

Mental illness is readily recognised as a significant challenge to global development outcomes (McGovern 2014; Gureje and Thornicroft 2015; Minas et al. 2015; United Nations 2015; Votruba and Thornicroft 2015). In 2010, mental, neurological and substance abuse disorders accounted for 258 million disability-adjusted life years (DALYs) – 10.4% of all-cause DALYs – which amounted to an increase of 41% since 1990 (Whiteford et al. 2015). It is estimated that by 2020 unipolar depression will be second among causes of disability worldwide (Flisher et al. 2007). The economic costs associated with mental illness are especially significant: the global costs amounted to US$ 2.5 trillion in 2010, and are projected to increase to US$ 6 trillion in 2030 (Bloom et al. 2012). Spending on mental health care is disproportionate across different regions, with lower-middle income countries (LMICs) spending US$ 1.53, upper-middle income countries spending US$ 1.96, and high income countries spending US$ 58.73 per capita on mental health in 2013 (WHO 2014). A recent economic analysis framed mental illness as a developmental rather than pure public health challenge, suggesting that the total investment required to address depression and anxiety disorders in 36 countries from 2016 to 2030 amounts to US$147 billion. However, the returns on investment in this study was calculated to have a benefit to cost ratio of 3.3–5.7 when considering the value of both economic and health benefits (Chisholm et al. 2016). The study included LMICs in its analysis, where the lack of mental health investment is especially tangible.

Mental illness exerts particular pressure on countries with underdeveloped health systems, which already have to contend with significant challenges associated with poverty, conflict and communicable diseases such as HIV (Okasha 2002; Awenva et al.

2010; Breuer et al. 2011). Suicide rates have been suggested to be highest in LMICs, and due to inadequate support systems individuals and their families are disproportionally affected by mental disorders (Mari and Thornicroft 2010). A major form of health system capital – mental health professionals – are also severely lacking in LMICs: in Africa there are 1.4 mental health workers per 100 000 population compared to the global average of 9 per 100 000 (WHO 2014). Despite global efforts towards the strengthening of mental health systems (Patel and Prince 2010; Becker and Kleinman 2013), mental health remains on the periphery of the global health agenda (Tomlinson 2013; Tsai and Tomlinson 2015). Development assistance for global mental health increased between 2007 and 2013, but remains low – the proportion of the development assistance attributed to mental health is calculated to be less than 1% of the US$ 133.57 million total amount spent (Gilbert et al. 2015). LMICs especially struggle to attract funding and buckle under chronic underfunding and lack of investment in services (McGovern 2014).

Against the backdrop of these global health governance dynamics, national governments increasingly have to strike an uncomfortable balance between responding to psychiatric need in the population, on the one hand, and producing gain in terms of cost effectiveness, on the other (Whiteford 2000; Mechanic, Mcalpine, and Rochefort 2014). This tension has led to the adoption of different models of integrated care, an intervention with promising clinical outcomes with possible reduced costs (Druss et al. 2001; Butler et al. 2008; Butler et al. 2011). Integrated care is a complex construct (Kodner and Spreeuwenberg 2002; Blount 2003; England and Lester 2005), and while integrated care has emerged as a central feature of mental health system reforms in LMICs (Breuer et al. 2011; Eaton et al. 2011; Petersen et al. 2011; Shidhaye, Lund, and Chisholm 2015), little attention has been paid to its forms and strategies in policy. The purpose of this chapter is to explore the nature and strategic forms of integrated mental health care in selected countries in the South African Development Community (SADC) region, specifically how integrated care is outlined in state-driven health policies. The importance of this exercise is to illuminate the first of three research focus areas of the study, namely to explore the dimensions and structure of integrated mental health care in South Africa (Chapter 1). It provides a structural base on which the case study in Chapters 5 and 6 is built.

Conceptualising integrated health care

An integrated care approach is consistently underlined as a strategy to address fragmented and uncoordinated health systems (Lamontagne 2013), and to increase accessibility to care (especially of disadvantaged communities) (Mills, Rasheed, and Tollman 2006). It is well established that integrated care is a multi-layered construct (Kodner and Spreeuwenberg 2002; Blount 2003; England and Lester 2005), and many authors have attempted to pin its meaning down. Integrated care has been used to describe the linking of services or programmes on similar levels of health care (for instance a multidisciplinary, integrated approach to diabetes mellitus management (Renders and Wagner 2002), known as horizontal integration, and to the linking of services or programmes on different health care levels (for instance primary and secondary level integration for the management of serious psychiatric disorders (Bindman et al. 1997), known as vertical integration (Gröne and Garcia-Barbero 2001).

Within this broad categorisation, integrated care has been used to refer to as a patient-centred, demand-driven linking of the health care system with other human service systems on multiple levels to address complex health needs (Hardy et al. 1999; Kodner and Spreeuwenberg 2002; Kodner 2009); the consolidation of a range of behavioural, medical and other elements into a single care or service package (Blount 2003); the creation of an organisational network providing a coordinated continuum of services to a defined population (Durbin et al. 2006; WHO 2008b); the amalgamation of continuity of care, shared care and seamless care (Protti 2009); an organising principle that aims to improve care through improved coordination of methods, processes and models in line with the patient's perspective (Shaw, Rosen, and Rumbold 2011); and as the collaboration of multiple professionals, organisations and sectors towards coordinated care (Tsasis, Evans, and Owen 2012).

It is noteworthy that most conceptualisations of integrated care have been penned in high-income country contexts, and often do not adequately reflect LMIC health system configurations and processes. In this respect the WHO has been a key driver in the introducing of suitable models of integrated mental health care to LMICs. In an influential report, the WHO together with the World Organization of Family Doctors provided guidance on integrating mental health into primary healthcare (PHC) (WHO 2008b). Given the proliferation of PHC as a foundation of health systems (especially) in LMICs, it made sense to use that as a platform from which to increase mental health care access. Many countries such as Brazil, South Africa and Uganda have in varying degrees introduced initiatives where mental health service capacity is fostered in PHC settings, whether this means training existing health workers or task-shifting related duties to lay health workers. Importantly, such clinical models of integration should be backed by solid national policy frameworks (WHO 2008b).

Eaton and colleagues (2011) provide an overview of different models of integrated mental health care that are recommended for and have been adopted by LMICs. These include: task-shifting mental health service provision from psychiatrists and psychologists to nurses and lay health workers; sharing mental health services with other core programmes such as immunisation, chronic conditions and HIV; task sharing to include support from families and community members, integrating mental health indicators within existing health information systems; and stronger collaboration with non-governmental organisations (NGOs). Common elements of integrated care in health policies in African contexts include decentralisation, as well as integrating mental health with general health services, especially at PHC level (Flisher et al. 2007).

Within the multitude of voices, there clearly has been a need to distil the many integrated care types and meanings. Taking into account the integrative functions of primary care, Valentijn and colleagues (2013; 2015) recently presented the Rainbow Model of Integrated Care, a comprehensive framework and taxonomy of integrated care. Firstly, the authors argue that the primary care principles of first contact care, continuous care, comprehensive care, and coordinated care play a central role in the integration and coordination of care. Then, integrated care is structured conceptually along micro, meso and macro dimensions. Macro-level integration refers to vertical and horizontal system integration. On the meso-level, integration is conceptualised to happen in terms of inter-organisational integration, through market, hierarchy, and network mechanisms, as well as in terms of partnerships between professionals within and between different organisations. Micro-level integration refers to clinical integration, that is, achieving a coherent and coordinated process of health care delivery to individual patients. Linking the macro, meso and micro-levels of integration are functional and normative integration. Functional integration refers to "Key support functions and activities…structured around the primary process of service delivery, to coordinate and support accountability and decision-making between organisations and professionals to add overall value to the system." Normative integration is defined as "The development and maintenance of a common frame of reference (i.e., shared mission, vision, values and culture) between organisations, professional groups and individuals" (Valentijn et al. 2013). These domains of integrated care were subsequently fleshed out in a more comprehensive typology (see Table 2). Though still relatively novel, the Rainbow Model has already been used to measure integrated care in the Singapore Regional Health System (Nurjono et al. 2016), and its comprehensive underpinnings present a robust framework with which to explore integrated mental health care in national policies.

Table 2: Rainbow Model of Integrated Care (Valentijn et al. 2015)

Micro-level	**Clinical Integration** The coordination of person-focused care in a single process across time, place and discipline.	
	1. Centrality of client needs	*The principle of care is to address the needs of clients in terms of medical, psychological and social aspects of health.*
	2. Case management	*Coordination of care for clients with a high-risk profile (e.g. identifying risks, developing policies and guidance).*
	3. Patient education	*Education for clients is focused on medical, psychological and social aspects of health.*
	4. Client satisfaction	*User satisfaction of the individual client is central to the organisation of care.*
	5. Continuity	*The organisation of care aims to provide fluid care delivery for an individual client.*
	6. Interaction between professional and client	*Attitude and behavioural characteristics between professional and client regarding all health needs of the client.*
	7. Individual multidisciplinary care plan	*Implementation of a multidisciplinary care plan at the individual client level.*
	8. Information provision to clients	*Provide unambiguous and understandable information at the individual client level.*
	9. Service characteristics	*Provision of services is focused on medical, psychological and social aspects of health.*
	10. Client participation	*Clients are (pro)actively involved in the design, organisation and provision of care at the operational level.*
	11. Population needs	*The interdisciplinary approach is consistent with the dominant needs of the population.*
	12. Self-management	*Tailor-made support of self-management at the individual client level.*
Meso-level	**Professional Integration** Inter-professional partnerships based on shared competencies, roles, responsibilities and accountability to deliver a comprehensive continuum of care to a defined population.	
	13. Inter-professional education	*Inter-professional education for professionals focused on interdisciplinary collaboration.*
	14. Shared vision between professionals	*A shared vision between professionals focused on the content of care.*
	15. Agreements on interdisciplinary collaboration	*Agreements on the establishment of interdisciplinary cooperation at the operational level.*
	16. Multidisciplinary guidelines and protocols	*Multidisciplinary guidelines and protocols are implemented in coherence with the operational level.*
	17. Inter-professional governance	*Inter-professional governance is focused on openness, integrity and accountability between professionals at the operational level.*
	18. Interpersonal characteristics	*Interpersonal characteristics of the professionals involved in the partnership (e.g. trust, equality, respect, values).*
	19. Clinical leadership	*Accepted leadership with power and influence at the operational level (e.g. professional status characteristics such as reputation, specialization, position and seniority).*
	20. Environmental awareness	*Environmental awareness of professionals with regard to economic, social and political developments.*
	21. Value creation for the professional	*Value is added for the individual professional through interdisciplinary collaboration.*
	22. Performance management	*Performance management at the operational level is focused on improving health outcomes for the individual client and the population.*
	23. Creating interdependence between professionals	*Creating mutual interdependencies between professionals regarding interdisciplinary collaboration.*
M	**Organisational integration**	

	Inter-organisational relationships (e.g. contracting, strategic alliances, knowledge networks, mergers), including common governance mechanisms, to deliver comprehensive services to a defined population.	
	24. Value creation for organisation	*Value is added through the collaboration of each involved organisation.*
	25. Inter-organisational governance	*Inter-organisational governance is focused on openness, integrity and accountability between organisations at the strategic level (e.g. joint responsibilities, strategy and policy).*
	26. Informal managerial network	*Informal network of managers within the collaboration.*
	27. Interest management	*A climate that attempts to bridge the various interests (e.g. social, organisational and personal) at the operational, tactical and strategic level.*
	28. Performance management	*Collective elaborated performance management between organisations within the collaboration.*
	29. Population needs as binding agent	*The needs of the population are central in the collective policy of the various organisations in the collaboration.*
	30. Organisational features	*Organisational features of inter-organisational collaboration (e.g. legal structure, number of organisations, profit vs. non-profit).*
	31. Inter-organisational strategy	*A collective elaborated strategy exists between the organisations within the collaboration.*
	32. Managerial leadership	*Leadership with power and influence at a strategic level (e.g. reputation, seniority and formal position).*
	33. Learning organisations	*Collective learning power between the organisations within the collaboration (e.g. joint research and development programs).*
	34. Location policy	*A collective location policy between the organisations within the collaboration (e.g. coordinated housing and facilities).*
	35. Competency management	*Collectively utilize and select competencies of professionals and staff to the greatest possible extent for the objectives of the collaboration.*
	36. Creating interdependence between organisations	*The organisation of the collaboration aims to create mutual interdependencies between organisations (e.g. multiyear rental agreement).*
Macro-level	**System integration** A horizontal and vertical integrated system, based on a coherent set of (informal and formal) rules and policies between care providers and external stakeholders for the benefit of people and populations.	
	37. Social value creation	*Value is added through the collaboration of social objectives and interests.*
	38. Available resources	*Available resources in the environment of the collaboration (e.g. usable buildings, (over)capacity, professionals and funding streams).*
	39. Population features	*Health determinants of the population in the environment of the partnership (e.g. population composition and use of care).*
	40. Stakeholder management	*Engagement of various stakeholders (e.g. municipality, patient organisations and health insurance companies).*
	41. Good governance	*Creating trust towards external stakeholders (e.g. municipality and health insurance companies) based on working method, reputation, management, control and/or supervision.*
	42. Environmental climate	*Political, economic and social climate within the environment of the collaboration (e.g. market characteristics, regulatory framework, competition).*
Macro, Meso, Micro-levels	**Functional integration** Key support functions and activities (i.e. financial, management and information systems) structured around the primary process of service delivery to coordinate and support accountability and decision-making between organisations and professionals in order to add overall value to the system.	
	43. Human resource management	*Aligned Human Resource Management within the collaboration (e.g. joint staffing and personnel).*
	44. Information management	*Aligned information management systems accessible at an operational, tactical and strategic level (e.g. monitoring and benchmarking systems).*
	45. Resource management	*Coherent use of resources (e.g. collective real estate and funding).*
	46. Support systems and services	*Aligned support systems and services at the operational level (e.g. facility management and secretarial support).*
	47. Service management	*Aligned service management for the client (e.g. collective telephone numbers, counter assistance and 24-hour access).*
	48. Regular feedback of performance indicators	*Regular feedback of performance indicators for professionals at the operational level to enable them to improve their performance.*
Macro, Meso, Micro-levels	**Normative Integration** The development and maintenance of a common frame of reference (i.e. shared mission, vision, values and culture) between organisations, professional groups and individuals.	
	49. Collective attitude	*Collective attitude within the collaboration towards open communication, sincerity and respect at operational, tactical and strategic levels.*
	50. Sense of urgency	*Awareness regarding the need and purpose to collaborate at the operational, tactical and strategic levels.*

	51. Reliable behaviour	*The extent to which the agreements and promises within the collaboration are fulfilled at operational, tactical and strategic levels.*
	52. Conflict management	*The ability to effectively manage interpersonal conflicts within the collaboration.*
	53. Visionary leadership.	*Leadership based on a personal vision that inspires and mobilizes people*
	54. Shared vision	*A collectively shared long-term vision within the collaboration at the operational, tactical and strategic levels.*
	55. Quality features of the informal collaboration	*Effectiveness and efficiency of the informal collaboration at the operational, tactical and strategic levels (e.g. group dynamics and attention to the undercurrent).*
	56. Linking cultures	*Linking cultures (e.g. values and norms) with different ideological values within the collaboration at the operational, tactical and strategic levels.*
	57. Reputation	*Individual reputation of those people involved in the collaboration.*
	58. Transcending domain perceptions	*The ability to transcend one's own professional domain within the collaboration at the operational, tactical and strategic levels.*
	59. Trust	*The extent to which those involved in the collaboration at operational, tactical and strategic levels trust each other.*

National and regional policy and integrated mental health care

Omar and colleagues (2010) suggest that "Mental health policies signal a government's intent to address the mental health needs of its citizens". In this vein, clarity of conceptualisations in health policy is paramount to the successful establishment of its intentions in implementing strategies, and it helps "to transport the issue from the ideological plane into practice, from a normative approach to a positive one" (Magnoli 2002). Coherent individual as well as communal understanding and sense-making of the components and purpose of complex social interventions are crucial mechanisms in its implementation (Murray et al. 2010; May et al. 2011). Although governing integrated mental health care has been a global challenge, it is especially Sub-Sahara African countries that have struggled to both develop and implement mental health policies (Omar et al. 2010). The wide-spread socio-economic inequalities in this particular region not only elevates the pressing need for integrated mental health care, but also contributes to mental illness (Burns 2015). Many LMICs and key regional organisations place increased focus on mental disorders (Minas et al. 2015). This increased focus is evident in the national strategic mental health care reforms that have taken place to varying degrees in sub-Saharan African countries during the past decade (Flisher et al. 2007;

Lund et al. 2008; Draper et al. 2009; Souza, Yasuda, and Cristofani 2009; Awenva et al. 2010; Kiima and Jenkins 2010; Mwape et al. 2010; Omar et al. 2010; Petersen et al. 2011; Monteiro et al. 2014; Marais and Petersen 2015; Shidhaye, Lund, and Chisholm 2015; Dos Santos et al. 2016; Mugisha, Ssebunnya, and Kigozi 2016).

Regional governing bodies certainly have a part to play in mental health system reforms, the importance of which is underscored during the on-going Ebola crisis in West Africa (Penfold 2015). The advent of global health governance highlights the interdependence of states and the increasing complexity of illness and disease responses, calling for cooperation among countries on issues that transcend national boundaries (Mooketsane and Phirinyane 2015). Regional and interstate collaborative governance have been shown to be an effective vehicle with which to address complex health system challenges, as exemplified by the activities of the Union of South American Nations and the WHO's South East Asian Regional Office (Penfold 2015). A key regional body in the Sub-Sahara African region is the Southern African Development Community (SADC), comprised of Angola, Botswana, Democratic Republic of Congo, Lesotho, Madagascar, Malawi, Mauritius, Mozambique, Namibia, Seychelles, South Africa, Swaziland, United Republic of Tanzania, Zambia, and Zimbabwe. Its Secretariat (seated in Gaborone, Botswana) have not forwarded any tangible policies related to mental health care, and has no dedicated body concerned with health or mental health. Notwithstanding these shortcomings, the SADC Secretariat did produce a Protocol on Health (South African Development Community 1999) which included a focus on mental health, and have shown promise in its development of cross-border initiatives for malaria and HIV (Penfold 2015).

Many SADC countries are yet to produce dedicated mental health policies. Limited evidence however suggest that in many African countries where mental health policies have been produced, these are often inappropriate, poorly implemented, and not translated into a detailed strategic action plan (Omar et al. 2010). In the absence of regional coordination from SADC, it is unclear which types of integrated mental health care are pursued by its members. Clarity in this matter is important, since the effectiveness of mental and neuropsychiatric disorders have been noted to be "largely determined by the health systems in which they are nested" (Lund 2015). Geopolitical health system differences (and associated socio-economic inequities) in many ways define the types of integrated mental health care unfolding in countries and regions (Mur-Veeman et al. 2003). For instance, in some countries such as Belgium (Eyssen et al. 2012), Canada (Fleury et al. 2014) England and the Netherlands (Mur-Veeman et al. 2003) integrated mental health care usually refers to collaborative activities among different, independent service providers. On the other hand, in many African countries integrated mental health care usually refers to the integration of mental health care into general health services, specifically on PHC level (Souza, Yasuda, and Cristofani 2009; Kiima and Jenkins 2010; Mwape et al. 2010; Petersen et al. 2011; Monteiro et al. 2014; Marais and Petersen 2015; Shidhaye, Lund, and Chisholm 2015; Dos Santos et al. 2016; Mugisha, Ssebunnya, and Kigozi 2016). These definitions are however highlighted by empirical field studies, and it remains unclear how integrated mental health care unfolds in national policy. Given the pressing need to study health policy and how it frames health systems (Gilson and Raphaely 2008; Gilson 2012; Ghaffar et al. 2016), the aim of the study was to explore the scope and focus of integrated mental health care in the SADC region.

Methods

In order to scrutinise the scope and focus of integrated mental health care in the SADC region, a policy analysis approach was pursued. A key part of policy analysis is to consider the influence of "ideas (arguments and evidence), over health system operations and policy change within them" (Ghaffar et al. 2016). National policy documents of five countries were scrutinised: Botswana, Malawi, Namibia, South Africa, and Zambia. Apart from Zimbabwe, these are the only countries with established national mental health policies in the SADC region (attempts to gain access to Zimbabwe policy documents were unsuccessful). Three policy documents were analysed from each country: the national health policy, the national health strategy, and the national mental health policy (Table 3). Far from being an exhaustive list of policies, the structuring of mental health service provision is not only contingent on these three types of policies, and many other strategies are potentially important – such as policies related to human resources for health, PHC, chronic illnesses, and so on. This being said, for the purpose of this chapter a national mental health policy certainly is most important, in addition to a national health policy. Also, strategic plans are important manifestations of national intent in terms of policy change, and so they were included. The SADC Secretariat offers little in terms of mental health-related strategy documents, the closest being its Protocol on Health (South African Development Community 1999). However, this particular regional strategy was not included in the formal analysis due to its lack of explicit focus on mental health care. Electronic versions of the documents were imported into NVivo (ver. 10) (QSR International 2016), and sections dealing with integrated care were thematically arranged within the 59 items of the Rainbow Model (Valentijn et al. 2015). NVivo allowed for the systematic analysis of documents, by providing a template within which researchers could thematically arrange integrated mental health care nodes. More specifically, a framework method was followed as described by Gale and colleagues (Gale et al. 2013). The thematic arrangement process was checked by and discussed with a researcher who was not part of the study, in order to increase trustworthiness. Both explicit and implicit indications of integrated mental health care were included.

Table 3: Policy documents included in the study

Country	Document
Botswana	*National Health Policy: Towards a Healthier Botswana (2011)* *Integrated Health Service Plan: A Strategy for Changing the Health Sector for Healthy Botswana 2010-2020 (2010)* *National Policy on Mental Health (2003)*
Malawi	*To the Year 2020: A Vision for the Health Sector in Malawi (1999)* *Malawi Health Sector Strategic Plan 2011 – 2016 (2010)* *National Mental Health Policy (2001)*
Namibia	*National Health Policy Framework 2010-2020 (2010)* *Ministry of Health and Social Services Strategic Plan 2009 – 2013 (2009)* *National Policy for Mental Health (2005)*
South Africa	*White Paper for the Transformation of the Health System in South Africa (1997)* *Department of Health Strategic Plan 2014/15 – 2018/19 (2014)* *National Mental Health Policy Framework and Strategic Plan 2013-2020 (2012)*
Zambia	*National Health Policy (2011)* *National Health Strategic Plan 2011 – 2015 (2011)* *Mental Health Policy (2004)*

Results

The assessment undertaken revealed that all dimensions of integrated care – in terms of mental health – are manifested in national policy documents in the SADC region. An overview is provided in Table 4.

Table 4: Integration strategies manifested in national policy

Integration dimensions	**Countries**				
	Bots	Mal	Nam	RSA	Zam
Clinical Integration					
1. Centrality of client needs	x	x	x	x	
2. Case management		x	x	x	x
3. Patient education					
4. Client satisfaction					
5. Continuity	x		x		x
6. Interaction between professional and client	x				
7. Individual multidisciplinary care plan					
8. Information provision to clients	x				
9. Service characteristics		x	x	x	
10. Client participation				x	
11. Population needs	x		x		
12. Self-management	x	x		x	
Professional Integration					
13. Inter-professional education				x	
14. Shared vision between professionals					
15. Agreements on interdisciplinary collaboration		x	x	x	x
16. Multidisciplinary guidelines and protocols					
17. Inter-professional governance					

18. Interpersonal characteristics					
19. Clinical leadership				x	
20. Environmental awareness					
21. Value creation for the professional					
22. Performance management	x	x	x		x
23. Creating interdependence between professionals	x			x	
Organisational Integration					
24. Value creation for organisation	x	x	x	x	
25. Inter-organisational governance	x	x	x	x	x
26. Informal managerial network					
27. Interest management	x	x	x	x	x
28. Performance management					
29. Population needs as binding agent	x	x	x	x	x
30. Organisational features	x	x	x	x	x
31. Inter-organisational strategy	x	x	x	x	x
32. Managerial leadership					
33. Learning organisations				x	
34. Location policy	x	x	x	x	x
35. Competency management					
36. Creating interdependence between organisations	x	x	x	x	x
System Integration					
37. Social value creation	x	x	x	x	x
38. Available resources	x	x	x	x	x
39. Population features	x	x	x	x	x
40. Stakeholder management	x	x	x	x	x
41. Good governance	x	x	x	x	x
42. Environmental climate	x	x	x	x	x
Functional Integration					
43. Human resource management	x	x	x	x	
44. Information management	x		x	x	x
45. Resource management		x		x	x
46. Support systems and services					
47. Service management	x	x			
48. Regular feedback of performance indicators	x	x	x	x	x
Normative Integration					
49. Collective attitude	x	x	x	x	x
50. Sense of urgency	x	x	x	x	x
51. Reliable behaviour					
52. Conflict management					
53. Visionary leadership	x	x	x	x	x
54. Shared vision	x	x	x	x	x
55. Quality features of the informal collaboration					
56. Linking cultures	x		x		x
57. Reputation					
58. Transcending domain perceptions					
59. Trust					

Clinical integration

Several strategies emerged in terms of clinical integration (coordination of person-focused care in a single process across time, place and discipline – see Table 2). The *centrality of client needs* was a consideration forwarded in most of the policies and included elements such as ensuring protection against discrimination and providing sheltered employment for patients suffering from mental illness (Botswana); the provision of "integrated, promotive, preventive, curative and rehabilitative mental health services" (Malawi); and the integration of mental health and social welfare services to ensure the meeting of all client needs (Namibia). In terms of *case management*, special provisions were made for strategies dealing with vulnerable, high-risk groups and their care (Malawi, Namibia, South Africa, Zambia). *Information provision to clients* was not a prominent strategy, though mention was made of the provision of adequate information to clients (Botswana). *Continuity* manifested in several ways, such as the continuity and harmonisation of comprehensive care by different service providers (Botswana), streamlining "fragmented services/programmes/functions" for example linking programmes with known co-morbidity such as maternal health and tuberculosis (Namibia), and strengthening communication and transport between levels of care within referral processes (Zambia).

Interaction between professionals and clients received less focus, but there was mention of the importance of well-trained and supported personnel in ensuring positive client outcomes (Botswana). Regarding *service characteristics*, mention was made of the integration of psychological services with general medical services (Malawi, Namibia, South Africa), though not much focus was placed with its integration with social and welfare services. *Client participation* was referred to in terms of engaging with clients in policy development, implementation, and service planning and monitoring (South Africa), while *population needs* was mentioned as a consideration in service development (Botswana, Namibia). Finally, *self-management* as an integration strategy was expressed through the establishment of a patient's charter highlighting taking responsibility for their own health (Botswana) and the promotion of self-help services (South Africa). In general, most policies touched on some clinical integration strategies. However, it should be kept in mind that the policies assessed were broad, macro-level documents, and individual needs received less focus than population needs in terms of integration strategies. Types of integration such as *patient education*, *client satisfaction*, and *individual multidisciplinary care plan* received little focus.

Professional integration

Selected professional integration (inter-professional partnerships based on shared competencies, roles, responsibilities and accountability – see Table 2) emerged from the policy documents assessed. *Inter-professional education* did not receive much focus, though mention was made of the training, support and mentoring of staff working in general health settings, as well as the task-shifting of psychosocial work to non-specialist workers supervised and supported by specialists (South Africa). *Agreements on interdisciplinary collaboration* was especially manifested in directives towards multidisciplinary teams (South Africa), the collaboration among mental health workers and general health workers (South Africa, Namibia, Malawi) and among mental health workers and traditional healers (South Africa, Namibia, Zambia). Mention was made of *clinical leadership* in terms of the positioning of mental health specialists providing mentorship and support to non-specialist health workers in the context of task-shifting (South Africa). *Performance management* was manifested in monitoring and evaluating service provision (Malawi), ensuring that mental health personnel are well-trained and committed (Botswana), and implementing a performance management system (Namibia, Zambia). Finally, *creating interdependence between professionals* was detailed by the strengthening of referral systems, linkages and communication among health care workers (Botswana), as well as task-shifting strategies (South Africa). In general, focus on agreements on *interdisciplinary collaboration* and *performance management* received particular focus. Further, South African policies placed more value on professional integration strategies than its neighbouring states.

Organisational integration

Organisational integration (inter-organisational relationships, including common governance mechanisms – see Table 2) emerged intermittently. *Value creation for organisation* was manifested in the out-contracting of services to NGOs and private organisations (Botswana, Malawi, Namibia, South Africa). Strategies such as aligning programmes among service providers (Botswana), ensuring the participation of private organisations, civil society, traditional healers, and international agencies in service delivery, and a collaborative and referral strategy among the three tiers of health care provision (Botswana, Malawi, Namibia, South Africa, Zambia) were all suggestive of *inter-organisational governance, interest management, organisational features, inter-organisational strategy,* and *creating interdependence between organisations*. *Population needs* were considered in a description of national health statuses and burden of disease, as well as socio-economic aspects such as poverty (Botswana, Malawi, Namibia, South Africa, Zambia).

Learning organisations – the idea that organisations should develop and maintain a culture of constant learning by its members – is manifested in directives such as the training in mental health care of non-health related public-sector workers and civil society partners through in-service training (South Africa). In terms of *location policy*, not much was mentioned in terms of collaborative initiative among government and non-government organisations sharing facility space, although much attention was paid to government facility decentralisation, the providing of mental health care in PHC clinics, districts and regional hospitals (Botswana, Malawi, Namibia, South Africa, Zambia). Organisational integration strategies are key mechanisms which lead to integrated mental health systems. In the policies assessed, several strategies emerged generally uniformly across different countries. It has to be kept in mind that "organisations" in the country policies refers to both state-funded and non-state health facilities and the relations among them. This is opposed to its meaning in other contexts, for instance in some West European countries where mental health care is provided by independent organisations.

System integration

System integration (horizontal and vertical integration based on a coherent set of rules and policies between care providers and external stakeholders – see Table 2) was widely highlighted in the policies assessed. All country policies acknowledged the importance and value of collaboration in service design and provision, in line with *social value creation*. *Available resources* are manifested in acknowledgements of limited resources, and the need to optimise these resources through appropriate cross-subsidisation and private-public service mix (Malawi, Namibia, South Africa, Zambia); simply put, "The assumption that all health care should be provided by government is, in many countries, unrealistic - the necessary resources simply do not exist." (Botswana). In terms of *population features*, the regional burden of communicable as well as non-communicable diseases was acknowledged, with HIV especially highlighted; social determinants of health such as poverty and lack of access to health services were also underlined (Botswana, Malawi, Namibia, South Africa, Zambia). *Stakeholder management* and *good governance* were highlighted under directives to engage with stakeholders such as private practitioners, traditional healers, NGOs, and faith-based organisations (Botswana, Malawi, Namibia, South Africa, Zambia). *Environmental climate* was manifested in the particular pluralistic health system configurations of the countries assessed, allowing collaboration among government and non-government service providers; such collaborative activities as well as decentralisation-type integration were central features of the policies. It is not that surprising that system integration received a strong focus among the country policies, given the macro scope of system integration dimensions.

Functional integration

Several functional integration strategies (key support functions and activities structured around the primary process of service delivery to coordinate and support accountability and decision-making – see Table 2) emerged. *Human resource management* was highlighted in terms of directives such as a multi-stakeholder human resource steering committee that is intended to provide strategic oversight related to human resources planning activities (Botswana); agreements with NGOs to train health care workers (Malawi); and mental health training for all health care workers, government as well as non-government (Namibia, South Africa). *Information management* was expressed in directives that promote the standardised collection of data from all health service providers (Botswana, Namibia, South Africa, Zambia). *Regular feedback of performance indicators* was promoted in terms of disseminating monitoring information to stakeholders (Botswana, Malawi, Namibia, South Africa, Zambia). *Resource management* was mentioned in the form of public-private partnerships in constructing and upgrading health facilities (Malawi, Zambia) and the use of community-based resources (South Africa). *Service management* was highlighted in terms of a directive ensuring 24-hour access to mental health services (Botswana, South Africa). While all countries included functional dimensions in their approaches to integrated mental health care, some elements were lacking – most notably, *support systems and services*, and *service management*. Again, these exclusions could be due to the micro scope of the particular integration strategies, as national policy documents often do not directly speak to the operational level.

Normative integration

The normative dimensions of integrated care (the development and maintenance of a common frame of reference between organisations, professional groups and individuals – see Table 2) were more difficult to assess in the policies under scrutiny, principally due to the inherent need for more wide-ranging empirical investigations. This is especially evident in aspects such as *reliable behaviour*, *conflict management*, *quality features of the informal collaboration*, and *trust*. Nevertheless, the aim was to explore strategies that underscore and support normative integration. In this way, *collective attitude* and *sense of urgency* were suggested by aspects such as promoting relationships with and coordinating multiple stakeholders in providing mental health services; the state is often positioned as custodian of health care, but clearly needs input from all service providers within collaborative relationships (Botswana, Malawi, Namibia, South Africa, Zambia). *Linking cultures* was evidenced by directives to harmonise and align health service provision activities across all stakeholders (Botswana, Namibia, Zambia). The mere presence of a national mental health policy that promotes integrated care through collaborative relationships could be taken as an aspect of *visionary leadership* and a *shared vision*, although the common challenge of policy/implementation discordance makes this difficult to assess. Normative integration strategies also involve a relational focus, which makes it difficult to adequately assess the inclusion of dimensions such as collective attitude, reliable behaviour, and quality features of the informal collaboration in national state-driven policies. Finally, the lack of focus on *transcending domain perceptions* and *trust* could undermine the multi-professional aspirations of the mental health system reform strategies pursued by countries in the region.

Discussion

The purpose of this chapter was to provide an overview of the scope and focus of integrated mental health care of countries in the SADC region. To this end, the Rainbow Model proved to be a useful tool with which to interrogate relevant strategies that are promoted by national health policy. The findings revealed several strategies related to integrated mental health care, across micro, meso and macro domains. While several strategies were mentioned in the policies, several were also absent. A lack of attention paid to clinical dimensions of integrated mental health care – for instance *client participation*, *information provision to clients*, *individual multidisciplinary care plan*, *client satisfaction*, and *patient education* – were especially worrying given the necessity of integrated care to be patient-focused (WHO 2008b; Monteiro et al. 2014; Dos Santos et al. 2016). Nonetheless, cutting across the six integrated care domains of the Rainbow Model, two broad integration strategies emerged within the policies analysed: one, integrating mental health care into PHC, and two, collaboration in service provision among government and non-government role players, as well as among different government sectors. These broad strokes confirm Flisher and colleagues' (2007) description of Sub-Sahara African mental health care systems.

PHC integrated mental health care

The integration of mental health into PHC is a well-known strategy in mental health reform processes globally, especially in LMIC settings (Hanlon, Wondimagegn, and Alem 2010; Eaton et al. 2011). At the heart of integrated mental health care are efforts to bring specialist services closer to PHC level service providers (Mechanic, Mcalpine, and Rochefort 2014) which links in well with the dominance of PHC in health systems of the SADC region (Chatora and Tumusime 2004; Kruk et al. 2010). The popularity of this approach lies in the parallels between the goals of integrated care and PHC, namely, increasing access to and equity and quality in health care services, as well as reductions in the costs associated with hospital-based health care. Additionally, by moving mental health care from specialist institutions to PHC clinics (i.e. closer to the community), the assumption is that community stigma towards mental illness will be ameliorated (Yasamy 2008; Mechanic, Mcalpine, and Rochefort 2014). The importance of integrated primary mental health care is underlined by recent developments in South Africa, where mental health is being integrated with other chronic disease programmes on facility, community and population level – in a similar fashion to an integrated chronic disease management model (Petersen et al. 2016). Such initiatives will no doubt be very much contingent on integration outcomes across the Rainbow Model spectrum.

In the policies assessed, integrating mental health into PHC was a central feature of reform strategies although these strategies were by no means uniform. For instance, some policies described this kind of integration simply as "integration of mental health into PHC", which means that efforts will be made to provide mental health at PHC facilities. Nevertheless – in line with the lack of professional integration dimensions highlighted in the policies – it remains unclear whether this means that mental health services will be provided by dedicated mental health professionals, whether it will be integrated with other PHC programmes such as maternal and child health, or whether all PHC staff will be trained to provide mental health services. The exception in this regard is South Africa, where a task-shifting approach is forwarded which involves the training, mentoring and supervision of lay health workers by specialist mental health practitioners to provide basic mental health services. This approach has been well-described (Petersen et al. 2011; Petersen, Lund, and Stein 2011; Lund et al. 2012; Petersen et al. 2012b).

Possible concerns could be raised in terms of integrating mental health into PHC. Some integration aspects lacking in the policies, while arguably not essential, could at least prove to be influential in the implementation of integrated primary mental health care. These include professional integration components such as *shared vision between professionals*, *inter-professional governance*, and *value creation for the professional*. Further, *normative integration* components such as *trust*, *transcending domain perceptions*, *reliable behaviour* and *conflict management* were found to be largely lacking. These professional and normative – or soft – dimensions of integrated care are suggested to be especially salient influences in its implementation on PHC level (Valentijn et al. 2015). Ideological and cultural differences among professionals, as well as poor conflict resolution practices, have been suggested to impede inter-professional collaboration. For instance, the diagnosis and effective management of mental illness in PHC settings has been suggested to raise resistance among general health care practitioners (Allwood 2000). Petersen (1998, 2000) highlighted the ways in which dominant biomedical discourses in PHC settings impede mental health care provision in South Africa, while Patel and colleagues (2013) noted a lack of clarity in objective setting and outlining the responsibilities of professionals and managers in integrated primary mental health care efforts. By neglecting such strategies, the integration of mental health into PHC might be met by a range of challenges that may otherwise have been leveraged by normative and professional strategy inclusion.

Inter-service collaboration

The second current of integrated care in the policies was inter-service collaboration. Comprehensive mental health care denotes a range of psychological, medical and social services, which in turn needs to be coordinated and organised within a multifaceted effort (Johnson et al. 2003; Nocon and Sayce 2008; Mechanic, Mcalpine, and Rochefort 2014). Collaboration among different service providers is an established feature of modern health systems, and a key strategy in continuity of care and effective resource utilisation

(Robinson 2006). More specifically, successful integration efforts are strongly related to the extent of public, private and voluntary sector collaboration (Mur-Veeman et al. 2003). The presence of such collaboration in health policy is partially due to the assumption that the struggle to effectively respond to rising demands for health services is in part due to a lack of partnership between the state, and private and voluntary sectors (Rummery 2006). While the private sector – due to its for-profit nature and financial and working conditions incentives – often have superior human and other resources, the non-profit sector have been suggested to increase human rights of people with mental illness within reforms towards integrated mental health care (Makhashvili and van Voren 2013). The policies under focus frequently emphasised the need for collaboration among stakeholders; these were mostly between state-funded health service providers, and between state-funded health service providers and private and non-profit providers. Additionally, collaboration with traditional healers was frequently mentioned, a key consideration in mental health reforms in the SADC region (Freeman, Lee, and Vivian 1999; Rosen 2006; Sorsdahl et al. 2009; Stein et al. 2010).

Some normative dimensions of integrated care related to inter-organisational collaboration were not well articulated. Examples such as *linking cultures* and *transcending domain perceptions* have been underlined as important mechanisms influencing successful collaboration within integrated care (Mur-Veeman et al. 2003). An especially salient aspect of inter-organisation collaboration in integrated mental health care is *trust* – which, although it has been increasingly perceived as essential by national governments (Hudson et al. 1999), was not well emphasised. Trust has often been suggested to be a precondition for successful inter-organisational collaboration (Hudson et al. 1999; Meijboom, De Haan, and Verheyen 2004), a lack of which has been described in terms of hostility, mistrust and fighting (Vangen and Huxham 2003). Similar to inter-organisational relations, trust has also been suggested to be an essential aspect of inter-professional collaboration (San Martín-Rodríguez et al. 2005), elevating its importance in the aforementioned integrated primary mental health care strategies. Finally, the importance of trust is intimately tied to power relations (Vangen and Huxham 2003; Mur-Veeman et al. 2003), an element to some extent absent in the Rainbow Model. A paucity of knowledge remains in terms of the power relations at play in integrated care initiatives – along with the governance of the relations within which they play out. For instance, efforts towards the shifting of mental health services towards PHC clinics might well result in a less central role for hospitals in service delivery, although hospitals will have a substantial power advantage over their PHC partners in the service network (Nicaise, Dubois, and Lorant 2014).

Integrated mental health care, the Rainbow Model and regional governance

Although buoyed by its robust development and comprehensiveness, the Rainbow Model failed to identify additional macro-level elements of integrated care. Important aspects such as national economic and legal frameworks that are crucial in supporting the implementation of integrated care models can therefore be neglected in an analysis like the present. On regional level, sustained progress in global mental health requires close engagement with, among others, governments (Summergrad 2016). Regional strategies are important influences in priority setting for mental health (Cooper et al. 2011). The WHO Africa Regional Strategy for Mental Health 2000-2010 (WHO 2000) called for countries to adopt both the integration of mental health into general and primary health care, as well as to increase collaboration among relevant stakeholders. The SADC Protocol on Health (South African Development Community 1999) calls for collaboration and harmonisation of health system activities among its member countries, as well as mutual support and assistance in mental health care, including its integration into PHC systems.

The advantages and stabilising effects of such a strategy were illustrated in regionally harmonising mental health policies, legislation, information systems and general structures (Kucukalic et al. 2005). Among the policies analysed in this chapter, Botswana, South Africa and Zambia recognised the significance of supra-national approaches to health and health care, for instance calling for inter-country collaboration in developing human resources for health, and calling for good regional health governance. SADC – specifically the SADC Secretariat – could potentially play a significant role in strengthening integrated mental health care development. Possibilities include the support of regional civil society and the training and retention of mental health professionals (Mooketsane and Phirinyane 2015; Penfold and Fourie 2015; Penfold 2015). Evidence-based interventions such as collaborative stepped care, task-sharing and alternative approaches to human resources for health development (Shidhaye, Lund, and Chisholm 2015) – key aspects of integrated care – could be supported from a regional governance level. Regional support could also be instrumental in supporting contemporary collaborative mental health initiatives on population, community and neighbourhood levels recently outlined (Petersen et al. 2016).

The neglect of integrated care related to decentralisation processes – a key aspect of LMIC health system reform – is telling. The absence of such strategies could be ascribed to the acknowledged lack of macro-policy expert input in the development of the Rainbow Model (Valentijn et al. 2015). Also, an argument could be made for the differences in health system configurations in the content of the Rainbow Model. In the countries under scrutiny health services are offered in a pluralistic, free market type systems. In contrast, the bulk of integrated care research has been based in Beveridge (state-provided health care largely financed by public taxation, e.g. UK, Canada) and Bismarck (state coordination and regulation of health care instead of provision, e.g.

Belgium, The Netherlands) models of health systems. Health system configurations have been shown to be influential in the provision of integrated care and how it its related policies are implemented, as they significantly influence the positions and power of the state and other stakeholders, and the ways in which health system processes such as integrated mental health care are governed (Kümpers et al. 2002; Mur-Veeman, van Raak, and Paulus 2008). Ultimately it can be argued that the Rainbow Model leans towards individualistic (as opposed to collective) values, in line with the knowledge base chiefly derived from European and North American contexts. This argument is strengthened by the frequent emphasis in the policies under discussion of the input, consideration of and collaboration with local communities in the provision of integrated mental health care – an aspect not picked up by the model.

The study has several limitations. Several policy documents were omitted in the analysis due to time constraints, which include national policies on human resources for health and primary health care. The inclusion of pertinent social policies such as those dealing with crime and education is a limitation and opens up an area for future exploration. Contradictions and coherence across the national policy spectrum will no doubt hold consequences for integrated mental health care. The vagueness with which strategies were described in the policies necessitated that subjective assumptions were made in classing these strategies under relevant forms of integrated care. Nevertheless, it should be stressed that the purpose of the present chapter was not to measure integrated care as such, but rather to clarify its strategic meaning. Additionally, the discrepancy between policy content and implementation is well-known, and the integration strategies discussed do by no means reflect real-life integrated mental health care in the countries assessed. SADC countries without mental health policies were omitted under the assumption that the lack of explicit policy documents equates a lack of integrated mental health care, which might not necessarily be the case. It is important to keep in mind that the present analysis took place on the strategic, rather than operational, level.

Conclusion

Within the contexts of global reform initiatives, mental health care systems are changing. Integrated mental health care is an established feature of these restructurings and fill a particularly important place in LMICs reforms. It promises to move us closer towards long-held aspirations for quality, equitable and accessible mental health care for those traditionally situated on the peripheries of society. However, this potential is significantly contingent on political will, both on national and supra-national levels. While political resolve is captured in policy, the details are more than just discourse; it is of crucial importance that we are clear about the scope and focus of integrated mental health care in order to better plan and facilitate implementation efforts.

The findings build on recent attempts to clarify integrated mental health care by investigating its meaning both on national and regional levels, significantly drawing from a robust model and applying it to LMIC contexts. Much progress has been made during past decades towards the provision of integrated mental health care under the guise of established models of care. Nevertheless, the present findings highlight the absence of important supportive integrated care strategies which could prove to be influential in the translation of intentions into reality. In terms of the broader study, this Chapter underlined the centrality of state and non-state service collaboration in South African health policies. It illuminates the research objective of exploring the dimensions and structure of integrated mental health care in South Africa (Chapter 1), and provides context the case study in Chapters 5 and 6.

The Rainbow Model proved to be a useful tool with which to interrogate a complex health system strategy. Despite its minimal drawbacks, the model lays a strong foundation for prospective empirical research. In this respect, future studies should be mindful of the multi-layered nature of integrated mental health care, which paves the way for much empirical fieldwork that explores the finer nuances of the ways in which integrated mental health care unfolds – particularly in LMICs. Such knowledge will no doubt prove to be useful amendments to frameworks such as the Rainbow Model. Further, given the global nature of health system dynamics, more research is needed on the ways in which regional governance could contribute to mental health system reform. Ultimately, theory-led insights on integrated care are decisive to its deployment success and in shaping better mental health systems.

Chapter 5: State and non-state mental health service collaboration

With the elementary apparatus of population, relationship, category, and network, the basic tasks of social description become manageable.

- Charles Tilly, Big Structures, Large Processes, Huge Comparisons (1984)

Prelude

Continuing from the previous chapter, this chapter narrows the study focus to an organisational level. In line with the relational approach of the research, a social network analysis is conducted of mental health service provision in a South African district. Special focus is given to the relations between state and non-state service providers, and the structural dimensions of integrated mental health care is described. This provides a snapshot of powerful actors in the service delivery network, in line with mainstream conceptions of power. In the next step, service network relations are explored more in-depth, and further relational dynamics emerge. Ultimately, the chapter provides a prologue to a deeper understanding of the dynamics of governance and power in collaborative service provision, provided in Chapter 6.

State and non-state mental health service collaboration in a South African district: A mixed methods study

Article: Janse van Rensburg A, Petersen I, Engelbrecht M, Kigozi G, Bracke P, Fourie P. The nature and extent of state and non-state mental health service collaboration in a South African district: A mixed methods study. *Health Policy and Planning*, 33(4): 516-527.

This article was conceptualised by André Janse van Rensburg, who also wrote the first draft. Co-authors provided valuable critique and input. Following critique by anonymous reviewers, André Janse van Rensburg adapted and re-submitted the article.

Abstract

The Life Esidimeni tragedy in South Africa showed that, despite local gains in integrated public mental health care during the past decade, crucial gaps remain. State and non-state mental health service collaboration is a recognised strategy to increase access to care and optimal use of community resources, but little evidence exists about how it unfolds in low-to-middle income countries. South Africa's Mental Health Policy Framework and Strategic Plan 2013 – 2020 (MHPF) underlines the importance of collaborative public mental health care, though it is unclear how and to what extent this happens. The aim of the study was to explore the extent and nature of state and non-state mental health service collaboration in the Mangaung Metropolitan District, Free State, South Africa. The research involved an equal status, sequential mixed methods design, comprised of structured and semi-structured interviews. Structured interviews were conducted with collaborating state and non-state mental health service providers. Semi-structured interviews were conducted with collaborating partners and key stake holders. Descriptive network analyses of the social network analysis (SNA) data were performed with Gephi, and thematic analysis of the semi-structured interview data were performed in NVivo. SNA results suggested a fragmented, hospital centric network, with low average density and clustering, and high authority and influence of a specialist psychiatric hospital. Several different types of collaborative interactions emerged, of which housing and treatment adherence a key point of collaboration. Proportional interactions between state and non-state services were low. Qualitative data expanded on these findings, highlighting the range of available mental health services, and pointed to power relations as an important consideration in the mental health service network. The fostering of a well-integrated system of care as proposed in the MHPF requires inter-institutional arrangements that include both clinical and social facets of care, and improvements in local governance.

Key words: Mental health services; integration; public/private; health services research; networks.

Introduction

Major global investment has been made in public mental health service improvement during the past decade, exemplified by the WHO Mental Health Action Plan; the Movement for Global Mental Health; an increase in research investment (highlighted in several dedicated series in prestigious journals); and the inclusion of mental health as a priority under Sustainable Development Goal 3.4 (Horton 2007; Tomlinson et al. 2009; Collins et al. 2011; Patel et al. 2011; Patel and Saxena 2014; Thornicroft and Patel 2014). The South African mental health community took advantage of the global mental health movement (Patel et al. 2011) by producing a comprehensive national mental health policy in 2012. The Mental Health Policy Framework and Strategic Plan 2013 – 2020 (MHPF) (South African National Department of Health 2013) is a comprehensive and ambitious document, focusing in broad strokes on improving mental health service delivery on primary, secondary and tertiary levels of the public health system. In step with post-apartheid legislation and health policy approaches, it re-affirms the responsibility of the state to provide public mental health services (section 8). Important steps have recently been taken towards integrating mental health care into the primary health care (PHC) system through a task-shifting approach (Petersen and Lund 2011; Petersen et al. 2012b; Jack et al. 2014; Lund et al. 2016; Petersen et al. 2017). While various forms and types of integration have been conceptualised (Kodner and Spreeuwenberg 2002; Kodner 2009), integration is essentially a social process involving the management and delivery of a continuum of curative and preventative, multi-level health services, according to the needs of clients (WHO 2008b).

In South Africa, there is perhaps no more striking example of the consequences of the disintegration of mental health services than the Life Esidimeni tragedy. In this botched deinstitutionalisation attempt, the Gauteng Department of Health ended a long-standing public-private partnership with a major private hospital group, transferring 1 371 mental health service users from specialist care settings to non-governmental organisations (NGOs) during 2016 (Makgoba 2017). To date, more than 144 have died due to gross negligence, while an unknown number remains missing. The state purportedly followed global narratives that underline the primacy of deinstitutionalisation, despite a well-established historical account of the pitfalls of such strategies (Koyanagi 2007; Morrow, Dagg, and Pederson 2008; Sheth 2009; Shen and Snowden 2014; Thornicroft, Deb, and Henderson 2016). At the minimum, the Life Esidimeni tragedy is a spectacular failure of collaboration between state and non-state parties, and laid bare serious dysfunction of referral, regulation, and information systems, as well as pointing to a lack of stewardship on a grand scale (Makgoba 2017). The incident was further complicated by a structural disjuncture in governance between the Department of Health (DoSD; who oversee health facilities and services) and the Department of Social Development (DoSD; who regulates the activities and services of NGOs), speaking to a degree of siloed working in mental health service provision. Additionally, the incident unfolded in contexts where the relationship between the state and NGOs are fraught with conflict. In South Africa, the establishment of the National Association of Welfare Organisations and Non-profit Organisations (NAWONGO) led to a lengthy court case against the state for improved access to funding (Free State High Court 2010). For Ferguson (2006), this is part of a transnational phenomenon in LMICs, and similar conflicts emerged in India in the wake of the 2010 introduction of the Foreign Contribution Regulation Act. Importantly, the MHPF is geared towards addressing these crucial concerns, particularly improved collaborative activities.

The MHPF built on a host of post-apartheid mental health reform strategies that have repeatedly stressed the importance of state and non-state collaboration (Janse van Rensburg and Fourie 2016; Janse van Rensburg et al. n.d.a). Non-state health service providers include both for and not for profit organisations (Wolvaardt et al. 2008). For-profit organisations include private hospitals, clinics, mental health professionals, and physicians. On the non-profit space of the spectrum, non-governmental organisations (NGOs) provide mental health services to recipients who cannot afford private care, and may include organisations in different local, national and international capacities, with different approaches. NGOs refer to “a broad spectrum of voluntary associations that are entirely or largely independent of state and that are not primarily motivated by commercial concerns” (Najam 2000, 378), and in South Africa traditional healers are also counted among these service providers (Sorsdahl et al. 2009; Campbell-Hall et al. 2010). NGOs have gradually been recognised as an important resource to tap into and have become key collaborating actors in LMICs, exemplified by global initiatives such as mhNOW and #NGOs4mentalhealth call to action (Kleinman et al. 2016).

Collaboration here involves voluntary inter-organisational participation – with mutual adjustments – in arrangements that encompass the distribution of responsibilities and rewards among collaborators (Hill and Lynn 2003; Axelsson and Axelsson 2006), resulting in the provision of a multi-organisational service delivery network (May and Winter, 2009). Conceptually, two distinct (but intersecting) features of collaboration can be distinguished, namely the degree of collaboration, and the contexts behind collaborative activity (Wanna 2008). Collaboration is a core feature of organisational integration, the vertical and horizontal forms of networking and collaboration, both formal and informal, between health service providers (Kodner and Spreeuwenberg 2002; Durbin et al. 2006). In South Africa's pluralistic health system, this involves, to a certain degree, collaborative ties between state and non-state service providers.

Recently, world health leaders including Jim Yong Kim, president of the World Bank Group, and Margaret Chan, Director-General of the WHO, called for a collaborative response to mental health care strengthening that stresses community-level, integrated mental health care (Kleinman et al. 2016). While the apparent global and local supportive policy environment should be applauded, many challenges remain. Importantly, evidence of health service requirements for mental health integration scale-up (Semrau et al. 2015) and the organisation, planning, infrastructure, and inter-sectoral linkages of referral systems (Rathod et al. 2017) are left wanting. There is an identified need to explore the types and interactions of state and non-state actors providing health services in LMICs (Cammett and MacLean 2011). Simply put, improved coordination and stakeholder involvement are crucial in translating mental health policies into tangible outcomes (Hanlon et al. 2017), and increasing collaboration is an essential step for "mental health to come out of the shadows" (Kleinman et al. 2016, 2274). To this end, the aim of this study was to provide understanding of the nature and extent of mental health service collaboration among state and non-state service providers in the Mangaung Metropolitan District in the Free State province of South Africa. The nature of collaborative activities here refers to the structure, type and dynamics of relationships, while the extent refers to the degree of collaboration. The first of two articles reporting on a case study, this Chapter addresses all three research objectives (Chapter 1), namely (1) the dimensions and structure of integrated mental health care in South Africa; (2) referral and collaborative ties in a mental health service provider network; (3) and the relations between state and non-state mental health service providers.

Methods

Setting

The study was conducted in the Mangaung Metropolitan District, in the Free State Province, South Africa. With a population of 759 693, the district includes a city and several small towns and villages. The district includes areas that were designated Bantustans (territory set aside for black inhabitants) during apartheid, and socio-economic and health inequities remain. In 2016, a poverty headcount of 5% was estimated (a compound measurement of 11 indicators of health, education, living standards and economic activity, resulting in an indication of the proportion of households that are "multidimensional poor"). In 2015, 27.8% of households received government grants and subsidies (Statistics South Africa 2016a).

Approach and design

The study draws from a mixed methods research approach. Nestled in a pragmatic research paradigm (real-world oriented, problem-centred, pluralist practices), mixed methods here refer to the collection and integration of both quantitative and qualitative data towards forming a more complete understanding of a research topic (Cresswell 2014). The study was informed by social network analysis (SNA), and heeding to suggestions that SNA should not be only used as a descriptive tool and that its combination with other approaches yield better explanation (Marshall and Staeheli 2015; Wölfer, Faber, and Hewstone 2015), the study employed semi-structured interviews as well. The data collection, analysis and integration of the two methodologies were conducted sequentially, while maintaining the same approximate weight in importance. The study design therefore can be described as an equal status, sequential mixed methods design, the quantitative phase (SNA) preceding the qualitative phase (Johnson and Onwuegbuzie 2004). SNA is an effective method with which to explore integrated care and other health system concerns (Goodwin 2010; Blanchet and James 2012), and has been shown to be a useful way to explore inter-organisational linkages among health-oriented organisations in LMIC settings (Van Pletzen et al. 2013) and mental health care integration (Nicaise et al. 2013, 2014; Lorant et al. 2017). The procedures were informed by the steps described by Blanchet and James (2012). Accordingly, the study sought to (i) describe the set of actors and members of the network; (ii) characterise the relationships between actors; and (iii) analyse network structures.

Instrument development

The structured interview schedule (SNA data collection instrument) was developed based on sections of Bruynooghe and colleagues' (2008) instrument investigating cooperative relationships among human service organisations. Questions related to the research study were added, including descriptive questions about the organisations and the nature of mental health services and referrals offered. Semi-structured interviews with key participants were guided by a schedule informed by Purdy's (2012) Framework for Assessing Power in Collaborative Governance Processes combined with probes related to state and non-state interactions, mental health system dynamics, and state stewardship.

Data gathering

To obtain network data, three steps were followed. First, a list of state health care facilities in Mangaung Metropolitan was obtained from the Free State Department of Health (FSDoH). This included 41 PHC facilities, three district hospitals, one regional hospital, and one specialist psychiatric hospital. From October to November 2015, the 46 facilities on the list were visited, and the social network instrument was administered face-to-face with health care professionals in charge of mental health care in their respective facilities. This step produced a list of state and non-state service providers with whom state facilities collaborated in mental health care. Second, the non-state providers identified in this step were visited and the social network instrument was administered by trained researchers face-to-face to the person in charge of mental health care in each organisation. Third, an additional list of NGOs providing mental health services was obtained from Families South Africa (a local NGO who kept records of available NGOs in the district), that was also visited in a similar manner as in other organisations. In total, twenty NGOs were identified. Ultimately, a total network of 66 mental health service collaboration partners, both state and non-state, was identified across the district.

Following an initial analysis of this network, clusters of state and non-state collaboration were identified, from which eleven participants were identified for semi-structured interviews. These key informants were asked to identify additional influential actors in mental health service provision not yet identified during the research, resulting in another nine participants identified. Ultimately, 20 semi-structured interviews were conducted, with durations spanning 40 to 80 minutes. All participants identified during these processes were contacted for appointments, and following informed consent procedures, semi-structured interviews were conducted in their offices. All participants were fluent in English, and all interviews were conducted accordingly in English.

Data management and analysis

SNA data was electronically captured and structured in Microsoft Excel (Microsoft 2010), and transferred to Gephi Graph Visualization and Manipulation software (version 0.9.1) (NetBeans 2016) for network analyses. Basic descriptive analysis was performed, producing indications of node (mental health service providers) and edge (relationships) numbers; network diameter (the shortest distance between the two most distant nodes in the network); average path length (the average number of steps along the shortest paths for all possible pairs of network nodes); density (proportion of the potential network connections that are actual connections); average degree (an average calculation of the number of edges connected to each node); clustering coefficient (the degree to which nodes tend to cluster together in the network); eigenvector values (measures of the relative influence of nodes in a network), and authority rankings (indications of the relative importance of nodes in a network). Gephi's No Overlap algorithm and centrality function were applied to produce an illustration of the network that affords nodes with more centrality a larger size. Filters were applied to isolate different types of collaborations. Approximations of the weight of interaction among state (split into primary and hospital level) and non-state service providers were calculated in Excel.

The qualitative phase of the research focused on two groups of participants: 1) collaborating state and non-state collaborating service providers (Table 5), and 2) key informants (Table 6). Semi-structured interviews were audio recorded and transcribed verbatim to Microsoft Word (Microsoft 2010). Transcriptions were transferred to NVivo10 (QSR International 2016) for management during analysis. Interview transcripts were thematically analysed (Saldaña 2014). Pre-determined themes were deductively derived from the SNA instrument, namely, *Available mental health services*, *Reasons for collaboration*, and *Quality, effectiveness, efficiency of care*. *Power* emerged inductively during the data analysis process. Themes and their content were negotiated among three researchers to remove overlap or irrelevance from the data. Direct quotations – de-identified – are used to support thematic categorisation.

Table 5: List of state/non-state mental health collaborations

State facility		**Non-state facility**	
Code	*Services provided in collaboration*	*Code*	*Service provided*
PHC A3	Out-patient drug treatment	NGO A2	Housing, rehab, treatment adherence
PHC A8	Out-patient drug treatment	NGO A1	Social/welfare services, psychotherapy
		NGO A2	Housing/rehab, treatment adherence
		NGO A4	Housing/rehab
		NGO A5	Substance abuse rehab and prevention
		NGO A7	Housing, treatment adherence
PHC A10	Out-patient drug treatment	NGO A1	Social/welfare services, psychotherapy
SH A1	Acute and serious case processing; social/welfare services	NGO A1	Social/welfare services, psychotherapy
		NGO A4	Housing/rehab
PHC B12	Out-patient drug treatment	NGO B1	Housing, treatment adherence
DH B1	Out-patient drug treatment; acute and serious case processing	NGO B1	Housing, treatment adherence

Table 6: List of key informant positions and affiliations

Position	Affiliation
	State
Senior psychologist	Government department; Specialist hospital
Programme director	Government department
Psychiatrist	Psychiatry outreach team; District hospital
Psychologist	District hospital
Mental health nurse	District hospital
Mental health nurse	PHC clinic
	Non-state
Case worker	Non-profit organisation
CEO	Private for-profit psychiatric hospital
Director	Non-profit organisation

Ethical considerations

All research participants were informed of the purpose of the research and their role in it both verbally and in writing. Signed informed consent was obtained from participants, and data anonymity and confidentiality were achieved by assigning codes to data sources. Participants were offered freedom of participation, and none opted out of the study. Ethical clearance was obtained from the Stellenbosch University Research Ethics Committee: Human Research (Ref: HS1156/2015), and permission to conduct the research was obtained from the FSDoH.

Study findings

Extent of collaboration

As shown in Figure 6, a striking feature of the network of mental health service providers is the centrality of hospitals, especially the state psychiatric hospital (SH A1). Three distinct network groupings can be observed. The largest of the three is the city of Bloemfontein, which helps explain the larger concentration of service providers – especially NGOs. The two smaller groupings denote small towns which previously were situated in an apartheid-era Bantustan (Botshabelo and Thaba Nchu), resource-poor and geographically removed from specialist services.

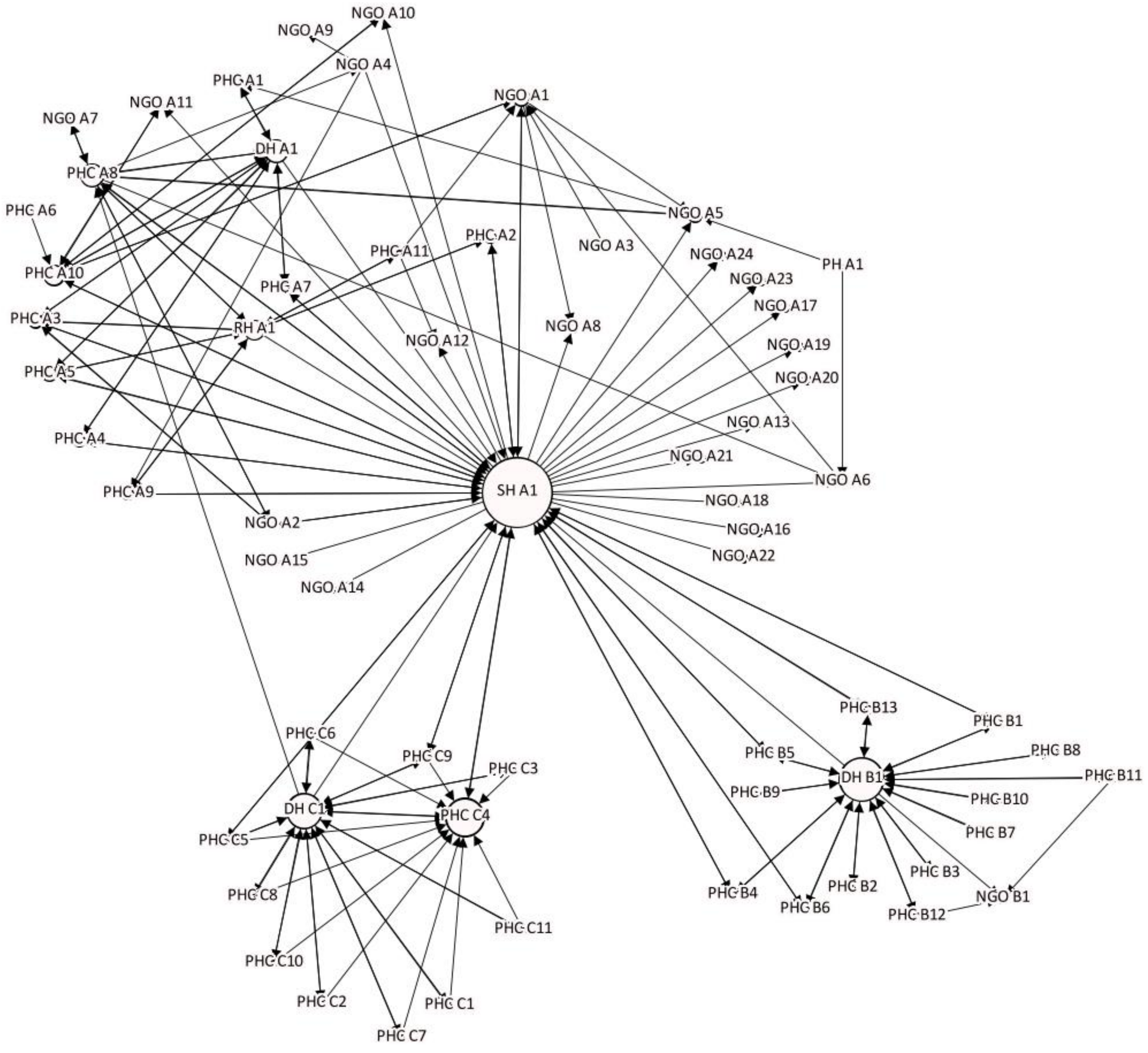

Figure 6: Total network

Table 7 provides an overview of descriptive network statistics. The total network had 66 nodes (mental health service providers), and 175 edges (relationships in the network). The network diameter – the largest distance between two nodes – was six, meaning that it took six connections to join the two service providers farthest apart from each other in terms of collaborative relationships. The average length of the relationship paths between nodes was almost three (Table 7: Average path length = 2.9). The low number of indirect relationships is also reflected by an overall low level of network density (Table 7: Density = 0.041), as well as by a low average degree (Table 7: Average Degree = 2.652). The clustering coefficient – a calculation of the probability that two separate nodes connected to a given node are connected two, therefore indicating clusters of triangular connections among nodes – was also relatively low at 0.247. Estimated between zero and one, this suggests few clusters of collaborative relationships throughout the network. It is important to note that the statistical averages presented here conceal a substantial discrepancy in terms of a high number of edges attached to selected service providers while other service providers have only a few edges attached to it. This reflects considerable inequality in the network, along with suggesting a hierarchical structure characterised by a broad base and a narrow top. The state-run psychiatric hospital (SH A1) was the most powerful node in the network. Apart from its superior degree centrality, it was the most influential service provider according to its high eigenvector centrality value (1.0) and its high network authority (0.385) relative to other nodes.

Table 7: Descriptive network statistics

Nodes	*Edges*	*Diameter*	*Ave. path length*	*Density*	*Ave. degree*	*Ave clustering coefficient*	*Highest eigenvector value*	*Highest authority*
66	175	6	2.90	0.041	2.652	0.247	SH A1: 1.0	SH A1: 0.385

Proportional interactions – that is, the proportion of the total possible interactions between groups, indicated by a number between 0 and 1 – among different service providers were analysed in three groups: hospitals, PHC facilities (both state-driven), and NGOs. Given the disparity in distribution of mental health professionals between primary care on the one hand, and secondary and specialist care on the other, state facilities were divided accordingly. As shown in Figure 7, most interactions took place between hospitals and PHC clinics, with comparatively less interactions between these two groups and non-state facilities. The highest number of relationships between state and non-state was the referral of patients from hospitals to non-state facilities. A possible reason here – described in the qualitative section – is the concentration of state mental health professionals in hospital care, who might be more likely to collaborate with non-state actors.

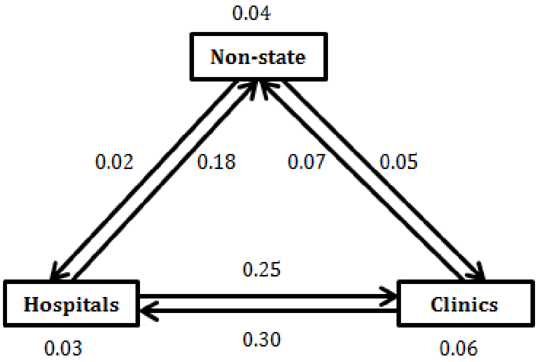

Figure 7: Proportional interactions between service providers

Nature of state and non-state mental health service collaboration

Range of services offered

The semi-structured interviews shed light on the range and nature of the core services that were offered by different service providers in the district. State and non-state service providers seemingly provided different kinds of care to mental health service users. The hierarchical structure of state health facilities according to primary, secondary and tertiary levels were concomitant with concentration and availability of specialist human resources for health. The specialist psychiatric hospital provided a broad range of services across all ages – outpatient drug therapy, in-patient services (that included occupational therapy), psychotherapy, treatment adherence, alcohol and drug rehabilitation, and forensic and social services. The hospital's ties to the university provided a pool (albeit a relatively small one) of specialists, especially psychiatrists, clinical psychologists, social workers, psychiatric nurses, and occupational therapists. As the SNA results suggested, there seemed to be a geographical inequality in terms of distribution of types of services, the more socially-aligned services were more concentrated in more urbanised areas (Figure 6). In more rural areas, participants mentioned that some mental health service users access care from traditional healers, though no formal referral or collaboration was found between the participants and possible traditional healers in the district.

Some of the NGOs provided a range of basic care services, of which housing was especially prolific. Mental health service users were brought there by their families, and the NGOs took care of them – usually in a restructured private home, with several beds and mattresses for mental health service users. Instances were found where as many as 30 mental health service users (both male and female) were housed in a three-bedroom house, with one bathroom. Nevertheless, their core services included housing, food, and treatment adherence. Mental health service users based in places like this did seemingly not have access to any psychotherapy or rehabilitation, and their care comprised of drug adherence and basic human needs. A key service that emerged during this narrative is the "containment and management" of mental health service users. This is illustrated below:

> *Yes, they escape. All of them, they will pop the windows. They break the windows. At night. We do not sleep then. We walk around, check the place* (CC_NGO1).

Very little psychotherapy, rehabilitation and support existed outside large public hospitals in urban areas. This was apart from fee for service facilities, which had little contact with public health services due to their for-profit motive. An especially strong actor in this sense was a local NGO who specialised in assisting mental health service users who are not able to afford private mental health care, employing social workers. Their core service package included home-based psychotherapy, group therapy, social support, community awareness and education campaigns, and referrals to other necessary services. Some NGOs did not specialise in mental health care, and rather encompassed it as part of its main focus. Examples include an organisation that provided support and services in line with anti-occultism, alcohol and drug rehabilitation facilities, and organisations focusing on geriatric care. Geriatric facilities were cited as a way in which care can be extended to mental health service users, given the presence of medical and around the clock care. One faith-based organisation provided a spectrum of services, as explained here:

> *We have seven main services. The old age centre, family care, child and youth care, adoption services that are international and national, and then also hospital care and disability care. Then we also have substance dependence programmes, the prevention and alleviation of poverty, and forensic services* (CC_NGO4).

The only for-profit organisation identified in the network was a private psychiatric hospital, with significant human resource capital, but very little collaboration with other service providers. Their package of care was extensive, and included psychotherapy, dietary care, physiotherapy, and frequent access to psychologists and psychiatrists. This particular facility was established following the exchange of psychiatric beds in private hospitals for more profitable surgical beds. Given a perceived rise in mental health needs (especially among middle-class populations who have medical insurance), this market gap was filled. Many of the mental health professionals employed by the facility have dual roles, occupying positions in both the private hospital as well as providing services in state hospitals. The profit motive of this particular facility restricted collaboration with NGOs and state facilities. The little service exchange that did occur unfolded in cases where mental medical aid funds were depleted, viewed with disdain by some participants:

> *The only time that we engage with them is when the money runs out and then they send them to us, so that actually happens a lot. Yes, around June, July, the patients come from private and then their funds are depleted* (SW_TH).

Referrals

SNA findings suggested that PHC facilities tended to refer mental health service users with perceived serious mental conditions, as well as acute cases that often involved psychosis, to hospitals. Hospitals tended to refer discharged mental health service users to PHC facilities for outpatient drug treatment. An important point of collaboration between state and non-state service providers was referral of mental health service users to NGOs that provided housing, basic needs and treatment adherence. Specialised services such as drug and alcohol rehabilitation and psychosocial therapy and rehabilitation were only concentrated in a few NGOs. Available family support services were sparse (Table 8).

Findings from the semi-structured interviews suggested that public health facilities tended to follow provincial referral policy. In this vein, PHC clinics generally screened mental health service users for signs and symptoms of mental illness, and referred them accordingly. In serious cases, mental health service users were referred upwards to district hospitals, which referred upwards to the regional hospital in the district, which in turn referred to the psychiatric hospital. Hospitals in turn referred mental health service users downwards to PHC clinics for outpatient treatment. Given the paucity of mental health expertise in PHC clinics, an outreach team made up of medical residents in psychiatry and clinical psychologists visited certain clinics in the district in order to increase access to treatment initiation and adaption. Mental health service users are booked for a predetermined date and then seen by the outreach team at a clinic or hospital. Cases deemed to be serious were referred to district hospitals where mental health service users were assessed for a period of 72 hours before being referred further (as stipulated in the Mental Health Care Act). This was perceived to be a necessary policy to prevent the overburdening of the specialist psychiatric hospital: “We do not want to be flooded and stuff” (CP_TH).

However, the capacity of district hospitals to offer this particular service was questioned, particularly in terms of adequate space and available mental health professionals. Apart from the official provincial referral system, which dictates that public health facilities have to refer mental health service users to other public health facilities according to a pre-determined referral list, very few state facilities had any formal referral rules in place for referral to non-state service providers. In this vein, the social work unit at the psychiatric hospital was the exception, being a key point of collaboration with NGOs.

Reasons for mental health service collaboration

In the second phase of the network analysis, filters were used to isolate relationships that were identified by the research participants. During the semi-structured interviews, participants were asked to name the main mental health service that they provide in relation to other mental health service providers. These parts of the service delivery network are presented in Figures 8-14, and in Table 8. Seven different reasons for collaborative relationships among service providers were identified by participants: Outpatient pharmaceutical care; Serious cases; Drug and alcohol rehabilitation; Psychotherapy and psychosocial rehabilitation; Acute cases; Family support; and Housing and treatment adherence It should be noted that these relationships are not clear-cut, and that many overlaps occur. From the network depictions there is a suggestion of network density disparity between biomedically-oriented services (Outpatient drug therapy, Acute cases, Serious cases) and social support and psychotherapeutically-oriented services (Housing and treatment adherence, Drug and alcohol rehabilitation, Psychotherapy and psychosocial rehabilitation, and Family support). That is, the continuum of mental health care seems to be more skewed towards biomedical than psychosocial approaches. This schism is further bolstered by disparities in terms of the balance of biomedical services subsisting predominantly in the state sphere, while psychosocial services were largely rooted in the sphere of non-state services (see Table 8 for a breakdown of number of interactions per service). The apparent biomedical-psychosocial disjuncture was also underlined in terms of a sector split between the DoH and the DoSD. DoH is the steward of health, and in charge of health facilities. DoSD leads psychosocial rehabilitation and housing, while also regulating the NGO sector. The suggestion therefore is that not only is a disparity between state and non-state services, but also between the DoH and DoSD.

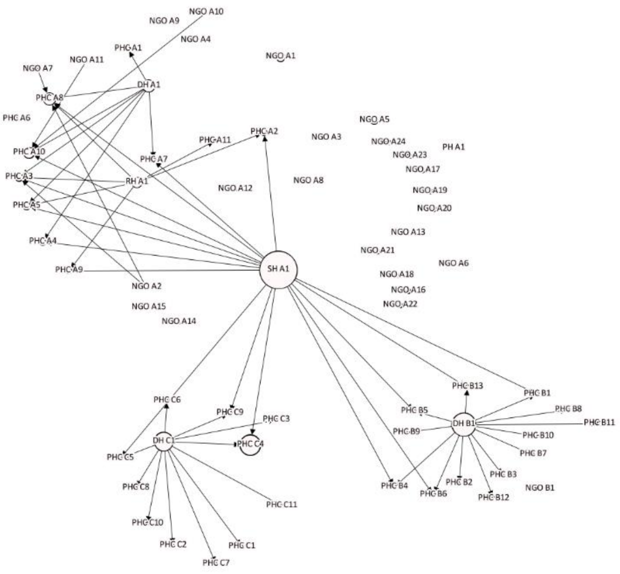

Figure 8: Outpatient pharmaceutical care

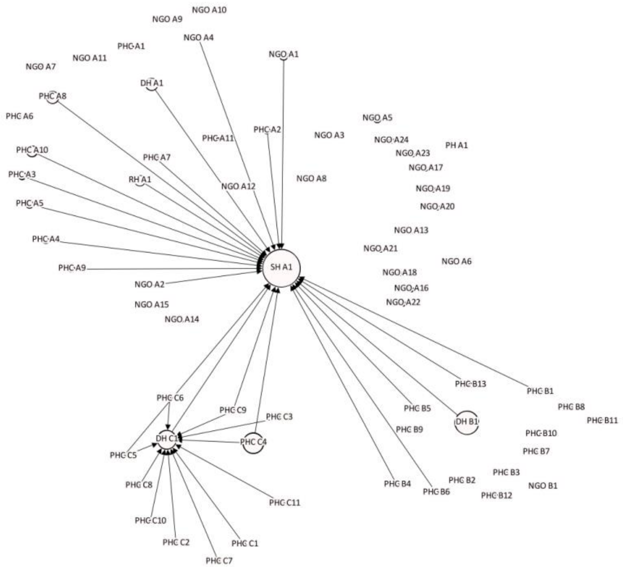

Figure 9: Serious cases

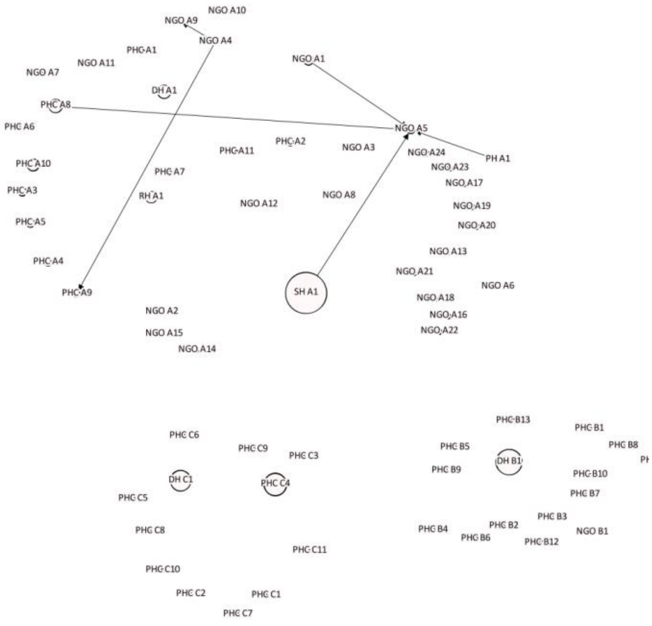

Figure 10: Drug and alcohol rehab

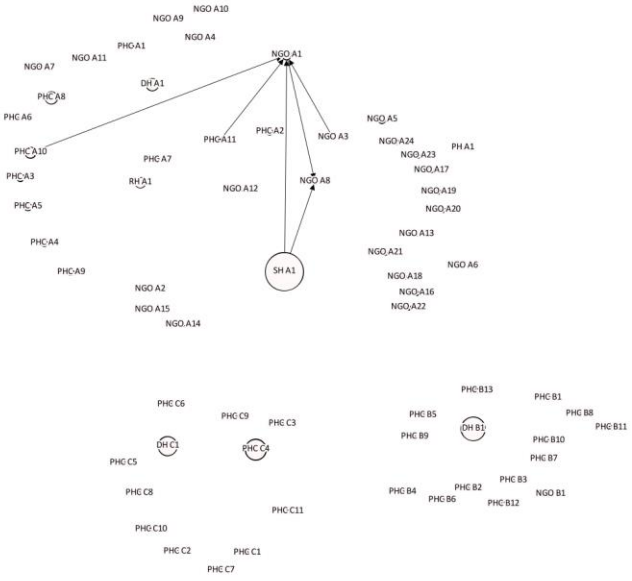

Figure 11: Therapy and rehab

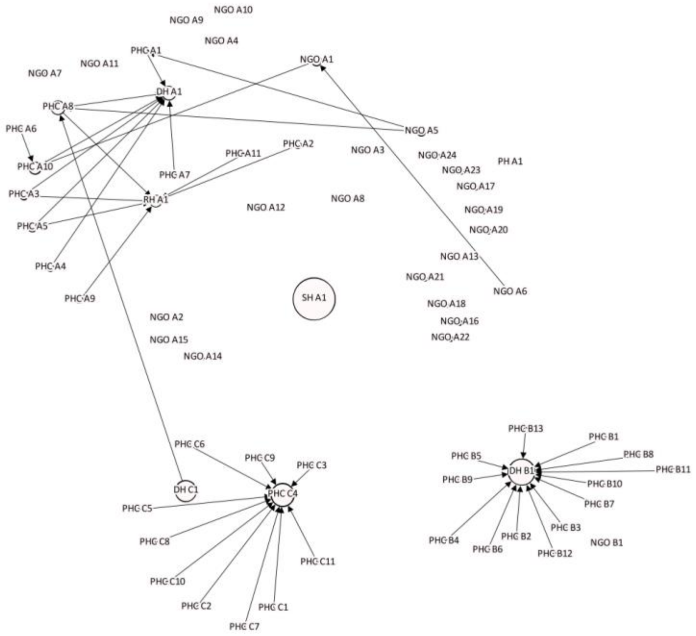

Figure 12: Acute cases

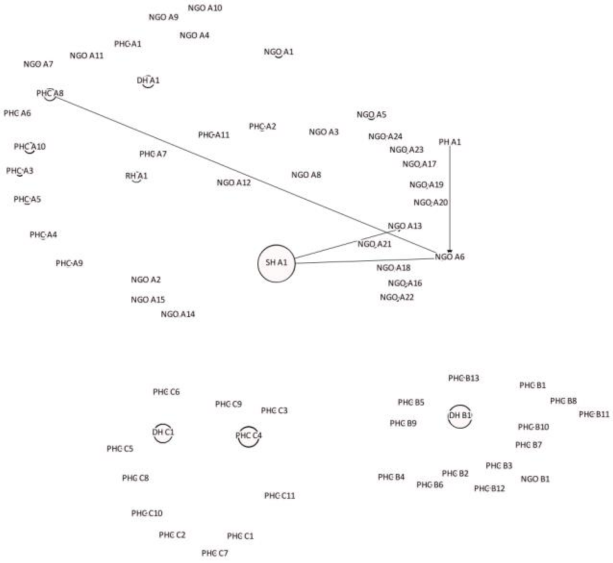

Figure 13: Family support

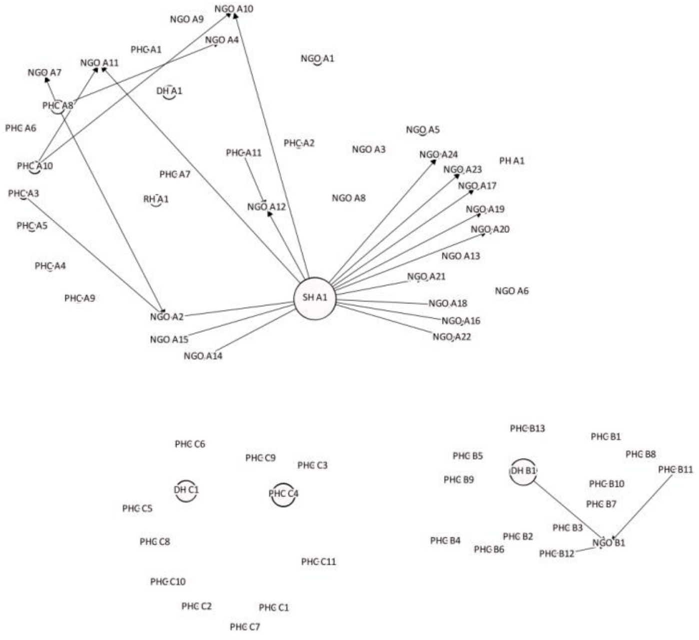

Figure 14: Housing and treatment adherence

Table 8: Types of network interactions

Reason for collaboration	**Number of interactions**	
	n	%
Outpatient drug therapy	*58*	33.14
Acute cases	*42*	24.0
Serious cases	*34*	19.43
Housing	*25*	14.29
Drug and alcohol rehab	*6*	3.43
Psycho-therapy	*6*	3.43
Family support	*4*	2.28

Semi-structured interviews further illuminated the reasons for collaboration. The point was made – especially by PHC clinics – that in the absence of adequate community-based assistance for mental health service users, there is a great deal of state reliance on NGOs. NGOs created a link between the state health system and mental health service users in the surrounding communities. By identifying people in need, and providing them with housing and basic needs, these organisations also linked them up with their local PHC clinics and district hospitals for psychiatric care. Facilities with a presence of social work as a core service voiced appreciation for collaboration with NGOs. This said, singular participants viewed NGOs providing mental health services with contempt and suspicion, and did not see a necessity to collaborate. Such participants were of the opinion that the state should solely be responsible for service provision, and recommended that collaboration with NGOs that provide housing services should be replaced with state institutionalisation of mental health service users. The most important reasons for collaboration between state and non-state service providers were drug and alcohol rehabilitation; psychotherapy and psychosocial rehabilitation; family support; and housing and treatment adherence. While all these functions fall in the regulatory sphere of the DoSD, there was some overlap with the DoH in that state health facilities referred mental health service users to NGOs that provide housing and treatment adherence. It was not entirely clear to what extent such NGOs were regulated. Several state health care workers voiced concern about the conditions of these NGOs, but very few had visited these facilities, citing NGOs as the purview of the DoSD and social workers. NGOs in turn relied heavily on state health care facilities for the clinical and pharmaceutical treatment of their clients, even though some alleged that mental health service users are neglected when seeking care in state facilities. The state psychiatric facility collaborated with NGOs in terms of the processing of statutory and forensic cases, as well as relying on non-state social workers to access communities to follow up on deinstitutionalised mental health service users. In cases where mental health service users became violent or experienced psychosis, the local police station was contacted for transport support. Many participants mentioned difficulties in transporting mental health service users suffering from psychosis between facilities. Subjectivities of dangerousness and risk emerged, that were tied together with inflections of stigmatising attitudes of state health care workers towards mental illness. A general unwillingness of state health facilities to "deal" with mental health service users who exhibited psychotic episodes was described, and ambulance services were dismissed as a possible transportation option. Despite an apparent lack of training and willingness of police officers to assist, transporting mental health service users was seen as a police function, because "…we can't carry the patient of something into a car. It's not as if he will say, 'please, thank you I will get in', and drive away" (CC_NGO8). In the absence of police assistance and ambulance service availability, local NGOs were asked to assist with transportation. One NGO participant mentioned that he frequently used his pick-up truck to move mental health service users from state health facilities to his housing facilities, stating that "They want to get rid of that person. They then they phone us" (CC_NGO3).

Power

Power emerged in several forms. As suggested by the SNA results, state hierarchy alongside provincial health service referral policy was a particularly strong primer for collaboration. Power in terms of network centrality (Figure 6) was closely associated with professional capacity. Accordingly, hospitals with stronger concentrations of mental health professionals seemingly received and referred more mental health service users, resulting in a hospital-centric referral system. One participant expressed frustration that

– despite regular awareness – PHC level state-run facilities did not refer mental health service users to them for further care and support, rather opting for hospital referrals:

> *It is a farce, because this organisation is 68 years old and they don't even know our name* (CC_NGO2).

This observation and the salience of professional power was supported by a state mental health nurse, who expressed unwillingness to refer mental health service users to non-state actors due to a perceived lack of psychiatric expertise on their part:

> *We advise them to not go there…Because I don't think they are with us. You can see other referrals. They are not with us. There's no private doctor who can think he can manage psychiatry* (PN_DH2).

It emerged that different mental health professionals equated different sources of power. A clinical psychologist remarked that nobody had a voice in mental health care, except for psychiatrists. Psychiatry and clinical psychology was almost exclusively concentrated in hospitals, and PHC clinics relied heavily on the psychiatric outreach team to process mental health service users' clinical treatment regimes. This source of power was also evident in terms of NGOs linking up with state hospitals (and not with PHC clinics). The significance of this power dynamic was particularly reflected in the reluctance of some participants to refer mental health service users to facilities outside the state services sphere – supporting the suggestion of weak state and non-state service providers (Figure 7). The biomedical slant and clinical nature of state facilities – compounded by the apparent chasm between the DoH and DoSD – further blocked participants from more holistic approaches that take into account living conditions and employment as key elements of mental health care. In this vein, a crucial form of professional power in facilitating state and non-state collaboration was the influence of social work as a profession. There seemed to be a suggestion that social workers are key agents in bridging the state and non-state collaboration gap, and several instances emerged that substantiate this deduction. For example, state social workers had power to provide forensic and specialised treatment for mental health service users, while non-state social workers had access to community settings and people's homes. These services were an important point of collaboration between the state psychiatric hospital and an NGO.

Quality, effectiveness and efficiency of care

Finally, when probed on what is necessary to improve mental health services, study participants made several recommendations. Efficient health information and referral systems were viewed to be dysfunctional, making tracking mental health service user care almost impossible – especially between state and non-state service providers. This is illustrated in the following outtake:

> *You're giving a date and say: 'Go there". So as soon as this person walks out of here, we don't know. Because they never bring back, like even our patients themselves never bring it back to us and say: 'I went there and this is what happened'. So we're not sure what happens at the end* (PN_PHCC3).

The need for reliable and appropriate transportation for moving mental health service users between service providers was widely discussed. This need was especially pressing in cases where there was reliance on police assistance with transporting people experiencing psychotic episodes to hospitals. District hospitals – who are supposed to admit and evaluate people suffering from psychosis for a mandated 72-hour period – lack both the appropriate infrastructure and mental health professionals to achieve this objective, often leading to mental health service users being discharged before receiving adequate care. Drug stock-outs were mentioned by some participants on PHC level. NGOs providing housing and treatment support highlighted a need for state funding, better physical infrastructure and facilities, and more clinical support from state mental health professionals. Shortages of mental health professionals, especially in community and in rural settings, were highlighted. A lack of state stewardship, leadership and governance in mental health care was discussed by both state and non-state participants, both on provincial and national levels. As mentioned above, and related to this challenge, NGOs called for alternative funding structures, as well as for improved compensation for services rendered. Financial need was discussed by the bulk of participants, which relate to operational costs, infrastructure, and human resources – all translating into the quality of care provided. This was simply illustrated as follows:

> *Without money, we cannot provide services. You can't fill your car with petrol and you can't drive to see your clients. I can't drive to conduct my group sessions and drive to go do community work* (CC_NGO2).

Discussion

Despite global mental health service improvements during the past decade (Horton 2007; Tomlinson et al. 2009; Collins et al. 2011; Patel et al. 2011; Patel and Saxena 2014; Thornicroft and Patel 2014), and the introduction of a dedicated mental health care policy in South Africa (South African National Department of Health 2013), our findings suggest that much is left to be achieved at local levels of service delivery. The MHPF adds to calls underlining the primacy of strong collaboration between state and non-state service providers (Janse van Rensburg and Fourie 2016; Savage et al. 1997; Millward et al. 2009), though it may seem that the 'wicked problem' of mental health in health policy (Hannigan and Coffey 2011) indeed produces few success stories (Mur-Veeman, Van Raak, and Paulus 1999).

Regarding the extent of state and non-state mental health service collaboration, the network data suggested a sparse, relatively weakly integrated network with low network density and average degree. Worryingly, and in contrast to policy directives – centrality measures suggested that the collaboration network was largely dominated by hospitals, particularly by the state psychiatric hospital. The absence of contact between service providers and traditional healers was surprising. This support previous qualitative findings from South Africa that suggested a lack of collaboration between the formal health sector and traditional healers in mental health, compared to programmes such as HIV (Campbell-Hall et al. 2010). Indications that a large proportion of South Africans seek mental health care from traditional healers (Sorsdahl et al. 2009) elevate the importance of this collaborative gap. Ultimately, this particular network was weakly integrated in terms of sub-optimal primary and community care and the domination of acute care sectors (Mur-Veeman, Van Raak, and Paulus 2008). The complete absence of formal service agreements further puts the network at the weak end of the integration spectrum (Nicaise et al. 2013). The necessity of NGOs as conduits to communities becomes pressing in spaces where the formal state is relatively weak (Donahue 2004), and our study add to previous indications that very little mental health service collaboration occurs on district-level in South Africa (Hanlon et al. 2014),

There is a distinct silence in academic literature on mental health service networks in LMICs. In one of very few empirical articles related to the subject, Van Pletzen and colleagues (2013) explored partnership networks of health-related NGOs in South Africa, finding wide variations in numbers, resources, and orientation of partnership networks. Studies that focus on state and non-state sector collaboration remain crucially under-researched. This is an important omission, given the development potential of social network analysis to foster stronger state and non-state collaboration (Provan et al.

2005). In South Africa, this ideal is crucial in the wake of the Life Esidimeni tragedy. The country's substantial disease burden, as well as its significant inequalities and inequities in terms of race, sex, spatiality and access to health care – a result of centuries of colonialism and apartheid rule – further elevates the need for improved service integration (Fourie 2006; Coovadia et al. 2009; Harrison 2009; Harris et al. 2011; Mayosi et al. 2012; Van Rensburg and Engelbrecht 2012). Our findings underline the persisting legacy of apartheid policy, in that rural, poorly resourced areas still suffer from a lack of service access. This is not to say that quality services are readily available in urban areas, and inequitable access in terms of richly-resourced private for-profit and less well-endowed public service remains a crucial structural challenge in mental health service reform. By drawing from the diverse group of service providers on district level and therefore pooling resources, much progress can be made towards universal coverage (Axelsson and Axelsson 2006).

Similar to other contexts (Mur-Veeman et al. 2003; Fleury et al. 2012; Nicaise et al. 2014), several different points of collaboration – though limited – emerged. Non-state service providers largely relied on state facilities for outpatient pharmaceutical care; serious psychiatric cases; drug and alcohol rehabilitation; and psychotherapy and psychosocial rehabilitation. State facilities in turn relied on non-state sectors for drug and alcohol rehabilitation; psychotherapy and psychosocial rehabilitation; family support; and housing and treatment adherence. Following the Life Esidimeni tragedy, housing and treatment adherence was an especially salient point of collaboration. Instances of distrust in the capacities of NGOs to provide this service, as well as concern over the conditions of some of these NGOs and lack of regulatory oversight, were not entirely unfounded. While investigating the conditions of NGOs falls beyond the scope of this study, the fissures between the DoH and DoSD spheres of governance help to explain some of the main features of the Life Esidimeni tragedy: a breakdown in coordination and communication between state departments and NGOs, lack of regulatory oversight, and importantly, poor stewardship. It is telling that the DoSD does not feature in the official report into the tragedy, despite being stewards of the NGO sector (Makgoba 2017).

Indeed, the nature of collaboration between state and non-state mental health service providers was characterised by an apparent fragmentation between the governance spheres of the DoH and the DoSD, in other words, between medicine and the social. There was an apparent schism between medical-oriented services (outpatient drug therapy, acute cases, serious cases), provided mostly by the state, and socially-oriented services (housing and treatment adherence, drug and alcohol rehabilitation, psycho-therapy, family support), provided largely by non-state services providers. This is not a challenge unique to South Africa, and a lack of health and social service integration within delivery networks has also been noted in high-income countries such as Belgium, the Netherlands, England, and Canada (Mur-Veeman et al. 2003; Fleury et al. 2012; Nicaise et al. 2014). Similar bodies of evidence from LMICs are unfortunately almost non-existent. Knocking down the “Berlin Wall” between health and social care has been an onerous and persistent challenge faced by governments globally (Dickinson and Glasby 2010), and its presence in the present case was telling. The primary goal of state and non-state collaboration is to produce outcomes that cannot be achieved by separate actors and sectors (Emerson, Nabatchi, and Balogh 2012). The inter and intra fragmentation of coordination between government (DoH, DoSD, and police) and NGOs can result in mental health service users not receiving the most basic elements of care such as safe transport and shelter, as was vividly illustrated in the Life Esidimeni case. To a large degree, fragmented mental health care on organisational level boils down to failures in stewardship and leadership. Participation in a mental health service network is closely tied to effective leadership, determined by leaders whose interpretations and motivations influence the choice of collaborative partners (Purdy 2012). The responsibility for fostering multisectoral and state and non-state collaboration is at the feet of provincial government (South African Government 2004), who need to fulfil their constitutional mandate. The critical mechanisms of mental health stewardship and leadership in this network is described elsewhere, with particular attention paid to the promise of regular stakeholder roundtable discussions as a governance strategy with which to foster stronger collaboration (Janse van Rensburg et al. n.d.a).

Many challenges to organisational integration are rooted in relations among network members, each whom have their own interests and agency (Provan et al. 2005). In many instances, collaboration serves ulterior political motives, taking on a "perfunctory, cosmetic" veneer (Wanna 2008, 10). Our findings revealed power – a key feature of integrated health care policy implementation (Erasmus and Gilson 2008; Gilson and Raphaely 2008; Lehmann and Gilson 2013; Janse van Rensburg et al. 2016) – in different forms. State government hierarchy and provincial health system referral policy were seemingly strong influences in collaboration. Authoritative power – "power over" – is firmly couched in the hierarchical health service organisation of South African districts (Lehmann and Gilson 2013). Implementation of integrated care policy is difficult in divergent networks with significant power disparities and conflicting perceptions of service delivery (Fleury, Mercier, and Denis 2002). Resistance to such power structures can be found in health care workers bypassing traditional lines of authority, as well as in coalitions between NGOs, as has been the case in the establishment of NAWONGO (Janse van Rensburg et al. n.d.b). These features of power require further unpacking, similar to other work on power and resistance in health service provision (Lehmann and Gilson 2013, 2015; Scott et al. 2014).

Limitations

The cross-sectional study design may have limited the possibility of valid claims – network depictions require frequent revision given the longitudinal dynamics of inter-organisational service collaboration (Mur-Veeman et al. 2003). The strategy followed to identify the mental health network in this study has an inherent drawback, in that isolated mental health service providers are under-represented. It could be that the identified network is not all-inclusive, since some organisations that provide mental health services might just not be effectively linked to the network under scrutiny. Genuine mental health service reform requires sincere participation of all stakeholders (Fleury, Mercier, and Denis 2002), and both organisational and population perspectives inform integrated mental health service networks (Fleury 2005). Our study did not include the voices of mental health service users and their families, which certainly opens avenues for further research. Referral rates are a common indicator of inter-organisational collaboration (Craven and Bland 2006). The weight of network referral linkages – an original goal of the study – could not be determined due to the almost non-existence of coordinated, valid monitoring data. An important facet of fostering integrated mental health services lies in the measurement of system performance by means of indicators that transcends policy domains (Plagerson 2015), a feature sorely missing from the present district health information system.

Recommendations

The Life Esidimeni crisis (Makgoba 2017) in many ways exemplified South Africa's protracted struggle towards comprehensive public mental health care provisioning. LMIC mental health services have been typified by resource investment in the clinical, facility-based aspects of mental health care with a focus on symptomatic and short-term care (Saraceno and Dua 2009). The social dimensions of care have been shifted to the sphere of NGOs, who are often inadequately supported, disparate and not well integrated with state health services, rendering the continuum of care disjointed (Petersen, Lund, and Stein 2011). A re-assessment of funding models is required here, as investments need to follow mental health service users from hospitals and clinics to the community. Crucially, integrated health services require inter-institutional arrangements such as policy and financial re-structuring, but also attitudinal, cultural and power changes and professionals' consensus on the division of labour (Mur-Veeman et al. 2003). In order to create and foster appropriate models of integrated community-based care, an expansion is required from the "clinical" to the "social" dimensions of care, to include vital human rights aspects such as functioning, disability and social inclusion (Petersen, Lund, and Stein 2011). The MHPF already underline these ideals (South African National Department of Health 2013), but provinces are required to formulate and operationalise area-specific plans in line with this policy. This is an important consideration towards creating contextually-sensitive mental health services, as uniform policy implementation may not adequately accommodate the variations of state and non-state service providers, nor the marked differences between rural and urban settings (Van Pletzen et al. 2013).

Conclusion

The fractured nature of mental health service provision in LMICs persists, despite significant progress during the past decade. This study underlines crucial gaps in organisational integration among mental health service providers, as well as pointing to complex dynamics among state and non-state sectors in health care provision. Many mental health service gaps were touched upon, including fragmented services, low engagement between partners, and hospital-centric care. Power remains a key consideration towards better understanding how policies unfold in different contexts and among different actors. The coordination and collaboration explored here require inputs from mental health service users and their families, a substantial missing piece in including the voice of policy beneficiaries and building towards better care continuity. These complexities can only be comprehended through a lens of plurality, and require evidence-based, rigorous research. Ultimately, the window of opportunity in terms of the global, regional and national momentum gained during the past decade towards building public mental health services in LMICs should be grasped in its entirety. The purpose of this Chapter was to empirically explore the three objectives of the research, namely (1) the dimensions and structure of integrated mental health care in South Africa; (2) referral and collaborative ties in the mental health service provider network; (3) and the relations between state and non-state mental health service providers. In the following Chapter, some of the key findings of this chapter is explored in more depth.

Chapter 6: Governance and power in mental health service provision

> *And the greatest evil of government, what makes it a bad government, is not that the prince is wicked, but that he is ignorant.*
>
> ***- Michel Foucault, The Birth of Biopolitics*** (2008, 17)

Prelude

In the final empirical chapter, the key arguments of the study are put forth. Drawing from additional qualitative research on the study in Chapter 5, it is suggested that important structural ills in the governance of mental health care – notably the disjuncture between health and social development sectors, state and NGO relations, and the commodification of PLWMI – are the result of governmentality practices inherent to the conditions of advanced liberalism in post-apartheid South Africa. Importantly, the chapter aims to bring together selected strands of the dissertation, namely the complexities of integrated mental health care; the different dimensions of governance, power, and resistance; and the conditions that encompass the relations between key stakeholders in mental health service provision in a South African district. Additionally, the chapter points to an important consideration in this study, namely the stewardship of mental health care, and briefly explores how it is shaped by neoliberal conditions.

At the coalface of collaborative mental health care: Governance and power in district-level service provision in South Africa

Article Janse van Rensburg A, Khan R, Wouters E, Fourie P, Van Rensburg H and Bracke P. At the coalface of collaborative mental health care: A qualitative study of governance and power in district-level service provision in South Africa. *Accepted for publication in The International Journal of Health Planning and Management*.

This article was conceptualised by André Janse van Rensburg, who also wrote the first draft. Co-authors provided valuable critique and input.

Abstract

Background

Globally, there is an urgency to address fragmented mental health systems, especially in low-to-middle income countries. In pluralistic health systems, closer collaboration between state and non-state mental health service providers have become a central strategy to strengthen care. Both the structure and governance of integrated models of care are crucial mechanisms towards fostering better systems of care, though empirical evidence remain sparse. The aim of this study was to understand power in governance processes of public mental health service provision, in a South African district.

Results

Collaborative processes were significantly state-owned, in terms of funding models, administrative and legislative jurisdiction, and state hierarchical referral structure. No

formal agreements were in place, elevating the importance of key network actors to bring less-endowed NGOs into collaborative relationships. Wide variation in terms of access to resources emerged, especially regarding of mental health professionals. Psychiatrists and social workers were especially powerful resources. Although NGOs were a vital part of the service network, they were hamstrung by resource constraints. Sectorial fragmentation between the Departments of Health and Social Development were telling in district forums, were several siloed meetings took place regarding mental health service provision. An apparent split emerged between state facilities providing biomedical services, and NGOs providing socially-oriented services. There was a general lack of consensus on the nature and definition of mental illness. People living with mental illness were incentivised as forms of income for NGOs. Regarding stewardship, funding models were tied to physical dimensions of disability, and mental health was de-prioritised as a welfare concern. Selected instances of resistance to power structures unfolded, some participants sidestepping traditional hierarchies and inflating disability to gain access to funding and support.

Conclusion

The paper highlights the complexities and different facets of power that underwrite the governance of integrated mental health care in a South African district, adding to growing literature on the social mechanisms that influence collaboration. The study confirms and expands on previous studies of the crucial role of health system governance, and, importantly, illuminates the role of power in integration and fragmentation of mental health services.

Key words: Mental health services, Collaboration, Governance, Power, South Africa

Introduction

Globally, there is growing urgency to address mental, neurological and substance abuse disorders in integrated, cost-effective ways – especially in low-to-middle income countries (LMICs) (Patel et al. 2007, 2013; Ngo et al. 2013; WHO 2013; Jack et al. 2014; Patel et al. 2015; Wainberg et al. 2017). In South Africa's pluralistic, state-driven health system, close collaboration between public and private mental health service providers is a key strategy in addressing the burden of mental illness (Janse van Rensburg and Fourie 2016). Private (non-state, non-government, or third-sector) organisations are an established and core component of local public service provision. However, research into their dynamics with public entities remains limited (Bovaird 2014). What is known is that the organisation of these relationships unfolds in hierarchies, markets, networks, or – in South Africa's case – hybrid structures of service delivery (Markovic 2017). The inclusion of NGOs and other private partners in healthcare provision has gained traction due to weakening formal states and the loss of legitimacy in centralised state governance, as well as the gradual acceptance that complex social problems cannot be resolved by the state alone (Donahue 2004; Emerson, Nabatchi, and Balogh 2012).

Similarly, mental illness cannot simply be resolved with pharmacology and psychotherapy, but requires collaboration across services to effectively address its devastating effects on both individuals and communities (Thornicroft and Tansella 2002; Millward et al. 2009; Mechanic, Mcalpine, and Rochefort 2014). Despite increased global efforts to achieve the ideal of comprehensive mental health care by integrating social and health services, success has been mixed (Mechanic 2003; Butler et al. 2008, 2011; Maruthappu, Hasan, and Zeltner 2015). Paradoxically, integrated care initiatives have been plagued by fragmented approaches, across different contexts, health systems, cultural and governance structures, and definitions of key terms (Kodner and

Spreeuwenberg 2002; Ouwens et al. 2005; Kodner 2009). Indeed, collaboration and partnership across the structural and cultural boundaries of siloed approaches has become something of a unicorn, both attractive and seemingly unattainable (Fimreite and Lægreid 2009). The division between health and social sectors particularly affects socially marginalised people, with chronic conditions including people with mental illness (PWMI) (Nicaise et al. 2013). In South African healthcare, "operational governance is embedded within and influenced by the organizational and system-level governance arenas", and local service managers are often faced with constraints from broader organisational and system design issues (Scott et al. 2014, 67). The failure of national mental health policy implementation on district levels is an effect of decentralised governance to provinces, leading to fractured prioritisation, implementation and monitoring (Draper et al. 2009; Van Rensburg and Engelbrecht 2012). In such settings, integrated systems of care become even more difficult to achieve (Mechanic 2003).

The fragmentation of care is a real and pressing concern for health systems. In the case of mental illness, the knocking down of the "Berlin Wall" between health and social care has been an persistent challenge (Dickinson and Glasby 2010). Across the past two decades, a wealth of literature has spawned addressing how to break down this wall and create integrated health systems, with governance highlighted as especially critical (Mitchell and Shortell 2000; Mur-Veeman et al. 2003; D'Amour et al. 2008; Valentijn et al. 2013; Valentijn et al. 2015; Janse van Rensburg and Fourie 2016; Janse van Rensburg et al. 2016). The dynamics of governance mechanisms in collaborative arrangements are crucial in fostering beneficial partnerships (Hill and Lynn 2003), but evidence of the particularities of the governance processes are lacking (Willem and Lucidarme 2014), as are questions on how to effectively govern networks geared towards 'wicked problems' (Cristofoli, Meneguzzo, and Riccucci 2017). Simply put, we cannot expect to begin to understand outcomes before opening up the black box of the social processes of governing public-private collaboration (Brazil et al. 2005; Pawson 2006). The governance of service delivery networks requires empirical insight into the processes of power and influence (Heen 2009), and herein lies our study focus. Building on the findings of Chapter 5, in this Chapter we interrogate the relations between state and non-state mental health service providers, in a South African district (Chapter 1). Accordingly, the principle aim of this study was to understand power in governance processes of district-level public mental health service provision.

Methods

The findings were derived from a larger, mixed methods study that involved social network analysis as well as key informant interviews. As a study of governance dynamics within a geopolitical delineated space, with distinctive units of analysis, this study employed a qualitative single-case embedded design (Yin 2009). From October to November 2015, all 66 public and non-state health facilities providing mental health care in Mangaung Metropolitan District were visited, and social network data were collected. Following initial analysis, pertinent network groupings of public and non-state service collaboration were identified for further in-depth analysis (see Table 5 for breakdown). These participants were augmented with key informants identified through a snowball sample that involved asking participants to identify influential actors in district-level mental health care (see Table 6 for breakdown). 20 semi-structured interviews were conducted in face-to-face settings, yielding 23 hours of discussions. As all participants were fluent in English, all interviews were conducted in English. Interviews were audio recorded, transcribed verbatim, and analysed with the assistance of NVivo10 (QSR International 2016).

Table 9: List of state/non-state mental health collaborations

State facility		Non-state facility	
Code	*Services provided in collaboration*	*Code*	*Service provided*
Clinic	Out-patient drug treatment	NGO	Housing, rehab, treatment adherence
Clinic	Out-patient drug treatment	NGO NGO NGO NGO NGO	Social/welfare services, psychotherapy Housing/rehab, treatment adherence Housing/rehab Substance abuse rehab and prevention Housing, treatment adherence
Clinic	Out-patient drug treatment	NGO	Social/welfare services, psychotherapy
Psychiatric hospital	Acute and serious case processing; social/welfare services	NGO NGO	Social/welfare services, psychotherapy Housing/rehab
Clinic	Out-patient drug treatment	NGO	Housing, treatment adherence
District hospital	Out-patient drug treatment; acute and serious case processing	NGO	Housing, treatment adherence

Table 10: List of key informant positions and affiliations

Position	**Affiliation**
	State
Senior psychologist	Government department; Specialist hospital
Programme director	Government department
Psychiatrist	Psychiatry outreach team; District hospital
Psychologist	District hospital
Mental health nurse	District hospital
Mental health nurse	PHC clinic
	Non-state
Case worker	Non-profit organisation
CEO	Private for-profit psychiatric hospital
Director	Non-profit organisation

A thematic analysis approach was followed, namely, “summative, phenomenological meanings of text… [that] represent the essences and essentials of humans’ lived experiences” were categorised according to a theoretical framework (deductive) and were constructed from repeated reading of the transcripts (inductive) (Saldaña 2014: 596). Pre-determined themes were deductively generated from the Framework for

Assessing Power in Collaborative Processes (Purdy 2012). Themes related to health system stewardship emerged inductively during the data analysis process. Three researchers negotiated themes and their content to achieve consensus, and to remove overlap from the data. De-identified direct quotations were used to support thematic categorisation. Participants were informed in writing and verbally of the purpose of the research, were guaranteed anonymity and confidentiality, and all provided informed consent. All ethical approvals were obtained from the researchers' institution.

Findings

The findings are presented as follows: First, the themes derived deductively from Purdy's Framework for Assessing Power in Collaborative Governance Processes (2012) are presented, according to the processes of collaborative governance in public administration. This includes *Participants*, *Process Design*, and *Content*, presented in terms of different arenas of power. Second, during the analysis several themes emerged inductively from the data, which were merged after negotiation and consensus among researchers. These themes largely related to *Mental health stewardship* and included the sub-themes *Information and monitoring systems*; *Mental health financing structures*; *Prioritisation*; *Mental health within broader reforms*; and *Strategic leadership*. Finally, limited indications of *Resistance* to governance processes emerged.

Participants

Participants and Formal Authority

Participation in the district mental health service delivery network was influenced by state health system hierarchy, a key feature of formal authority. Public participants mentioned that they are firmly bound to provincial referral policy that omits non-state service providers. Private participants in turn were cognisant of the importance of adhering to these formal rules. NGOs sought out PHC clinics in their geographical area to access clinical care for clients suffering from mental illness. Public facilities in turn referred people suffering from mental illness for psychosocial aftercare to NGOs. However, the limited service capacities of NGOs in rural areas were perceived by public service participants as constraints to collaboration. NGOs were further heavily dependent on Department of Social Development (DoSD) funding, and Department of Health (DoH) participants seemingly did not engage in this issue, and showed reluctance to operate outside of the DoH governing sphere. Identification documents, welfare grant management and other social support issues were perceived to be within the ambit of NGOs with social workers in their workforce – under the legislative governance of the DoSD. Public participants often chose organisations that provided basic care and housing to collaborate with, in agreements that in some cases spanned several decades. In this vein, old age homes were mentioned to be particularly "useful", since facilities for geriatric care were perceived to be appropriate for the management of mental illness. In an almost complete absence of public substance abuse rehabilitation facilities, several public facilities collaborated with an organisation providing substance use rehabilitation, subsidised by the DoSD for limited beds on a monthly basis. It was made clear though, that the state maintained responsibility for mental health care, as illustrated by the following excerpt:

> *Whether they get funded through grants, or through tax increases, or whatever, the work that NGOs do is the state's responsibility. The only reason that they do it is because they do it on behalf of the state. So you can never financially untie yourself from an NGO* (SW_TH).

Participants and Resources

Participants varied in their access to resources within collaborative arrangements, demonstrated by the affordances to differing professional backgrounds. The bulk of clinical experts – including psychiatrists, psychologists, mental health nurses, and social workers – were situated in public health facilities, particularly in hospitals. NGOs leveraged occupational therapists at public hospitals in order to complete assessments required for their clients to gain access to welfare grants. The discipline of social work was highlighted as a key mechanism in collaboration between service providers. Social workers' embeddedness in and access to community-based resources was highlighted as a vital point of collaboration with different partners. For example, social workers were valuable role-players in a collaborative arrangement between the public psychiatric hospital and a specialised mental health NGO. Social workers at the hospital served as gatekeepers for the NGO to specialised services, while social workers from the NGO conducted home visits and provided other community-based services for the hospital.

Participants and Discursive Legitimacy

Discursive legitimacy emerged in terms of the status of participants and the use of coalitions to further interests. There was a sense of distrust in the capacities of public officials to lead mental health care, due to concerns related to corruption and political venality. On the other hand, some public participants were distrustful of NGOs providing mental health care. Others were of the view that NGOs are an essential part of the service delivery network, and opined that "at times it seems as if even we rely on them more than they rely on us really" (PN_PHCC1). Some NGO participants thought that they had special abilities to work with and manage mental illness (especially psychosis), not tied to professional mental health disciplines:

> *We know how to handle them. I think it is my work from the heaven because if I come here and talk to the people with mental (sic), they listen to me* (CC_NGO1).

NGOs varied widely in terms of resources, with one participant stating “skilled workers equals money, and money is our only drawback” (CC_NGO4). A constrained funding environment resulted in some participants using personal resources to keep their organisations afloat. While some NGOs employed mental health professionals, others focused on providing basic care such as clothing, housing and treatment adherence and were therefore dependent on public facilities for clinical services, as well as public funding. Well-funded NGOs saw themselves as superior to public service providers in terms of quality, cost-effectiveness and efficiency, and one stated that “the state does not have the resources. They don’t have the money to keep this massive machine going” (CC_NGO3).

Less well-funded NGOs that provided mental health services were perceived to be struggling not only in attaining human resources, but also financially – especially in contrast to well-funded programs such as HIV. Some public participants revealed a degree of sympathy towards the plight of mental health NGOs in light of little support from DoSD. This status did however afford NGOs the status of champions for the poor and neglected, despite the personal financial constraints faced by workers. NGOs sometimes used strategic partners as a source of power, engaging with influential state actors in order to ensure service delivery. For example, an NGO providing housing, treatment adherence and basic social care to PWMI struck up a relationship with a mental health focal person in a district hospital, giving them access to district mental health meetings and increasing their visibility to PHC clinics in the area. In return, the district hospital viewed the NGO as a halfway house, where PWMI can be managed in terms of treatment adherence.

Less-endowed NGOs suggested they were equal partners with the state. Some public participants echoed this sentiment, although others were less enthusiastic about the status of NGOs providing boarding and treatment support to PWMI. Deeper state engagement in monitoring NGO activities was recommended, with increased involvement of mental health professionals. The legitimacy of both non-state and non-clinical actors was called into question, rooted in a strong belief that public mental health professionals providing care in hospitals are a superior strategy in service delivery. One mental health nurse made it clear that NGOs are “outsiders”, supported by the state, suggesting that NGOs are service providers rather than partners. Many public participants had little insight into the services rendered by NGOs and had never visited the premises. This said, one public mental health nurse expressed a desire to visit these NGOs to provide assistance and clinical support, however hospital management made it clear that this responsibility falls beyond the DoH’s sphere.

Psychiatrists were identified as particularly powerful in district mental health decision making, due to psychiatry’s legitimacy compared to that of social work, psychology, and nursing. In service delivery, the psychiatric hospital was seen as having elevated status, which was amplified as it also served as the base for psychiatric outreach, NGOs mentioned that the bulk of their clients are discharged patients from the psychiatric hospital, suggesting a level of dependency on the hospital for a client base. NGOs also had the status of being an agent conduit for community access, in that public health workers often relied on them to follow-up on patients and assess their living conditions – a responsibility that fell through the cracks between social work in DoH and social work in DoSD. This again illustrated the role of social work in the service network, as these workers created a bridge between public and non-state spheres. A fitting example is the arrangement was seen between the public psychiatric hospital and an NGO run by social workers, where the NGO was used to provide services falling outside the sphere of legitimacy to patients.

Process Design

Process Design: Formal Authority and Resources

Collaborative processes were significantly state-owned. This is apparent in the dependence of NGOs on state funding, administrative and legislative support, as well as the hierarchical nature of referral patterns according to levels of public health care. No formal agreements were in place, and collaboration occurred in a piecemeal, informal fashion, dependent on key actors in health facilities to reach out to others in order to extend the scope of care for patients suffering from mental illness. It was expected that NGOs refer patients in need of clinical treatment to public facilities, or in rare cases where patients had appropriate medical insurance, to a private psychiatric institution. Public facilities, in turn, were expected to refer patients to relevant NGOs according to geographical access and specific needs. Expectations between public and private service providers generally depended on the specifics of collaborative relationships. In general, the expectation was that public facilities provide clinical treatment, while NGOs provide different types of social care – including housing, treatment adherence support, psychosocial rehabilitation and psychotherapy, and drug and alcohol rehabilitation. Participants from NGOs frequently visited public facilities while accompanying patients in their care, while public participants rarely ventured out of the public service provision sphere. The responsibility to initiate and foster collaboration with non-state service providers was the states responsibility, both by public and private participants.

Instances of conflict among NGOs and public facilities emerged in administration of correct paperwork and patients' personal identifying documentation. The importance of this expectation was tied to both NGOs and their clients' dependence on social welfare grants, a procedure that relies heavily on correct documentation. Public participants expected NGOs to bring identification and medical documentation with them during visits, sending NGOs back if documents were absent. Given the processing and governance value of such documentation in healthcare access, this expectation placed public facilities (with their clinical expertise) in an advantageous position. In turn, NGOs provided information of their services to public collaborators. In one collaborative case, between a public psychiatric hospital obtained information on types of therapy and psychosocial support groups available from the NGO, so that they could refer patients accordingly.

Meetings between public and non-state collaborating partners differed substantially, ranging from informal telephonic contact to regular formal face-to-face meetings. The psychiatric hospital offered a yearly catered social as a way of thanking NGOs for their efforts. The most prominent space for contact was a quarterly mental health district forum, held at and paid for by the DoH provincial headquarters. Selected non-state service providers in the service network were invited and participated. While many public participants felt that this meeting proved an opportunity for collaboration, private participants seemed less encouraged about the effectiveness of these meetings. Some went as far as to describe the meetings as political grandstanding, having no clear structure, aims and outcomes, stating:

> *If you look at what is said in Batho Pele [national patient rights charter] that every person has a right, have a right to best health services that he can get. I go to the Free State mental health*

> *meetings, where the police and all that sit and then you have to listen to countless promises and whatever, and I just shake my head* (CC_NGO3).

Process Design and Discursive Legitimacy

Sectorial fragmentation emerged in district forums, where several siloed meetings related to mental health were held between public and private participants. Some participants took part in a forum for mental health (driven by DoH), some in a forum for NGOs (driven by a NGO coalition), some focused on addiction and rehabilitation (driven by DoSD), and some in a forum focusing on disability (driven by DoSD). The participants did not seem to perceive mental health as a cross-cutting, multifaceted phenomenon, and it was often framed in terms of a medical challenge under the stewardship of the DoH.

Communication about the collaboration processes occurred in some instances via referred patients the patients themselves carrying their own medical information with them. However, the NGO expressed dissatisfaction with the process, as some patients would be referred without notice and little information. Additionally, public PHC clinics also expressed this sentiment, seeing a lack of communication and coordination when NGOs brought their clients for care.

Content

Content and Formal Authority

Within one public and non-state relationship, there was a mutual expectation that the NGO would provide six weeks of care for patients, after which patients would return to the psychiatric hospital for outpatient care. However, participants from this particular NGO took part in this arrangement somewhat begrudgingly, questioning the fairness of the weight in the division of labour. For more than a decade preceding the interviews, tension had been building between NGOs and the state – specifically the DoSD – based on compensation for social, welfare, and mental health services provided. One NGO made it clear that the care of people suffering from mental illness was the states' responsibility, and that NGOs fill the role of contracted service providers (that had to be used because of the claim that they can provide higher quality, more cost-effective social services):

> *Now the answer is given – it is the state's responsibility, this is said in the Constitution [but] they must prove that they can do the services better and provide cheaper ones. Otherwise, they must use our services* (CC_NGO4).

The nature and governance of district-level mental health collaboration was subjected to intense scrutiny, when, more than a decade earlier, Free State-based NGOs formed a national coalition with the purpose of taking the DoSD to court in order to clarify the role and compensation of non-state entities in providing social and behavioural services. The coalition – the National Association of Welfare Organisations and Non-Government Organisations (NAWONGO) – was particularly geared towards providing a stronger position for NGOs in their relationship with the state. Some NGO participants were particularly aware of their precarious position, providing independent civic services on the one hand and becoming service providers who are dependent on the state on the other: "sometimes [they] feel as if they are walking on eggs, you don't want to annoy them because you are afraid of losing your funding" (CC_NGO7). The arbitrary nature of choice of investment into NGOs by the DoSD was questioned, in that they are supposed to fund organisations with the best capacity to provide the services they need. The point was further made that NGOs and government departments cannot work in partnership, due to a perception that the state uses the term to shift responsibility to NGOs.

Unification of NGOs was perceived as providing greater bargaining power and pooled resources for court and legal fees. Thus, unity in the coalition based on alignment to better funding structures was questioned by some participants, given the multitude of different interests voiced by different NGOs – who also essentially are in competition with each other (referred to as "a minefield" by one participant). Following a narrative of economic cost-benefit considerations, sentiments of despondency were raised:

> *Look, the court case did result in a small increase in subsidy, but if you look at the bigger picture, the increase that did occur was so minimal. Literally minimal, and I really don't think that it was worth the effort* (CC_NGO7).
>
> *The problem is, they ultimately negotiated in such a way that we are painted into a corner. The state said: OK, we will pay you what you should get, but then only the first four organisations on the priority list will be subsidised. We would have fallen away to number ten or twelve, and prevention to number 30. So it would have meant that we would receive no subsidy* (CC_NGO5).

Content and Resources

In the absence of a unified mental health information system, little or no routine information was gathered and shared among service providers. In the public sphere, one of the only indicators gathered by the district health system is the number of new patients. Little evidence emerged that this was used in planning and governance processes. Furthermore, the infrastructural challenges faced by smaller community-based NGOs severely restricted their method and frequency of voice, given that often they did not have a telephone, fax or internet presence, making them dependent on larger NGOs and public mental health actors to access the mental health service network.

Information shared among public and private participants mostly involved telephone conversations and email. For instance, a participant at the public psychiatric hospital queried a mental health NGO to follow up on discharged patients requiring additional support, including assistance with financial management, acquiring identification documents, accessing disability grants, and processing curatorship. Some NGOs did not have initial access to the quarterly mental health forum, and were dependent on key public participants to be formally invited. As far as could be determined, the dialogue was led by the DoH, and minutes were not circulated. The bulk of private participants had no knowledge of the existence of a national mental health policy, and therefore did not analyse mental healthcare according to its strategic parameters. A fractured understanding of institutionalisation emerged. While most public participants voiced that institutionalisation was to be avoided according to public policy, NGOs who specialised in providing housing and basic care framed it rather as a necessity in protecting families from harm, based on their observations:

> *They are beating them. They are beating their mothers, they make so many bad things at home. Their fathers, their families. Their families suffer too much* (CC_NGO1).
>
> *And they assaulted the families and those type of things because the families did not understand from the beginning. The families left them alone and this lead to them for instance being without medication, they guys start using drugs and drink and then they get home and put the house on fire, hit the mom and dad and now everyone is scared, you see?* (CC_NGO3).

Content and Discursive Legitimacy

There was a palpable lack of official strategy and awareness about mental illness and approaches to it, across sectors and service providers. Key differences among mental health providers translated into different interpretations of the causes, meaning and approaches to mental illness. As per the scope of this study, the focus was on mood disorders including depression and anxiety. However, throughout data collection it became apparent that the lack of consensus of what mental illness is and how it should be managed would render any attempt to ring-fence the focus of disorders futile. Therefore, participants' differing understandings of mental illness are described, and how these meanings translated into collaboration.

Perceived causes of mental illness included treatment non-adherence, substance abuse, relationship problems, poverty and the stress associated with life in poverty. Several participants noted that mental illness presented in terms of sleeplessness, loss of appetite, and a general sense of worry. It was noted that mental illness is nebulous in nature, not lending itself to easy diagnosis:

> *Because psychiatry is a difficult thing, you cannot see it. Is the guy depressed or not? I can fake depression* (CC_NGO8).

Some mental health professionals suggested that mental illness presents differently between different cultural and ethnic population groups. In one example it was proposed that white, English and Afrikaans speaking patients tended to complain of feelings of sadness, insomnia and loss of appetite. Conversely, it was suggested that black, seSotho speaking patients expressed symptoms of mental illness in slightly different ways, such as complaining of "warm blood" and more physical ailments – making DSM diagnoses difficult. Furthermore, it was suggested that the different presentations of mental illness lead sufferers to seek care from traditional healers, who were completely absent in the collaboration network of the study. Co-morbidity was cited as a major distraction in diagnosing psychosis, in that psychosis was perceived as a very common symptom of pneumonia, meningitis and HIV. A senior psychiatrist alleged that trauma doctors often refer patients presenting with psychosis directly to the psychiatry unit without further examination, leading to serious conditions such as tuberculosis and HIV being missed. Some were highly sceptical of any form of recovery outside the medical sphere, noting that NGOs should "take the patient when you need and bring it back, because psychiatric will remain psychiatric until they die. That doesn't change." (PN_DH2).

Both public and private participants suggested that many mental health service providers did not have an adequate understanding and appreciation for the complexity of mental health care. Participants rarely distinguished different types or classifications of mental illness. Differentiations that were made largely related to manageability and functioning of patients. Some participants used terms such as 'mental disability', 'mental retardation', 'mental illness', and 'psychotic' interchangeably. People living with mental illness were pejoratively referred to as "mentals", "psychiatrics", and schizophrenics". Often, little or no distinction was made between mental illness and mental disability, a conflation that assumed lower cognitive ability. Serious mental disorders such as bipolar disorder and schizophrenia dominated discussions on mental illness, and narratives related to psychosis, dangerousness, risk and confinement emerged. Accounts unfolded underwritten by the need for police intervention in cases where patients became "uncontrollable" and "dangerous", especially in the absence of adequate medical intervention. Most participants relied heavily on police assistance when confronted with people suffering from psychosis. Some questioned the suitability (as well as the willingness) of the police to transport people suffering from psychosis. A lack of police training in managing psychosis was a concern, the impetus placed on subduing the person in question by any means. This idea was closely related to approaches to mental illness in comparison with other health concerns:

> *If you get a heart attack they call an ambulance, then the ambulance arrives and he will take you to the hospital. If a psychiatric guy is difficult, then who do they call? The police* (CP_TH).

Though beyond the scope of this study, a few participants offered insight into the debilitating consequences of mental illness and the circumstances PWMI find themselves in. Stigma towards PWMI was often discussed: “The community does not view them as normal. So they are giving them names” (PN_DH1). Furthermore, it was suggested that PWMI had a slim chance to gain access to an open labour market. People whose condition debilitate them to the extent that they cannot access the labour market, are vitally dependent on a monthly disability grants paid to them by the DoSD via the South Africa Social Security Agency. In order to access this grant, they require assistance from a social worker and a physician. Within the contexts of abject poverty, many families become dependent on a grantee’s disability stipend. Given the lack of public funding for mental health and social care, many NGOs providing housing and treatment adherence to their tenants used a proportion of clients’ grant money to stay afloat.

A phenomenon materialized where PWMI become sources of capital for NGOs, an occurrence that – given the mentioned lack of regulatory oversight over NGOs – creates spaces for incentives for people rather than for their care. This narrative emerged particularly in discussions on relationships between public and non-state service partners. One participant remarked that the state is similar to someone owning a Kentucky Fried Chicken franchise, but “…if you all take away his customer, he's got nothing. So those customers [NGOs] need him [PWMI], and the same with the state”

(CC_NGO3). Subtle struggles emerged between public and private participants in terms of ownership of PWMI, exemplified by a PHC nurse complaining that collaborating NGO's boundaries of client retention:

> *Last time he even told sister on the phone that I'm even doing you people a favour for keeping these people here. He's doing us a favour? I don't know how. Because he's the one who's keeping the people* (PN_PHCC3).

Mental health stewardship

Mental health financing structures

Public mental healthcare was funded in two different ways. Facilities that provide mental healthcare in the public sphere received their funding from the DoH, while NGOs contracting and disability grants were by the DoSD. The capacity of the state, especially DoSD, to provide funding was called in question, with one participant remarking, "Social Development is obviously non-existent or non-functional" (CP_PHCC4). However, in the context of splintered approaches to mental health as a programme and the lack of provincial policy direction, confusion emerged from some NGOs in terms of under which sectoral governance structures operate.

Adding to confusion was the muddling of the roles of social workers employed by the DoH vis-à-vis social workers employed by the DoSD. DoH social workers were confined to hospital and clinic settings, while DoSD social workers were allowed into community settings. Participants stated that DoH is involved in screening for mental illness, though some were unsure to which extent DoSD funded NGOs provided housing and treatment adherence to PWMI. Funding seemed to be closely tied to the physical nature of disability. One NGO commented that they only started to engage with DoH after self-harm became a problem for clients suffering from addiction. The link between the visible infirmities and funding were further illustrated by the following narrative:

> *But, it is very difficult to get grants for these poor people, because it isn't a physical disability that one can see. One cannot see that his arm is off or that he is blind or whatever. So they have to provide ten times the proof before they are willing to give these poor people a disability grant* (CC_NGO2).

State funding for mental health focused on secondary and tertiary care, where most of mental health professionals were concentrated, which detracted funding from community mental health and PHC. PWMI, who have medical insurance, largely accessed services from a for-profit, private psychiatric hospital. The hospital was established in the context of an expanding private health care sector that did not include psychiatric services. As suggested by one participant, the real "money spinner" in general hospitals are theatre costs associated with surgery, while psychiatry costs are reduced to beds (where physicians are private contractors in this agreement) (CC_NGO8). This laid the foundation for a flourishing private psychiatric sector. Contributing to the previously mentioned theme of patients-as-capital, dissatisfaction was expressed by both public and private participants towards the management of medically insured patients by the private for-profit hospital, illustrated as:

> *What we see is that they [the private for-profit psychiatric hospital] refer guys to us after exhausting their funds. So they keep the guy there, deplete his funds and then there's some sort of crisis and then they say, go to [non-profit NGO], they'll do it for free as a state patient. It's a little hard to swallow* (CC_NGO5).

Prioritisation

The aforementioned court case that the NGO coalition brought against the state resulted in the court ordering clear-cut prioritisation of welfare programme spending. In this vein, the state was tasked with developing a priority list for funding NGO activities, with mental healthcare and substance abuse rehabilitation activities being shifted significantly down the priority list. Apart from this formal directive, it was also remarked that for DOSD mental health was "*not generally a passion – their focus is children*" (SW_TH). NGOs that are subsidised by the DoSD to provide housing to those in need were identified as more likely to receive funding if their tenants are physically disabled – they mentioned "invisibility" of mental illness as a barrier to prioritisation. This prioritisation was also linked to global health funding priorities. Some NGOs mentioned that they had to frame their mental health work in terms of overlap with HIV and tuberculosis programmes in order to access funding. They mentioned that "mental health drinks out of a large pot, from which many others drink" (CP_PHCC4), and that it "suckles on the back teat [getting the short end of the stick] when it comes to funding and support" (CC_NGO2). A perception emerged that the state is "tightening the screws in order to push guys who get funding out of the system, because funds are depleting" (CC_NGO7).

Despite singular instances of participants who suggested that provincial support for mental health was exemplary, it was asserted that the state does not take mental health programs seriously. Some noted that the provincial government made chimerical promises that do not translate any national programmatic directives into tangible outcomes, including fostering non-state collaboration. Further, it was noted that mental health is completely absent from current health reforms such as National Health Insurance and the overhaul of PHC systems. There was a discussion on integrating mental health into PHC clinics, in accordance with national policy guidelines. The current absence of mental health in PHC settings was perceived as a feature of an “archaic health system”. The absence of a mental health directorate until 2013 hampered the delivery of mental health care in PHC settings, though the nature of integration was somewhat misunderstood, and “integration” was reduced to screening for mental illness in PHC settings. In addition, the validity of the mental health screening tool was called into question, and only two of the seven questions were perceived to have any relevance, namely “Have you ever felt killing yourself?”, and “Do you often felt angry or worried?” One participant suggested that the screening tool was developed in haste only after a directive from top managers that mental health should receive more attention. Consequently, it was remarked that mental health “is dying a slow death” (PN_PHCC1). It was noted that existing state responses to mental illness as a public health programme were largely reactive, and not preventative as underlined in policy: “I think that patients are only helped once they really end up on the streets” (SW_TH).

Strategic leadership

Senior professionals noted that their inputs in policy processes and strategic decisions are routinely ignored, one participant remarking that mental health policy is national-driven. This observation was backed by another participant, who did not see the necessity of translating national policies into provincial contexts, framing the development of contextual provincial policy as redundant. Occasional friction sometimes emerged between national and provincial spheres of governance:

> *Regarding welfare, there is really an unhealthy conflict between the national departments and the provincial departments. The national department wants more power, which is good and bad, while the provincial guys also cling to their power because they say they want their own thing* (CC_NGO4).

An urgency regarding the need for competent, “dynamic expert leaders” emerged. This was not directed only to provincial-level leadership, but also to facility management. Over-bureaucratic structures and poor management resulted in the little funding assigned to mental health being mismanaged, frustrating public mental health professionals doing community outreach. A participant indicated that in one instance, after funds allocated to psychiatric community outreach work was depleted, the DoH assigned the team a helicopter (that was budgeted for in another programme but not appropriately used). A senior psychiatrist remarked “Yes, it was very nice for us, but my wife said that it was a [expletive] absurdity, absurdity. It is ridiculous, yes” (P_PHCC4). The fragmentation and disjuncture of mental health care delivery as a public health programme, especially between DoH and DoSD, did not only emerge in collaborative relationships, but was also as a feature of provincial state leadership. The political nature of public appointments was questioned, highlighted by the sentiment that the state “appoints teachers as hospital administrators” (CP_TH). One participant summed this sentiment up by alluding to Plato: “Expertise should be able to manage expertise, because if expertise does not administer expertise, it's something else” (CP_PHCC4).

Information and monitoring system

Using and generating information is a crucial aspect of stewardship, and many gaps emerged. A senior public official noted that policy objectives should be measured from a national perspective, suggesting that “by 2020 somebody has to review to check whether you actually achieved what you wanted to achieve” (MHCC). In line with the mentioned structural fragmentation, a fractured information system emerged, each NGO with its own paper-based forms, and public facilities with no mental health register, and minimal indicators, without any suggestion that this information is shared or used for strategic decision-making. Most information of patients suffering from mental illness were captured in paper-based files, that often were lost, in which case nurses had to engage with the patient by memory. In many cases, patients who accessed on-going care and stopped their treatment for more than a year had their case histories disposed of by the hospital – this necessitated PHC-level staff to re-create patient records in order to admit the patient to secondary levels of care. Further, the fractured information system made referrals challenging, especially in referral between public and non-state providers, where the responsibility often shifted to the patient:

> *So as soon as this person walks out of here, we don't know. Because they never bring back, like even our patients themselves never bring it back to us and say: 'I went there and this is what happened'. So we're not sure what happens at the end* (PN_PHCC3).

Resistance

Instances of resistance to existing mental healthcare public governance emerged. Some participants believed that to have their interests satisfied they had to subvert traditional government hierarchies. Following the official lines of communication in public departments rarely led to desired outcomes, and more than one participant mentioned the importance of having direct access to the politically elected (and powerful) departmental head. A mental health nurse employed by a public hospital had to visit NGOs after work hours in order to circumvent managerial policy that prohibits employees from working outside the public sphere. Some public participants worked with private participants to circumvent referral steps in order to expedite access to specialist care for PWMI. Normally, someone with mental illness is required to: a) present to a PHC clinic for screening (which occurs only once a month in some of the more rural clinics), b) after which referral to a district or regional hospital occurs (where there is a paucity of psychiatrists, who are sanctioned to provide clinical diagnosis and treatment), and c) after which referral to a specialist psychiatric hospital and psychiatric assistance can occur. Public health workers assist non-state organisations to obtain an order for involuntary admission to the psychiatric hospital according to the Mental Health Act (even if it is not strictly necessary) that provides PLWMI access more swiftly than traditional routes.

The severity of mental illness of patients was sometimes inflated in order to secure a disability grant, and it was highlighted that “depression does not qualify”, and that psychotic features are stressed towards facilitating disability grant access. In this way, schizophrenia and bipolar disorder are more desirable as a diagnosis (PN_PHCC1). Some of the NGOs claimed that they had to frame their activities in certain ways in order to be successful in gaining access to state funding – this included framing mental health as a HIV-related challenge, and diminishing its faith-based approach to appear more secular. One NGO made it clear that they refuse to work with the DoSD, because of the overly bureaucratic and stringent nature of assessing NGOs for state subsidy. Some were adamant that mental healthcare should not be unified, claiming that “the bottom line is, the state should care for who it is supposed to care for, and the private [sector] should care for the private” (CC_NGO8).

Discussion

Mental health and its governance was found to be highly fragmented – most strikingly in terms of public and non-state service providers, biomedical and social approaches to care, and disjuncture between the DoH and DoSD. The schism between public and non-state spheres was particularly striking, and the relation between the two service domains suggested resource-based influences, supporting previous indications that the resource-based power of NGOs significantly influence their relations with public government (Van Pletzen et al. 2013). These dichotomies block optimal collaboration and cooperation, and include key barriers to integrated care: professional domain conflicts; power relationships between services and professionals; distrust; vertical relationships with government; differences in expertise, organisational culture and service delivery approaches; bureaucratic structures; unclear roles; and funding mechanisms (Kodner and Spreeuwenberg 2002; Glendinning 2003; Browne et al. 2004; Wihlman et al. 2008).

Several themes related to public stewardship of mental healthcare emerged. Broadly, stewardship involves the governance of health system rules, ensuring equity among health providers and among health providers and patients, and setting providing strategic leadership for the health system as a whole (Murray and Frenk 2000). Strong leadership is a particularly strong mechanism in health system strengthening (Gilson 2007), and along with cross-sectoral approaches to health, it forms a protective barrier around public health in the context of competing interests (Frenk and Moon 2013). Indeed, a key feature of stewardship is the building supportive coalitions towards policy-specific outcomes (WHO 2000; Rispel and Setswei 2007). Our findings particularly illuminate previous suggestions of poor information systems and monitoring of mental health in LMICs (Hanlon et al. 2014), and affirms that provincial government managers hold significant power over programme funding and information (Lehmann and Gilson 2013). Strategic leadership was also cast in a negative light, a weakness that becomes more pressing against the background of broad and ambitious health system reforms such as the re-engineering of PHC and the introduction of a national health insurance scheme, as well as the identified need for structural and organisational re-orientation towards improved cooperation (Gilson and Daire 2011).

Having gained traction from its earlier beginnings, stewardship has been billed as one of the cornerstones of health system improvement, and "at its best, could provide an organizing principle for power in society transcending economics to base itself on the common interest” (Saltman and Ferroussier-Davis 2000, 735). Nevertheless, power is a nebulous concept, and framing its dynamics under the guise of serving interests is limiting – many other forms of power are at play (Deleuze 2004). In our findings public and formal health system hierarchies emerged as forms of power that guided the referral and collaborative behaviour of the mental health service network. Hierarchies and budgetary controls as forms of power – not subsisting in any individual or specific institution (Foucault 1980) – have been suggested elsewhere to be a feature of local health care provision in South Africa (Lehmann and Gilson 2013).

Further, it seems prudent to ask whose interests are being served within the stewardship and governance dynamic, and how policy subjects are problematized (Bacchi 2010). In this vein, we build on a narrative of competing public health priorities as a stark reality faced by PWMI in LMICs (Hanlon et al. 2014). The setting of public health priorities seemed to be strongly rooted in terms of certain types of differential value. Programmes such as HIV and tuberculosis were deemed more important than mental health; physical disability was deemed more pressing than mental disability; and children and the elderly attracted more funding than PWMI. The worst example of this type of prioritisation was illustrated in the Life Esidimeni crisis, where following the financial de-prioritisation of serious mental illness in a South African province led to 94 preventable deaths of deinstitutionalised patients suffering from serious mental conditions (Makgoba 2017). It is a strategy employed by a state with neoliberal tendencies, where certain populations are stratified and codified, often to their disadvantage (Wacquant 2009a, 2009b).

Mental health care is couched in the governance sphere of the DoH, but the position of NGOs under the governance sphere of the DoSD elevates the importance of multi-sectoral coordination. Such ideals are however hampered by structural divisions, separate policy and administrative spheres, complex and dissimilar funding structures, and distinctive professional backgrounds (Mur-Veeman, Van Raak, and Paulus 2008; Nicaise et al. 2013). Further, contestations among provincial programme managers often echo through to service delivery levels (Lehmann and Gilson 2013), a phenomenon that emerged in our study. The lack of integration between biomedical-oriented and socially-oriented mental health care – a persisting challenge emphasised before (Petersen 2000) – is particularly salient due to the nature of mental illness, which generally falls at the interface of biomedical health and social services (Rummery 2009).

Professional boundaries are in line with different understanding of and approaches to the classification, causes and treatment of mental illness, that have contributed to disjointed mental healthcare systems (Plagerson 2015). A bridge in this sense seemed to be the social work profession, who were highlighted to be particularly important referral agents, both to public and non-state service providers. Collaborations that involve significant social work engagement elevate the voice of patients as well as to increase community organisation improvements and social capital (Hultberg, Lonnroth, and Allebeck 2005; Postle and Beresford 2007; Rummery 2009). The importance of social work here is not only rooted in social workers' professional positions, but also an indication of deeper, more subtle forms of power in collaborative care (Janse van Rensburg et al. 2016). As suggested by Nikolas Rose (Carvalho 2015, 652), "social work is a kind of technology", involving a specific type of training and authority. Social workers certainly are not alone in this power dynamic, and the mental health professions each play a role in the management of people rendered subjects of state intervention.

In this way, the police (Foucault 1980), psychiatric nurses (Holmes and Gastaldo 2002), psychologists (Binkley 2011), and psychiatrists (Rose 1996; Dhar, Chakrabarti, and Banerjee 2013) all play a part in the governmentality of mental illness. To these idiosyncrasies of advanced liberalism and late capitalism (Dhar, Chakrabarti, and Banerjee 2013; Carvalho 2015) we can further add the commodification of PWMI that emerged in the findings. Drawing from Marx (1959), capitalist societies lead to both the commodification of labour and of the labourer. The state fosters legitimacy by claiming to provide for the well-being of the population, driven by an instrumental economic rationality of costs and benefits (Chatterjee 2004). Under these conditions, PLWMI – who have little chance of entering and remaining in the labour market – personifies Homo Sacer, the cast out, where "bare life" becomes the authentic subject of politics (Agamben 1998). They essentially exist under a "spectre of uselessness", a challenge to the state provision of welfare benefits (Sennet 2014). The state provides the infrastructure that fosters supportive conditions for the working of quasi-markets (Carvalho 2015), and the framing of PWMI as "useless" in modern society transforms them into objects of economic rationalities. These claims are demonstrated in our findings, in terms of PWMI getting caught up in a complex network where there are financial and information flows between public departments, between public and non-state service providers, and in interactions with for-profit psychiatric services.

Thus far, many different facets of power have been unearthed. Yet, "where there is power, there is resistance' (Foucault 1980, 95), and resistance is a central feature of power relations involving health care providers and government intervention (Doolin 2004). Within collaborative contexts, resistance often emerges in relation to power distribution and decision-making structures (Nilsen et al. 2016). In our findings, resistance emerged in several forms: resistance against funding structures (framing applications for welfare grants in certain ways); resistance against hierarchical power structures (bypassing referral lines in order to gain access to specialist mental health professionals); and resistance against the public and non-state divide (public mental health care professionals who visit NGOs in order provide care). The NGO that refused to engage with government funding structures is reminiscent of a form of passive resistance, a withdrawal from formal health system interfaces (Lehmann and Gilson 2013). These forms of resistance – while closely intertwined in the power relations within which it operates (Foucault 1980), can be interpreted as strategies that resist smooth and "complete malleability in the idealised schemes of a programmatic logic" (Miller and Rose 2008, 71).

Finally, the limitations of our theoretical framework (Purdy 2012) should be assessed. While a theoretical framework provides the researcher with "a map for combining the what with the why to gain a multidimensional understanding" of the phenomenon under focus (Evans, Coon, and Ume 2011, 278), no framework is without critique. In our study, we were confronted by a common problem in research, namely discrepancies between neatly delineated theoretical constructs and the messy reality of collaboration and local governance. The framework does not adequately encapsulate the informal, non-descript forms of contact between collaborators that emerged in our study, and we had to adjust accordingly. Further, the framework did not pay sufficient attention to the surrounding contexts of collaborative relationships, of which there are considerations. Governance and collaborative dynamics are nested in wider systems (Emerson, Nabatchi, and Balogh 2012), and our inductive amendment of public stewardship is one example of such a consideration. Nevertheless, use of the framework provided a necessary degree of robustness to the study, and offers the flexibility required for use in different contexts.

Conclusion

Mental illness truly represents a "wicked problem" in health policy (Hannigan and Coffey 2011), as its nature necessitates that it "axiomatically transcends a diverse range of professional and organizational boundaries and often at multiple levels" (Hunter and Perkins 2012, 45). Non-state mental health service providers are a real and important component of national health systems in LMICs, and close engagement between public and non-state actors is a key consideration towards achieving universal health coverage (Alliance for Health Policy and Systems Research 2015). The significance of this paper is rooted in its empirical illustration of local mental health service governance dynamics in a South African context. Importantly, the complexities and different facets of power relations that underwrite attempts towards integrated mental health care are showcased, adding to growing literature on the social mechanisms that influence collaboration. The study confirms and expands on previous studies of the crucial role of health system governance in South African settings (Scott et al. 2014; Marais and Petersen 2015; Hanlon et al. 2017; Petersen et al. 2017), and, importantly, illuminates the role of power in integration and fragmentation of mental health services (Janse van Rensburg et al. 2016). In this Chapter, the final objective of the research was addressed, namely, exploring the relations between state and non-state mental health service providers (Chapter 1). Significantly, this Chapter adds to the previous one, in explicating the role of power in integrated mental health care on district-level in South Africa. The significance of these empirical insights will be discussed in the next, and final, section.

Section III: Synthesis

Chapter 7: Conclusion

> *For months Anna K had been suffering from gross swelling of the legs and arms; later her belly had begun to swell too. She had been admitted to hospital unable to walk and barely able to breathe. She had spent five days lying in a corridor among scores of victims of stabbings and beatings and gunshot wounds who kept her awake with their noise, neglected by nurses who had no time to spend cheering up an old woman when there were young men dying spectacular deaths all about.*
>
> ***- J.M. Coetzee, The Life and Times of Michael K*** (1983, 2)

Introduction

The principal task of this study has been to provide a structured glimpse into the obvious as well as tacit dynamics at play in the governance of mental health care in contemporary South Africa. The potential scope for such an undertaking is both vast and ambitious; the constraints of doctoral research necessitated a narrow focus. In this vein, the main purpose of this study was to provide better understanding of the ways in which power influences the governance of mental health care. More specifically, the research sought to describe the different dimensions of integrated mental health care in South Africa in relation to its geographical neighbour states. Within this macro context, the research went further to craft a case study of the nature and extent of district-level mental health service collaboration among state and non-state mental health service providers. Finally, and perhaps most crucially, the study sought to offer insight into the specific and distinctive dynamics of power that emerge in collaborative governance processes between state and non-state mental health service providers. In Chapter 1, the key questions that drove and framed the study were laid out. These were addressed in an overlapping way, across the three articles that comprise Chapter 2, as well as in the three articles in Section 2. After summarizing the main findings of the study, the limitations of the study are described, followed by the main steps forward in terms of future research.

The policy implications of the study are set out, after which the Chapter and study are concluded.

The structure and nature of integrated mental health care

An important, subtler project of this study has been to clarify constructs that are often not well conceptualized (the significance of this task will become apparent). Accordingly, central terms of the study – mental illness, power, governance, integrated care, the state, and mental health service provision – had to be pinned down in the contexts of the post-apartheid South African milieu. These conceptualizations are neither comprehensive nor definitive. For example, a differentiation is made between "state" and "non-state" actors. Though this distinction leaves much space for debate, it was a necessary and appropriate differentiation that was ostensibly made by the actors themselves during fieldwork. Analysis of the qualitative data however, supported arguments by Foucault (2008), Bourdieu (1994) and Wacquant (2010) that underline the intertwined nature and fuzzy boundaries between the two groups – James Ferguson (2006) noted that the "N" in "NGO" increasingly fell away in Southern Africa's post-colonial era – opening up spaces for the interrogation of different streams of power (Scott 2001). However, the lack of consensus on the meaning of "integrated care" and "integrated mental health care" was the first challenge presented in the research, and here, Valentijn and colleagues' (2015; 2013) Rainbow Model provided a much-needed systematic framework with which to interrogate the nature and shape of integrated mental health care in South Africa (Chapter 4). This particular exercise attempted to clarify how integrated mental health care is framed in national health policies in the SADC region, and confirmed broad similarities across countries.

The study confirms tacit and accepted notions that district-level health mental health care remains fractured and unequally distributed (Harrison 2009; Harris et al. 2011; Van Rensburg and Engelbrecht 2012). Health policy in South Africa – forming a macro context within which health services are nested – do outline different dimensions of integrated care provision in South Africa, broadly focusing on 1) integrating mental health care into PHC systems, and 2) developing collaboration between service providers and sectors. In terms of the first directive, there is no coherent national vision on what this would entail, and details of how mental health would be integrated on PHC level did not receive the required attention. This is not altogether surprising, since large-scale research studies are currently underway that aim to create a blueprint for these integration processes, an example being the Programme For Improving Mental Health Care (PRIME) (Lund et al. 2012; Mendenhall et al. 2014; Lund, Tomlinson, and Patel 2016). The approach would seem to focus on "task-shifting", to train lay health workers to provide basic counselling and therapy in PHC clinics.

The lack of a multidisciplinary care plan, along with a lack of attention to shared inter-professional characteristics, vision, and governance, could possibly hamstrung such efforts, in large part due to the dynamics of professional power (Tousijn 2012). The lack of mental health care on PHC level was telling in the findings presented in Chapter 5, where PHC clinics – aimed to extend health system reach towards communities (Dookie et al. 2012) – served as referral sites rather than places where treatment is offered. The state response to this shortcoming was to send psychiatric outreach teams on a monthly basis to specified treatment sites, though due to the large numbers of patients seeking care, this entailed the distribution of psychopharmaceuticals. This service deficit is particularly troubling given that patient-level outcomes could be improved – if only in selected instances – by network characteristics. For instance, patients' social integration outcomes are improved by smaller, more centralised, and heterophilous networks (Lorant et al. 2017), though the social and biomedical split in this study's network could be a key barrier to improved care networks.

Beyond the obvious lack of holistic and continuous care, was an indication of a further entrenchment of a biomedical inflection in state provided mental health care (Petersen 1998, 2000). It also cements the professional power of psychiatry as a lens through which public mental health is provided (Rose 1998). The biomedical slant is part of a schism between two distinctive and different approaches to mental health care, and there is perhaps no starker illustration of this than the fractures between the DoH and DoSD. The DoH is the steward of mental health, inasmuch as it houses the National Mental Health Policy Framework and Strategic Plan 2013-2020 (South African National Department of Health 2013). The DoSD engages with mental health in terms of 1) funding and regulating NGOs; 2) managing state and regulating non-state centres for substance abuse rehabilitation; 3) legal and forensic aspects related to mental health; and 4) features of domestic and child mental health. Very rarely do the two sectors' activities overlap explicitly.

While there was little formal contact between the DoH and DoSD, they both relied heavily on non-state partners to provide services according the state's Constitutional mandate (see Figure 15). The DoH provided mental health care according to primary, secondary, and tertiary levels, mostly to those not able to afford privatised health care. The DoH also used public-private partnership (PPP) agreements to access more specialised services, and private service providers referred patients back to the public sector when they could afford private sector fees, or when their medical insurance funds become depleted. In terms of the non-state, non-profit sector, the DoH used community-based NGOs to provide basic care, housing, and in limited instances, basic psychotherapy.

NGOs in turn refer patients in need of medical intervention to public sector facilities. These NGOs are in large part dependent on DoSD support, and the NAWONGO case (Free State High Court 2010) exposed a significant power disjuncture here. NGOs in many LMICs have lost much of their advocacy, independence and bargaining power after global shifts towards state ownership of global health and development funds, exemplified by the Paris Agreement (Organisation for Economic Cooperation and Development 2008). This development unfolded in South Africa's post-apartheid period as well (Wolvaardt et al. 2008; Habib and Taylor 1999; Habib 2005), though not without resistance; the role of NGOs as a voice of communities was reignited in the infamous backlash to Thabo Mbeki's AIDS policy (Fourie 2006), and the NAWONGO case was a firm step towards clarifying state and non-state boundaries and responsibilities in terms of funding flows. Furthermore, the DoSD also provide a regulatory role over NGOs, the failure of which was spectacularly illustrated in the Life Esidimeni tragedy (see the article *Political dimensions of the governance of mental illness in post-apartheid South Africa* in Chapter 2). The fact that the DoSD was not mentioned in any capacity in the official report by the Office of the Health Ombud, further suggests the framing of mental health care as a fundamentally medical problem, and points to serious fissures between the DoH and DoSD. Crucially, fragmentation between health and social development particularly affects socially marginalised people, with chronic conditions such as mental illness (Nicaise et al. 2013). In this vein, it is essential that mental health service providers harness each other's different forms of capital towards common goals (Mur-Veeman et al. 2003). In this study, this did not seem to be the case.

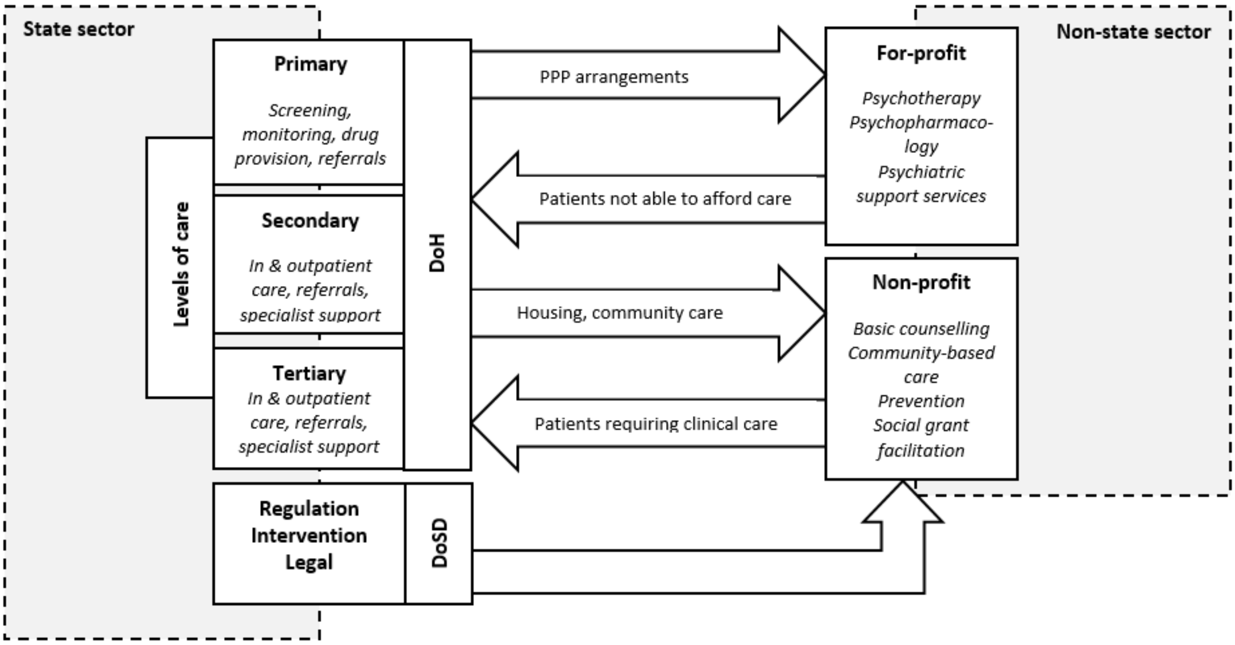

Figure 15: The structure of mental health care in Mangaung Metropolitan District

The significance of governance

In mental health care, one provider cannot deliver all the services required by clients, and transfer from clinical to community settings in partnership with NGOs is paramount (Fleury et al. 2012). This study suggested that state mental health service providers tended to refer more within the state sphere and hierarchy than to non-state counterparts. Homophily – the tendency to collaborate with similar agencies – has been suggested to occur as a consequence of health care providers who want to minimise threats to their autonomy, by choosing partners with whom there are established cooperation (McDonald, Jayasuriya, and Harris 2012). Nonetheless, the qualitative findings in Chapters 5 and 6 also point to the structural power of state hierarchy and the professional power of mental health professionals (who, in the public sphere at least, are largely concentrated in state facilities). Even though state and non-state mental health service collaboration is firmly embedded in health policy (Chapters 2 and 4), the state sector failed to optimally tap into considerable district-level NGO resources in terms of community access, scarce skills and complimentary services (Petersen et al. 2009; Van Pletzen et al. 2013). On the other hand, non-state facilities seemingly tended to refer very little, and mostly used state facilities for psychiatric services. However, NGO services were remunerated by the DoSD, and separate funding structures for health and social services are very salient challenges to integrated care provision (Rummery 2009).

The degree of integrated mental health service provision is significantly linked to the strength of collaboration between stakeholders, as well as the extent to which these relationships are governed (Mur-Veeman et al. 2003; D'Amour et al. 2008). With health governance, we allude to the rules that structure the relationships between service providers – the very organization of health care service provision – with public participation and management of expert resources, specifically focusing on continuous processes of strategic interaction and negotiation among a continuum of health care stakeholders (Flynn 2002; Graham, Amos, and Plumptre 2003; Touati et al. 2007; Fox and Ward 2008; Brinkerhoff and Bossert 2008, 2013; Janse van Rensburg et al. 2016). On a meso-level, different dimensions of governance emerged in the findings. A hybrid of hierarchy and network modes of governance emerged in the findings of Chapters 5 and 6, while the market as a governance mechanism emerged in the NAWONGO case. These forms of governance were rather loose and unclear, and in the absence of strong leadership and stewardship on provincial level placed the fostering of inter-service collaboration on service providers. However, strategic decisions about whether to collaborate, with whom, and on what level, are affected by both power relations and trust (McDonald, Jayasuriya, and Harris 2012) – this has been a telling feature of state and non-state collaboration. Findings from this study confirm low network density and the associated lack of mutual trust, negative perceptions of organisational and professional value, expertise, and legitimacy (Fleury, Mercier, and Denis 2002; Mur-Veeman et al. 2003; McDonald, Jayasuriya, and Harris 2012; Retrum, Chapman, and Varda 2013).

Key governance mechanisms to strengthen integrated mental health care include roundtable discussions with a range of stakeholders as well as formalized agreements between service providers (Fleury et al. 2012). The onus for setting up and fostering of collaborative partnerships falls on the provincial government (South African Government 2004), and the findings from Chapter 6 suggested shortcomings in leadership and stewardship. Roundtable discussions did occur, though from limited data the inclusiveness, depth and effectiveness of these sessions were questioned. We briefly need to consider the dimensions of governance provided in Chapter 2. No formalized agreements could be found during fieldwork. This brings us to the macro dimensions of governance, where government needs to create trust and cooperation between stakeholders in terms of work arrangements, management and supervision (Valentijn et al. 2015). Strong leadership is required to align health and social care sectors, as well as to drive accountability and shared interests (Goodwin et al. 2012). Health care leadership in cross-sectoral service delivery is a vital barrier to the negative consequences of competing interests, and strong stewardship is required when collaborative care provision is attempted (WHO 2000; Rispel and Setswei 2007; Frenk and Moon 2013), and in this study it was found wanting, exemplified by the lack of formalisation and the hierarchical structure of service provision. To be clear, this might not be the case in other health programmes, and examples of stronger governance have been shown in other initiatives, for example community health worker programme implementation in South African districts (Schneider and Nxumalo 2017); integrated community-based systems rooted in the "priority programmes" of tuberculosis and HIV (Schneider et al. 2015); and provincial PHC system reform (Schneider et al. 2014). These three cases all involved close collaboration between NGOs and government departments. It should be kept in mind that mental health care – as a government programme – is not high on the list of priority programmes, as exemplified by its low ranking in the NAWONGO case (Chapter 2), and findings from Chapter 6.

No strong inferences can be made regarding the influence of global capital and politics in the governance of mental health care in the case of Mangaung Metropolitan District. Nonetheless, local government sites have become "key sites of contradiction" in post-apartheid South Africa, and it is exactly these sites where the processes or de- and re-nationalisation unfold (Hart 2012). The tensions between state and non-state actors – specifically NGOs – are indicative of broader contradicting politics that the ANC government has to deal with in a globalising world. Ultimately, it suggests that globalisation processes did not render social politics irrelevant, but rather that politics have been pervading different spheres of South African society (Yeates 2002).

Power and its dynamics

Both mainstream and second stream approaches to power emerged in the study findings. That is, dynamics that speak to "corrective causal influences" (mainstream) as well as "persuasive causal influence" (second stream) were observed – the "elementary forms of social power" (Scott 2001, 12). Forms of legitimation unfolded inasmuch commitment was given to "agents whose views are treated as especially compelling because of their particular character and competence" (Scott 2001, 15), as was suggested by the central network-related power of the psychiatric hospital. Professional expertise – concentrated in hospitals – was a crucial form and arena of power. The limits placed on different professions (for instance, social workers that can work in the community, and in people's homes, nurses that are bound to the physical boundaries of health facilities) and the relative expertise and status of professions (psychiatry was suggested by one participant to carry more weight in terms of provincial policy) was notable (Purdy 2012). Medical professionals' relative intra and inter-professional position and status significantly frame their institutional reach (Currie et al. 2012), and this was especially noted in terms of social workers. The findings suggested that social workers serve a bridging function between the DoH and DoSD institutional spheres, and Nikolas Rose summarises their value and power as follows (Carvalho 2015, 652):

> *They have various techniques of intervention in relation to their subjects, they have certain powers that are given to them by law. They inhabit certain institutional forms, offices, buildings, they have files, they accumulate material in certain ways, they go into people's homes, they judge people in certain ways, they can deliver certain resources or they can take children away or they can do this, that and the other. So this is a kind of complicated dispositif, involving persons, forms of knowledge, types of action, modes of inscription.*

Expertise is also firmly tied to specialised knowledge, and the findings underwrite the importance of different types of knowledge in organisational integrated mental health care. Knowledge is "the currency of collaboration", and the degrees of sharing generated knowledge closely correlate with power (Emerson, Nabatchi, and Balogh 2012, 16). Further, professional expertise is more than the traditional debates rooted in "power over" narratives, and move beyond the ever-growing bodies of critique regarding biomedicine, doctor-centrism, the medical model, and disregarding the voice of patients or clients (Osborne 1994). Rather, it is intimately entangled with "the five great apparatuses of health" (medical administration of public spaces, the curative clinic, the hygienic direction of domestic life, medical staffing in populations, and insurance-based risk mitigation of suffering) that binds together with the relations between subjects and experts (Rose 1994, 63). In the findings, the deployment of experts – especially psychiatrists and social workers – to facilitate social welfare grant processing, to ensure that only beneficiaries who are disabled to a prescribed degree receive grant money, speaks to the "vital links between socio-political objectives and the minutiae of daily existence", established by expertise (Miller and Rose 2008, 56). Miller and Rose (2008, 56) go further to describe experts' role in governance as a "double alliance", where, on the one hand, they are tethered to political authority, problematisation and translation of political concerns into vocabularies of management, accounting, psychology etc. – here, "the largest room in the house is clearly that of psychiatry" (Habibis 2005, 310); on the other hand, alliances are sought with people living with mental illness (PLWMI) themselves, where narratives of daily worries and strife are translated into "a language claiming the power of truth" along with intervening by teaching techniques for improved quality of life (Miller and Rose 2008, 68).

In Chapter 5, it was suggested that state referral hierarchy acts as a frame that guides collaborative behaviour; different facets of power emerge here. First, it serves as an amalgamation of domination and constraint, whereby the state is afforded a degree of legitimation to provide direction to referral patterns and blueprints for collaboration, under the shadow of anticipated coercion. Second, it serves as a structure of "discursive formation", a form of domination rooted in complex dynamics associated with persuasive influence. More specifically, signification emerged in terms of persuading collaborative behaviour following the cognitive symbolism of state provincial referral policies (Scott 2001). In this vein, "integrated care" become a form of power itself, typifying a discursive script that steer relations among diverse actors (Reed 2013; Foucault 2000). Third, a telling – though perhaps neglected – feature of the Mangaung Metropolitan district case study is the spatial discrepancies and concentration of resources in the city of

Bloemfontein. This should not only be seen as the common discrepancy in resources between rural and urban settings, but also speaks to the structural and cultural barriers of language, customs and historical legacy (Purdy 2012). The geographical and spatial inequalities in terms of service network density in the findings are a result of the obstinate structural constraints imposed by colonialism and apartheid, underlining the enduring legacy and success of apartheid as a deeply immoral social experiment (Coovadia et al. 2009). In an institutional sense, "many formal institutions are specifically intended to distribute resources to particular kinds of actors and not to others. This is true for precisely those institutions that mobilize significant and highly valued resources (e.g., most political and political-economic institutions)" (Mahoney and Thelen 2010, 8). Fourth, the domination of Western models and approaches to mental health care, typified by the disconnect between the funded, formal system of state and non-state care on the one hand, with no contact with traditional healers on the other – despite their presence in the health system (Sorsdahl et al. 2009; Campbell-Hall et al. 2010). This cultural disintegration is further complicated by the conceptualization of mental illness, which diverge widely along cultural fissures (Pembertona and Wainwright 2014).

Throughout the study findings, oppositional conflicts were presented; most notably, these included state versus non-state service sectors, DoH versus DoSD approaches, and non-state service providers competing for state funds. These oppositional forces and the apparent boundaries between them are nonetheless not as clearly delineated as they seem, and, as described in Chapter 2, these forces play out within a bureaucratic field with internecine struggles (Bourdieu 1994; Wacquant 2009b). The NAWONGO court case described in Chapter 6 presented an example of struggles between lower and higher state nobilities, in that NGOs (lower state nobility) – having lost a degree of their non-governmental status in post-apartheid South Africa – react to funding constraints through protest and pressure (Scott 2001). Further, the NAWONGO court case also touched on struggles between the left and right hand of the state. Under neoliberal conditions, the "Janus-faced" state has a double identity; it leans towards welfare spending, while at the same time does not remunerate NGO mental health services (Wacquant 2009a) – fulfilling the "talk left walk right" metaphor (Bond 2014).

Mental health care governance processes took on a specific shape within the convergence of advanced liberalism and late modernity in post-apartheid South Africa, and the bureaucratic field – along with its underlying market-driven, economistic rationality (Wacquant 2009a; Žižek 2010) – significantly influenced how service providers relate to each other (Habib 2005). The ways in which global capital influenced the prioritization of social assistance programmes (with mental health care significantly down on the list of priorities), increased competition among service providers, and the framing of PLWMI in the findings point to "a vital over-arching global dimension to psychiatric care" (Richmond and Savy 2005, 228). In Chapter 6, one participant's comparison of the NGO enterprise to a Kentucky Fried Chicken was especially telling: under market-driven conditions, PLWMI have been rendered "useless" in the labour market (Sennet 2014). Under neoliberal conditions, individuals become Homo Economicus: self-promoting entrepreneurs, "the subject or object of laissez–faire" economics, "someone who is eminently governable" (Foucault 2008, 270). PLWMI however are afforded another status, namely that of Homo Sacer (the cast out) (Agamben 1998), "those who form the human base of the social pyramid- the outsiders and the poor, the unemployed and unemployable, the persecuted colored races, the inmates of prisons and mental institutions" (Marcuse 2002, 56–57). Much like poor, urbanised black populations became the objects and subjects of governmentality practices and became a source of revenue for private prisons in an almost hyper-neoliberal USA (Harcourt 2011), so do PLWMI become commodities, caught up in a complex web of exchange. Mental health care has been the subject of increased commodification, privatisation and marketization, within contradictory relations of care and control (Pilgrim 2012; Offe 1976, 1980). We should take heed from Foucault's (2008) warning to refrain from mixing economic rationality with governance; this becomes ever more challenging in the current climate, where capitalism's "insane rationality" has permeated almost all aspects of society, stressing greater efficiency, more profit, and where profit no longer is the means to better life, but rather the end in itself (Deleuze and Guattari 2000, 254). Simply put, behind the "dry stuff of economics…lies a world of human pain" (Berger 1974, 172). This political economy of mental health in the governance of service providers, where economic rationality become inscribed into governance practices (Foucault 2008) can be summarised as follow (Dhar, Chakrabarti, and Banerjee 2013, 286):

> *This aspect of an innate subhumanity of the other perhaps defines all work of neoliberal rhetoric and intervention, in which even well-meaning discourses on mental health get caught. Loss of economic value rather than actual mental states and the nature of suffering seem to be a matter of concern; as if any discussion on mental states must take into account the aspect of resource, efficiency, and loss in economic value.*

Limited instances of resistance to domination emerged in the findings. The NAWONGO court case suggests that NGOs (lower state nobility) resisted apparent domination by the state by means of different forms of counteraction, including strategies of protest (officially via the legal system) and pressure (creating a coalition, a lobbying body) (Scott 2001). Power is always closely related to resistance (Poulantzas 1978; Foucault 1980; Jessop 2008). State mental health service providers exhibited features of resistance to official state structures, by bypassing state and non-state borders, by side-stepping the hierarchical referral system, and by assisting PLWMI in accessing state funds which are skewed towards other disabling conditions. However, many more points of resistance exist in the mental health service network, which are subtler, and not easily detectable. It is determinedly intertwined with power, in a "strictly relational" way. The very existence of power relationships "depends on a multiplicity of points of resistance: these play the role of adversary, target, support, or handle in power relations. These points of resistance are present everywhere in the power network" (Foucault 1980, 95).

Finally, we need to consider the significance of mental illness itself, as a public health challenge, as subject and object for governance and power. The confluence "between the physical, the psychological, the social and cultural is always likely to be controversial and prone to change" (Pembertona and Wainwright 2014, 238). Mental health and illness is inherently political due to its focus on the biological and knowledge generation about it (Holmes and Gastaldo 2002). In Chapter 1, the complexities and intricacies involved in pinning down mental illness was laid out; it is an "important disease" (Sontag 1978, 58), with limited global consensus in terms of its causal roots and, more saliently, how to "manage" its bearers (Miller and Rose 2008). The past few decades has seen increased efforts to find evidence of biological correlates, though these efforts continue to fail in discovering anything "scientifically or clinically useful" (Timimi 2014, 209–10). This study was conducted in the aftermath of the introduction of a much-debated DSM-5. Thomas Insel, the former director of the influential National Institutes for Mental Health (NIMH), remarked that "while DSM has been described as a 'Bible' for the field, it is, at best, a dictionary, creating a set of labels and defining each" (Insel 2013). In South Africa, the DSM is instrumental in structuring risk-based medical insurance, in line with the power of auditing practices described in Chapter 2 (Power 2000).

Nonetheless, it remains unclear to what degree the DSM is used by medical and psychological practitioners apart from facilitating medical insurance payments. It is telling that the focus of this study was shaped by a lack of focus among mental health service providers in approaching mental illness, where the entire spectrum of mental illness was often cast under one broad stroke. The lack of nuance, along with the different kinds of terminology used to refer to PLWMI, was further exemplified by the absence of a clear definition of mental illness in South African health policy and legislation. Policy that promotes integrated mental health care becomes an example of discursive practices built in rules of formation that give them authority (Bacchi 2012, 2016), rendering mental health service providers, clients their families not subjects but subjectivities of government (Miller and Rose 2008). This leaves health service providers, and health managers, infinitely open to apply their own subjectivities to managing and governing PLWMI in South Africa. The fuzzy boundaries and lack of physicality of mental illness further played a role in the granting of welfare benefits, and the prioritisation of mental illness as a public health good. Presently, there no known biological markers with which to pin down mental conditions (2013), and it is exactly here where the NIMH has thrown its weight into pinning down the nature of mental illness. In reaction to the perceived "fuzziness" and lack of validity of the DSM, it launched Research Domain Criteria (RDoC) project, aimed to incorporate "genetics, imaging, cognitive science, and other levels of information to lay the foundation for a new classification system", "based on the biology as well as the symptoms must not be constrained by the current DSM categories", and, importantly, aiming to map out "the cognitive, circuit, and genetic aspects of mental disorders" towards improved treatment (Insel 2013). RDoC is rooted in the assumption that we will not be able to effectually treat mental illness without "carving nature at its joints" (Rose 2013). This approach does however open up new technologies of management, governance and biopolitics, shifting the power of experts of managing specific populations from psychiatry, psychology and social work, to that of neuroscience and genetics (Rose and Abi-Rached 2013). Here, the future of the classification and management of mental illness in South Africa is very much tethered to a global project.

Study limitations and areas for further research

Several limitations should be considered against the study findings. These relate broadly to the conceptualisation, study scope, methods and the contextual factors within which the study was embedded.

Conceptualisation and operationalisation of key terms

The study had an ambitious goal in mind, namely to showcase how different approaches to power play out governance and governmentality processes in organisational integrated mental health care. Such a goal is certainly beyond a doctoral research project, and as such this study should be perceived as a stepping stone for further development. While every attempt was made to delineate main and second stream power, along with governance and governmentality, the nebulous nature and different ontological foundations of these concepts was not always clearly demarcated. A pragmatist epistemology was used to bridge these concerns, though it would be naïve to accept that using multiple methods and conceptualisations in real-life social settings would not complicate the co-conceptualisation and co-operationalisation of governance, governmentality, and power. It must be asked to what extent these concepts can be used in the same research project. In the present study, inspiration was drawn from Loïc Wacquant, who managed to use the structure-agency conceptualisation of Bourdieu in concert with Foucault's ideas on the governance of risky populations. The compatibility of these two approaches might be questioned given the substantial ontological and disciplinary differences, though it is believed here that Wacquant achieved a degree of theoretical elegance in his studies on poverty (2009b) and prisons (2010). This said, future studies should be mindful of the pitfalls and possibilities of combining different approaches within a unified paradigm, engaging with contradiction within real-life contexts.

Another possible ambiguity in this study related to the conceptualisation of the non-profit sector. The delineation between state and non-state, for-profit and non-profit could be critiqued for being overly simplistic and ignoring more recent developments in the Third Sector field. This includes a growing emphasis on "hybrid" organisations that straddle the state and non-state, for-profit and non-profit divides. Non-profit mental health service providers in South Africa are organisationally much more basic and traditional than their counterparts in high-income countries. It eases the conceptualisation process, although it should be noted that such non-profits might well change and grow in global neoliberal conditions.

Structural scope

The study was skewed towards governance and power in its structural guise, thereby neglecting the role of agency. A prominent example of critique here lies in Ralph Miliband's (1973) instrumentalist critique of Nicos Poulantzas' structural approach to Marxist analysis. Another, more frequently levelled critique, is that of Foucault's apparent neglect of agency, especially in his earlier work: "For Foucault, individuals are subjected, and this in a dual sense; they are subjected to the complex, multiple, shifting relations of power in their social field and at the same time are enabled to take up the position of a subject in and through those relations. In other words, for Foucault, power is a condition for the possibility of individual subjectivity" (Allan 2002, 135). Nonetheless, it has also been argued that Foucault's approach transcends the traditional structure-agency debate towards more process-based ontologies in the form of discourse (Caldwell 2007): "Thus the development of the people as a political and determinate subject is the development of a political space where discourse *sanza rispetto is* possible and where force and authority are no longer the ground of social and political life" (Fontana 1993, 162). This study did touch on a key aspect of agency, namely the salience of resistance. The intertwining nature of discretionary power yielded by individual agents in policy implementation processes in South Africa has received focus, in underlining the ways in which health care workers and health managers resist authority and policy structures (Lehmann and Matwa 2008; Lehmann and Gilson 2013; Gilson et al. 2014). More attention should be paid to these agential processes in integrated mental health care processes, especially to the ways in which the spectrum of role players (including patients) resist forms of governmentality and economic rationalities. Agency becomes visible in strategies of resistance, and this paves the way for deeper methodological engagement with power on an individual level.

The meso-level focus of the study largely underwrote its structural focus. There have been several prominent works that attempt to consolidate the structure-agency divide, notably Bourdieu's (1977) Theory of Practice, Giddens' (1984) Structuration Theory, Bhaskar's Transformational Model of Social Action (Archer 1998), and Archer's (1995) Morphogenetic Approach. Similar to the suggestion in Chapter 2 that both streams of power analysis be used, it is suggested here that future research incorporate both structural and agential elements in its scope. More specifically, models such as the Transformational Model of Social Action fills a much-needed vacuum in its adoption of changes over time, another limitation of this study. This is an important consideration in South Africa, where large-scale health system reforms are underway and singular snapshots might not adequately represent structural and contextual changes.

An additional consideration regarding the scope of the study concerns the growing body of critical mental health scholarship that deals with race, ethnicity and colonial forms of structural violence (Dubow 1995; Mills 2014; Joseph 2015). These issues are deeply embedded in the South African socio-political, economic and cultural landscapes, and the well-known disparities along racial lines in terms of mental illness and mental health service provision were not adequately covered in the study scope. There remains much work to be done in this particular field, especially in generating African voices towards more emancipatory scholarship.

Design and methodologies

The study was rooted in a cross-sectional case study, and a common limitation attributed to this specific design is the restrictions placed on claims of causality and generalizability of findings. The study was not designed for the purpose of drawing causal linkages, but rather to empirically illustrate power relations in real-life contexts (Yin 2009), on the meso-level of mental health service provision, towards shedding light on "a larger class of cases" (Gerring 2009, 20). It is well established – though not without debate – that simple causal relationships do not exist in dynamic, open, complex systems, and any inferences made about causality becomes muddled, including "gold-standard" designs such as randomised control trials. The capacity of social network analysis to take a snapshot in time is limited, and there is much left to explore in longitudinal dynamics of networks. Ultimately, it is possible that some of the linkages described in this study are open to alternative explanations. For instance, the apparent schism between the DoH and DoSD could also be chalked down to internal ANC politics, cemented after two decades of internal struggles. The individual motivation in playing political games should not be ignored and could certainly be a key part of the division between the social and the medical, the weight of clinical expertise residing in the DoH. Although it has been argued that social workers act as a bridge between the DoH and DoSD, and between state power and individuals' personal life spheres, their motivations could point to another direction. Institutional ethnographies could add valuable scholarship to further clarifying the apparent oppositions that emerged in the study, by exploring in-depth how social relations structure the lives of patients, health care workers, health managers and other role players in integrated care.

Limitations in Chapter 4 are two-fold: First, the study focused only on health policy, and other sectors such as social development and education were not included. This should be a key consideration for future research. Second, the policy analysis was conducted in a normative way, and the methodological approach could have added to the lack of power unearthed in the findings. Future studies should take a more critical approach, and Bacchi's *What is the Problem Represented to Be* (WPR) approach (Bacchi and Eveline 2010; Bacchi 2010, 2016) holds much potential in better engaging with (especially second stream) power relations. In Chapters 5 and 6, we underscored the limited nature of cross-sectional SNA data, and more research into the longitudinal dynamics of mental health service provider networks (Mur-Veeman et al. 2003) remain elusive. Further, the quality of the district health information system hampered the collection of data that reflect the weight of collaboration between nodes. Such information could have provided an alternative illustration of power relations throughout the network, as well as influenced which participants were selected for further study. Future research should take this into consideration.

Participants

The methods employed in the identifying mental health service providers were limiting, and actors outside the described network were not included in the analysis. This was particularly telling in the absence of traditional healers in the study. Yet, the most important omission is that of patients and their caretakers. The relationships between patients and their care takers on the one hand and health service providers and managers on the other, is a core consideration in studying health governance (Brinkerhoff and Bossert 2008, 2013). The patient-health care provider interface in integration processes is of principal importance in its success, since the health and illness of people with mental illness can be both constrained and enabled by their interactions with health care providers in health service settings (Lamb et al. 2011; Kleintjes, Lund, and Swartz 2012). There is a pronounced need to explore how combinations of system, programme and provider factors influence integration and continuity of care, particularly from the perspective of patients (Durbin et al. 2006). Simply put, “only service users can represent service users and only carers can represent carers; service users and their families are the best people to comment on service quality” (Sweeney and Wallcraft 2010, 5). It would further be useful to explore how patients resist the identified modes of governmentality, and how their actions are both constrained and facilitated by the welfare grant system. The original research proposal included a work package to investigate this theme, but it had to be postponed to post-doctoral work due to time and funding constraints.

Policy implications

The limitations noted above prohibit strong recommendations for policy reform. The findings do however support existing knowledge regarding mental health care policy. Importantly, it provided insight into power relations in mental health service provision, insofar as it is structured by national policy. Governance and power play out in several mechanisms of structural change, of which 1) the availability of financial resources, 2) inter-organisational relationships, 3) organisation of government departments, and 4) political relationships play an especially definitive role (Ingram et al. 2012). Funding constraints to mental health service provisioning are well-known; when health budgets are being developed, mental health is often one of the first programmes to be cut down (Tomlinson and Lund 2012). The short-termism of these strategies is telling. It has been suggested that benefit to cost ratios for investment in mental health as a programme is 2.3-3.0 to 1 when economic value is considered, with 3.3-5.7 to 1 when health return value is also considered (Chisholm et al. 2016a). Given the relatively modest estimation of US$ 3-4 per capita per year necessary for mental health service provision in LMICs (WHO 2017), a degree of political gumption is required to translate this knowledge into government policy. Several strategies have emerged during the past decade that might further cut costs, most notably task-shifting approaches on PHC level (Mendenhall et al. 2014; Chisholm et al. 2016b; Lund, Tomlinson, and Patel 2016). In mental health care, one provider cannot deliver all the services required by clients, and transference from clinical to community settings in partnership with NGOs is paramount (Fleury et al. 2012). The study findings underline the fact that a wealth of community-based resources are not adequately harnessed in district-level mental health services, and NGOs especially offer resources to complement scarce mental health skills (Petersen et al. 2009; Van Pletzen et al. 2013). NGOs can be highly effective stakeholders in addressing psychosocial and social concerns (Fleury et al. 2012), and it is essential that mental health service providers harness each other's different forms of capital towards common goals (Mur-Veeman et al. 2003). The lack of provincial policy and stewardship is significant here.

As far as could be determined, this study was one of the first to focus on inter-organisational mental health service relationships in South Africa in a relational way, especially in terms of state and non-state relations. The relative sparseness, inequality and power imbalances within the collaborative networks of the findings support persisting health system challenges in post-apartheid South Africa (Coovadia et al. 2009). Higher network density has been shown to suggest more trust and greater perceptions of value, therefore, more interactions indicate higher levels of trust and a greater perception of value (Retrum, Chapman, and Varda 2013). Non-state service providers find state regulatory frameworks and bureaucracy constraining to entrepreneurship, while state providers perceive their non-state counterparts as dodging their authority and regulation (Mur-Veeman et al. 2003). Weak inter-organisational integration further go hand-in-hand with diminished recognition of stakeholder expertise and legitimacy (Fleury, Mercier, and Denis 2002; Mur-Veeman et al. 2003; McDonald, Jayasuriya, and Harris 2012). It is however prudent to note that it might be “impossible to design an optimal network for the different needs of patients with severe mental illnesses”, since integration strategies might conflict with one another (Lorant et al. 2017, 884). More services also lead to less contact with the whole continuum, and it is imperative that local contexts and resources be considered in collaborative partnering, as well as the saliency of governance.

Unlike state facilities, which have a degree of standardisation and hierarchy, non-state service providers are marked by a range of variations in terms of aspects such as ideology, scope, size, age, and target populations (Fleury et al. 2012), challenging collaborative efforts. The development and successful implementation of integrated service networks in mental health care require the coordination of several strategies in the different levels of integration as well as in the different levels of governance. These strategies are meant to encourage new interactions and increase pro-reform practices (Fleury 2005). It is imperative that integrated care is a clear feature of national, provincial and local policies (Mur-Veeman, Van Raak, and Paulus 2008), and this study’s findings suggested that – on national level at least – South Africa has a policy environment that is conducive to collaboration. Nevertheless, the breakdown of policy strategies on provincial and district level is problematic, and it has been pointed out that a single network structure is not always well adapted to the ideals of reform, particularly reforms that underline social integration (Lorant et al. 2017). In South Africa, the failure of national mental policy implementation on district level is an effect of decentralised governance to provinces, leading to fractured prioritisation, implementation and monitoring (Draper et al. 2009; Van Rensburg and Engelbrecht 2012). Service delivery actors on district, facility and community level often use their knowledge of local contexts to resist the power of provincial authority, many times against official directives (Lehmann and Gilson 2013). The strength of referral between NGOs and state facilities can be improved by formal agreements and close engagement at regular roundtable discussions (Fleury et al. 2012). In the absence of formal collaborative agreements between service providers, complementary services are not identified and used optimally (Nicaise et al. 2013). Nonetheless, trust-building and provincial leadership are crucial, since NGOs often hold on to a fear that formal agreements with state facilities might reduce their autonomy and induce the adoption of divergent practices (Fleury et al. 2012).

The organisation of the DoH and DoSD within the contexts of mental health care was fractured. This could help explain what NGOs (who fall under the auspices of the DoSD) was not adequately integrated with the public health system (under direction of the DoH). Globally, there has been a shift towards policy that attempts to foster collaboration between social and health care, in order to respond to shifts in welfare governance and rising service demands by means of service re-organisation and government-set targets (Rummery 2009). A particular challenge for the implementation of integrated care is that it is delivered within national frameworks and regulation. Existing legislative and financial structures and policy processes impede integrated health care, and are relatively inflexible to change (Mur-Veeman et al. 2003). A very salient challenge is separate funding structures for health and social services (Rummery 2009). Mental health care should – following its conceptual complexity outlined earlier – be approached in a multi-sectoral way, especially in terms of shared funding, information, accountability, and communication platforms. This holds significant consequences for the way in which the next mental health policy should be structured, as well as for a degree of flexibility in existing government structures.

Finally, the politics of health care relationships require consideration: "Health care decision making is not and cannot ever be value free. By its very nature it is a product of, and acts upon, powerful interests. It cannot escape the consequences of the politics of health" (Jones 2001, 68). The politics that underwrite the relationships between state and non-state mental health service providers have significant consequences for service delivery and the strength of integrated care. The potential benefits of collaboration are offset by its blurring of accountability and responsibility – most strikingly illustrated in the Life Esidimeni tragedy – along with applying a cosmetic veneer to state attempts to retaining legitimacy in terms of controlling health care provision (Wanna 2008). The underlying cost-effectiveness rationalities of state and non-state service collaboration also detract from deeper structural challenges facing the district health system (Doherty 2010). In terms of mental health, these challenges include a lack of clear consensus around the dimensions, nature and characteristics of mental health (and associated with this, little credible indicators available); the size of the burden of mental illness, and a lack of evidence-based interventions that can be scaled up to population level (Tomlinson and Lund 2012). Nonetheless, the trap of focusing on only the technical aspects of monitoring and evaluating mental illness should be avoided; in Habermasian terms, these technical aspects are part of the problematique of the lifeworld/system-world dissonance and are in themselves "profoundly political" (Jones 2001, 82).

Closing remarks

During the course of this study, the Life Esidimeni tragedy unfolded, touching on the very moral fabric of post-apartheid South Africa. In public arbitration hearings into the circumstances of the tragedy, former Deputy Chief Justice of South Africa Dikgang Moseneke (2018) remarked that it is a "total post-apartheid tragedy", "bigger than the Sharpeville massacre and Marikana". At the time of writing, more than 143 people living with mental illness had died, with many more missing. More worrying is the knowledge that people living with mental illness continue to live in atrocious conditions throughout the country; the very public focus on death negated a collective consciousness of the conditions under which people living with mental illness are sheltered by state and civil society responses. It is a stark example of the consequences of a disintegrated system of care, and serious faults in governance and the relations between state and non-state stakeholders. It needs to be underlined that, during the fallout of this tragedy, no clear intensions were expressed about bringing care for people living with mental illness in line with the ideals set out in the National Mental Health Policy and Strategic Plan, and similar tragedies are anticipated in the future. This elevates the importance of this study which – though limited by scope, time, and the nature of doctoral research – lays the foundation for building a body of work focused on further engagement with governance and power in mental health care. Hopefully the point has been made that mental illness and responses to it are intimately intertwined with multiple dimensions of power, and that the structural violence imposed on PLWMI is – in part, at least – a consequence of politics in the era of advanced liberalism, since advanced liberalism can be known in its *consequence* rather than in its *substance* (Foucault 2008). Until we can be able to "carve nature at its joints" and pin down mental illness on a biological level, its vagueness opens it up for a specific type of politics, where people living with mental illness are at the bottom of government and funding priority lists. Whatever the future may hold, it is clear that the social sciences – in the present case, sociology and political science – have a central role to play, as lenses that uncover the ever-present processes of power in society.

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Addendum A: Declarations

Declarations by the candidate:

With regard to Chapter 2, part 1, page 35 to 57, the nature and scope of my contribution were as follows (declaration with signature in possession of candidate and supervisors):

Nature of contribution	Extent of contribution (%)
Conceptualisation, writing first and subsequent drafts	85

The following co-authors have contributed to Chapter 2, part 1, page 35 to 57

Name	Email address	Nature of contribution	Extent of contribution
Asta Rau	RauAHM@ufs.ac.za	Critique	5%
Pieter Fourie	ppfourie@sun.ac.za	Critique	5%
Piet Bracke	piet.bracke@ugent.be	Critique	5%

With regard to Chapter 2, part 2, page 58 to 73, the nature and scope of my contribution were as follows (declaration with signature in possession of candidate and supervisors):

Nature of contribution	Extent of contribution (%)
Conceptualisation, writing first and subsequent drafts	80%

The following co-authors have contributed to Chapter 2, part 2, page 58 to 76

Name	Email address	Nature of contribution	Extent of contribution
Pieter Fourie	ppfourie@sun.ac.za	Critique	5%
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Dingie Van Rensburg	vrensh@ufs.ac.za	Critique	5%

With regard to Chapter 2, part 3, page 77 to 103, the nature and scope of my contribution were as follows (declaration with signature in possession of candidate and supervisors):

Nature of contribution	Extent of contribution (%)
Conceptualisation, writing first and subsequent drafts	85%

The following co-authors have contributed to Chapter 2, part 3, page 77 to 103

Name	Email address	Nature of contribution	Extent of contribution
Rabia Khan	ircrabia@gmail.com	Critique	5%
Pieter Fourie	ppfourie@sun.ac.za	Critique	5%
Piet Bracke	piet.bracke@ugent.be	Critique	5%

With regard to Chapter 4, page 122 to 147, the nature and scope of my contribution were as follows (declaration with signature in possession of candidate and supervisors):

Nature of contribution	Extent of contribution (%)
Conceptualisation, writing first and subsequent drafts	90%

The following co-authors have contributed to Chapter 4, page 122 to 147

Name	Email address	Nature of contribution	Extent of contribution
Pieter Fourie	ppfourie@sun.ac.za	Critique	10%

With regard to Chapter 5, page 148 to 173, the nature and scope of my contribution were as follows (declaration with signature in possession of candidate and supervisors):

Nature of contribution	Extent of contribution (%)
Conceptualisation, writing first and subsequent drafts	65%

The following co-authors have contributed to Chapter 5, page 148 to 173:

Name	Email address	Nature of contribution	Extent of contribution
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Michelle Engelbrecht	engelmc@ufs.ac.za	Critique	5
Gladys Kigozi	kigozign@ufs.ac.za	Critique	5
Dingie van Rensburg	vrensh@ufs.ac.za	Critique	5
Piet Bracke	piet.bracke@ugent.be	Critique	5

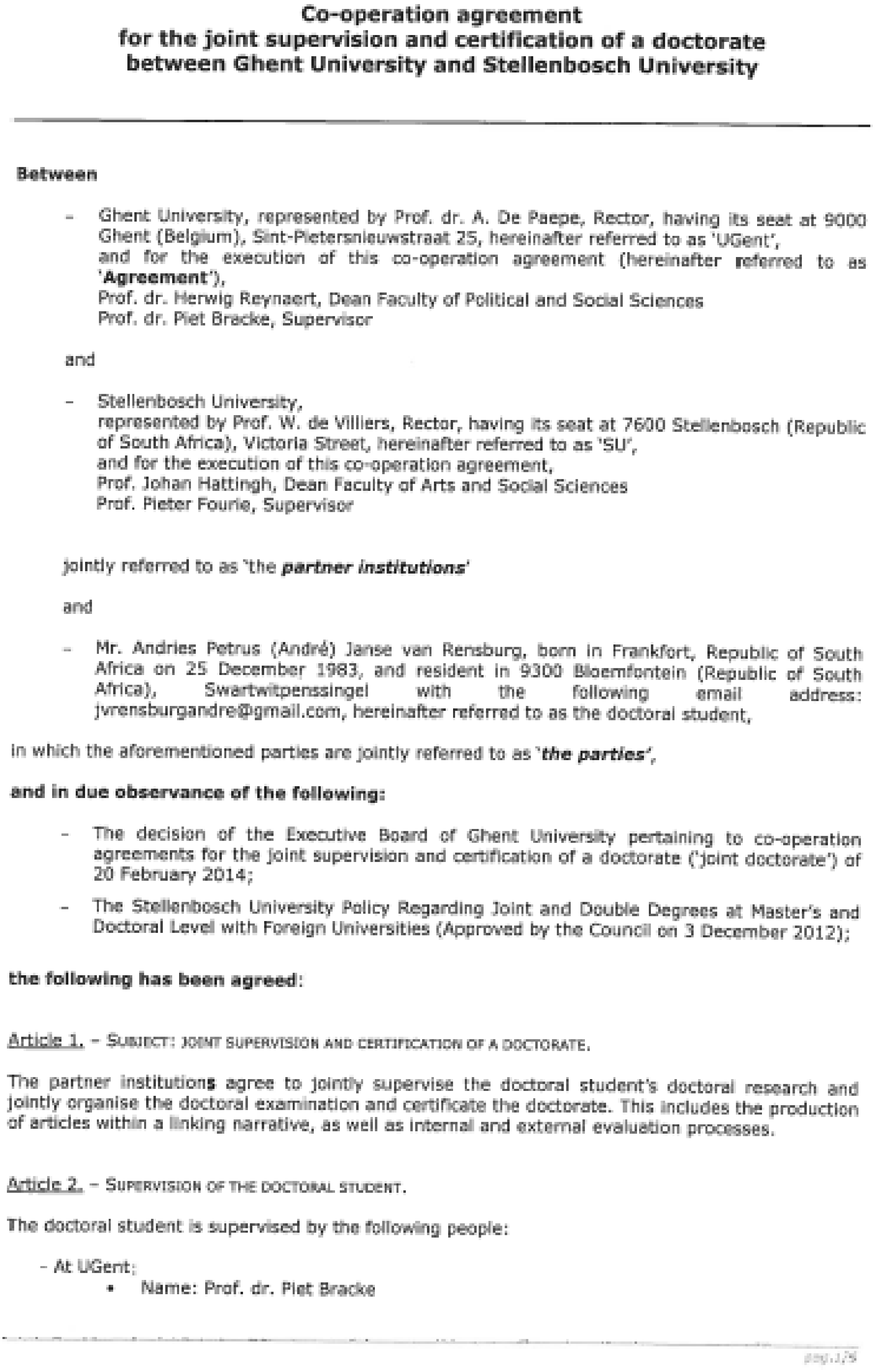
With regard to Chapter 6, page 164 to 191, the nature and scope of my contribution were as follows (declaration with signature in possession of candidate and supervisors):

Nature of contribution	Extent of contribution (%)
Conceptualisation, writing first and subsequent drafts	75%

The following co-authors have contributed to Chapter 6, page 164 to 191:

Name	Email address	Nature of contribution	Extent of contribution
Rabia Khan	ircrabia@gmail.com	Critique	5
Edwin Wouters	edwin.wouters@uantwerpen.be	Critique	5
Pieter Fourie	ppfourie@sun.ac.za	Critique	5
Dingie van Rensburg	vrensh@ufs.ac.za	Critique	5
Piet Bracke	piet.bracke@ugent.be	Critique	5

Addendum B: Formal joint-PhD agreement



Co-operation agreement
for the joint supervision and certification of a doctorate
between Ghent University and Stellenbosch University

Between

- Ghent University, represented by Prof. dr. A. De Paepe, Rector, having its seat at 9000 Ghent (Belgium), Sint-Pietersnieuwstraat 25, hereinafter referred to as 'UGent',
  and for the execution of this co-operation agreement (hereinafter referred to as '**Agreement**'),
  Prof. dr. Herwig Reynaert, Dean Faculty of Political and Social Sciences
  Prof. dr. Piet Bracke, Supervisor

and

- Stellenbosch University,
  represented by Prof. W. de Villiers, Rector, having its seat at 7600 Stellenbosch (Republic of South Africa), Victoria Street, hereinafter referred to as 'SU',
  and for the execution of this co-operation agreement,
  Prof. Johan Hattingh, Dean Faculty of Arts and Social Sciences
  Prof. Pieter Fourie, Supervisor

jointly referred to as 'the ***partner institutions***'

and

- Mr. Andries Petrus (André) Janse van Rensburg, born in Frankfort, Republic of South Africa on 25 December 1983, and resident in 9300 Bloemfontein (Republic of South Africa), Swartwitpenssingel with the following email address: jvrensburgandre@gmail.com, hereinafter referred to as the doctoral student,

in which the aforementioned parties are jointly referred to as '***the parties***',

and in due observance of the following:

- The decision of the Executive Board of Ghent University pertaining to co-operation agreements for the joint supervision and certification of a doctorate ('joint doctorate') of 20 February 2014;
- The Stellenbosch University Policy Regarding Joint and Double Degrees at Master's and Doctoral Level with Foreign Universities (Approved by the Council on 3 December 2012);

the following has been agreed:

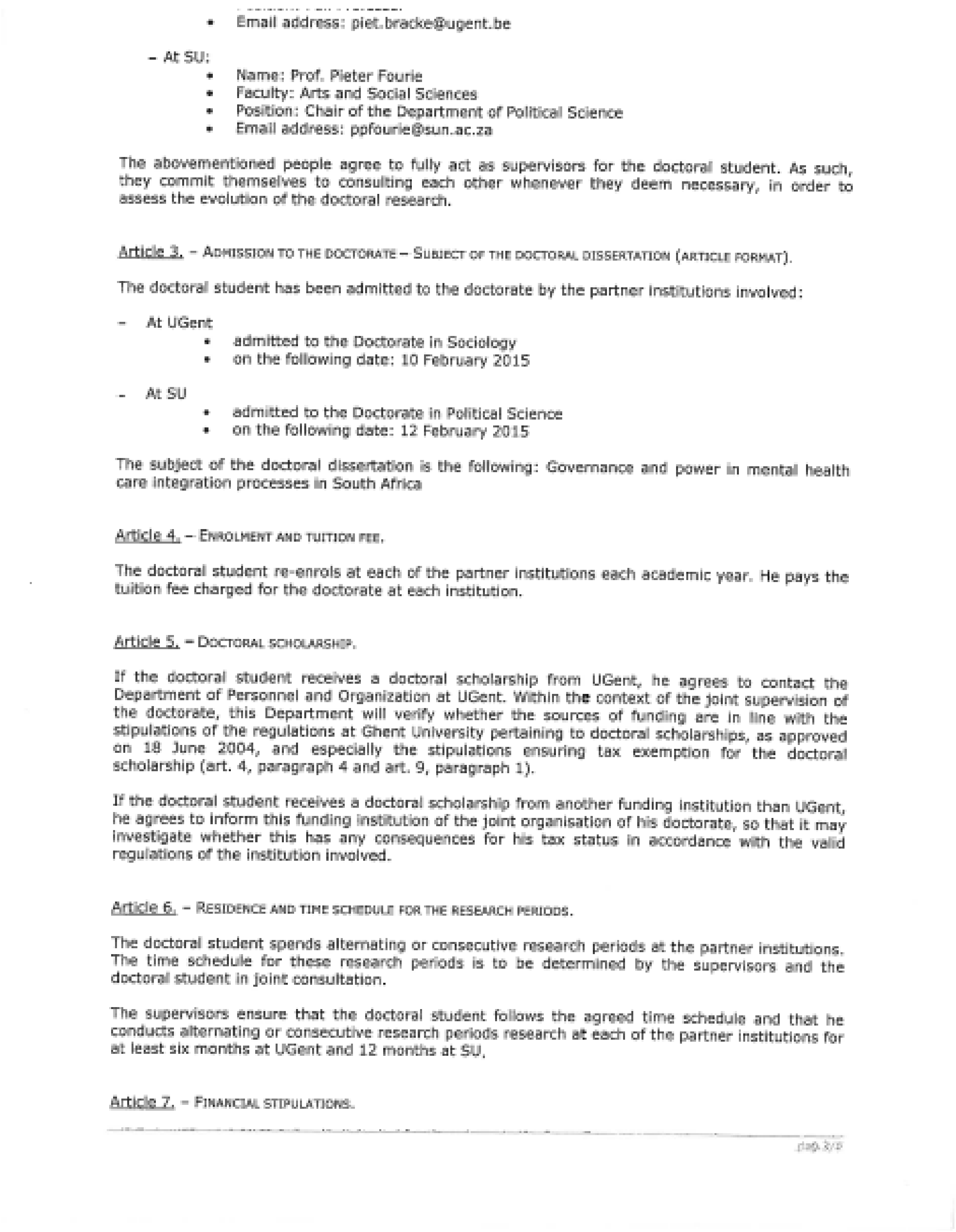
Article 1. – SUBJECT: JOINT SUPERVISION AND CERTIFICATION OF A DOCTORATE.

The partner institutions agree to jointly supervise the doctoral student's doctoral research and jointly organise the doctoral examination and certificate the doctorate. This includes the production of articles within a linking narrative, as well as internal and external evaluation processes.

Article 2. – SUPERVISION OF THE DOCTORAL STUDENT.

The doctoral student is supervised by the following people:

- At UGent:
  - Name: Prof. dr. Piet Bracke



- Email address: piet.bracke@ugent.be

– At SU:
  - Name: Prof. Pieter Fourie
  - Faculty: Arts and Social Sciences
  - Position: Chair of the Department of Political Science
  - Email address: ppfourie@sun.ac.za

The abovementioned people agree to fully act as supervisors for the doctoral student. As such, they commit themselves to consulting each other whenever they deem necessary, in order to assess the evolution of the doctoral research.

Article 3. – ADMISSION TO THE DOCTORATE – SUBJECT OF THE DOCTORAL DISSERTATION (ARTICLE FORMAT).

The doctoral student has been admitted to the doctorate by the partner institutions involved:

- At UGent
  - admitted to the Doctorate in Sociology
  - on the following date: 10 February 2015
- At SU
  - admitted to the Doctorate in Political Science
  - on the following date: 12 February 2015

The subject of the doctoral dissertation is the following: Governance and power in mental health care integration processes in South Africa

Article 4. – ENROLMENT AND TUITION FEE.

The doctoral student re-enrols at each of the partner institutions each academic year. He pays the tuition fee charged for the doctorate at each institution.

Article 5. – DOCTORAL SCHOLARSHIP.

If the doctoral student receives a doctoral scholarship from UGent, he agrees to contact the Department of Personnel and Organization at UGent. Within the context of the joint supervision of the doctorate, this Department will verify whether the sources of funding are in line with the stipulations of the regulations at Ghent University pertaining to doctoral scholarships, as approved on 18 June 2004, and especially the stipulations ensuring tax exemption for the doctoral scholarship (art. 4, paragraph 4 and art. 9, paragraph 1).

If the doctoral student receives a doctoral scholarship from another funding institution than UGent, he agrees to inform this funding institution of the joint organisation of his doctorate, so that it may investigate whether this has any consequences for his tax status in accordance with the valid regulations of the institution involved.

Article 6. – RESIDENCE AND TIME SCHEDULE FOR THE RESEARCH PERIODS.

The doctoral student spends alternating or consecutive research periods at the partner institutions. The time schedule for these research periods is to be determined by the supervisors and the doctoral student in joint consultation.

The supervisors ensure that the doctoral student follows the agreed time schedule and that he conducts alternating or consecutive research periods research at each of the partner institutions for at least six months at UGent and 12 months at SU.

Article 7. – FINANCIAL STIPULATIONS.

Article 8. – INSURANCE.

The doctoral student commits himself to taking out health insurance, insurance against accidental physical damage and civil liability during the execution of the tasks concerning his doctoral research at the partner institutions, in accordance with the institutional and national regulations that apply in the partner institutions involved.

Article 9. – PROTECTION OF THE RESEARCH RESULTS AND INTELLECTUAL PROPERTY RIGHTS.

The research results that arise from the doctoral research belong to both partner institutions.

The research results that arise from the doctoral research, including their publication and exploitation, are protected within the valid regulations in each country and each partner institution.

Article 10. – LANGUAGE OF THE DOCTORAL DISSERTATION AND THE DOCTORAL EXAMINATION.

The doctoral dissertation is written in English.
A summary of the doctoral dissertation is provided in English, Dutch and Afrikaans.

The internal and public defence of the doctoral dissertation will take place in English.

Article 11. – ADMISSION TO THE DOCTORAL EXAMINATION.

Regardless of the venue for the defence that is set in accordance with article 13, the doctoral student will follow the procedure for the admission to the doctoral examination that is in place at both partner institutions.

Article 12. – EXAMINATION BOARD FOR THE DOCTORAL EXAMINATION.

The examiners appointed by the partner institutions will form a Joint Examinations Committee. The Joint Examinations Committee for the doctoral examination (i.e. the dissertation and the defence) is composed of members of both partner institutions, and chaired by an independent chairperson appointed jointly by the partner institutions. From the members of the Examination Board a reading committee of four examiners will be composed. These four examiners will be:

Examiner 1 - A member of the Faculty of Political and Social Sciences of UGent, appointed by UGent. This must be a person who was not involved in the supervision of the dissertation

Examiner 2 - A member of the Faculty of Arts and Social Sciences of SU appointed by SU. This must be a person who was not involved in the supervision of the dissertation.

Examiners 3 and 4 - Two external examiners who are not a member of staff of UGent or SU, appointed by UGent and by SU after previous consultation between the partner institutions to decide on suitable people.

Article 13. – DEFENCE OF THE DOCTORAL DISSERTATION.

An internal defence of the doctoral dissertation will take place at SU, followed by a public defence at UGent, both defence processes being acknowledged by the partner institutions involved.

A copy of the deliberations report of the Joint Examinations Committee is sent to the bodies that are responsible for the administration for the doctoral student involved and his diplomas at each of the partner institutions. If required, the deliberations report is also translated into a national language of the other institution(s) or a lingua franca.

Article 14. – CERTIFICATION.

If the doctoral student passes the certified joint doctoral examination, the partner institutions award him a joint degree, which is acknowledged by both institutions, granting him the following degree certificates:

- Doctor of Sociology by UGent
- PhD in Political Science by SU

Although this will be two degree certificates, this will be one degree, jointly conferred by SU and UGent. Each degree refers to the joint supervision of the doctorate and the degree that the partner institution may award. The joint degree will only be issued if both parties agree on the award.

Article 15. – APPEAL.

If the doctoral student believes that he received a negative exam decision due to non-observance of his rights, he may file an appeal with the appeals procedures of the institution at which the internal doctoral defence has taken place, which notifies the doctoral student and the partner institution of its decision without delay.

Article 16. – COMMENCEMENT, VALIDITY PERIOD AND AMENDMENTS OF THE AGREEMENT.

This agreement enters into force upon signature by both partners and is terminated on February 2019.

If, during this period, one of the following elements of the agreement is amended, a modification agreement will be drawn up and approved by the partner institutions:

- intended doctorate
- faculty
- language of the dissertation
- language of the defence
- supervisor(s)

If the doctoral student has not publicly defended the doctoral dissertation before the deadline, this agreement may be extended, provided that all parties agree to this.

Article 17. –LANGUAGE OF THE AGREEMENT.

This agreement is drawn up in English.

Drawn up in Stellenbosch in six copies, on 5 June 2015,

Prof. dr. A. De Paepe, Rector UGent	Prof. Johan Hattingh, Dean Faculty of Arts and Social Sciences SU

Prof. dr. Herwig Reynaert, Dean Faculty of Political and Social Sciences UGent	Fourie 04/09/2015 Prof. Pieter Fourie, Supervisor SU
Prof. dr. Piet Bracke, Supervisor UGent	Mr. André Janse van Rensburg, Doctoral student

Addendum C: Information and informed consent

UNIVERSITEIT•STELLENBOSCH•UNIVERSITY
jou kennisvennoot • your knowledge partner

STELLENBOSCH UNIVERSITY
CONSENT TO PARTICIPATE IN RESEARCH

TITLE OF THE RESEARCH PROJECT: Governance of mental health care integration processes

REFERENCE NUMBER: HS1156/2015

RESEARCHER: André Janse van Rensburg

ADDRESS: Department of Political Science
University of Stellenbosch
6th Floor, Arts Building
cnr. Merriman Ave. and Ryneveld St.
Stellenbosch
7600

CONTACT NUMBER: 0823020259

To whom it may concern

My name is André Janse van Rensburg and I am a PhD student at Stellenbosch University. I would like to invite you to participate in a research project entitled "Governance of integrated mental health care processes".

Please take some time to read the information presented here, which will explain the details of this project and contact me if you require further explanation or clarification of any aspect of the study. Also, your participation is **entirely voluntary** and you are free to decline to participate. If you say no, this will not affect you negatively in any way whatsoever. You are also free to withdraw from the study at any point, even if you do agree to take part.

This study has been approved by the **Humanities Research Ethics Committee (HREC) at Stellenbosch University** and will be conducted according to accepted and applicable national and international ethical guidelines and principles.

The study seeks to explore integrated mental health care, that is, the extent to which service providers collaborate with one another in providing mental health services. Specifically, the study focuses on governance processes, meaning the way in which the interactions between stakeholders influence mental health care. You have been identified as an important stakeholder in this regard, and your input would add value to the research. The possible negative consequences of your participation are minimal. The time you have to spend taking part in the interview may cause you inconvenience and, since you might be asked to recall past work-related events, possible discomfort. There are no direct benefits resulting from your participation in the interview, though the ultimate aim of the research is to aid is a better understanding of mental health service provision and ultimately add to health system strengthening. You will not receive any form of financial remuneration. With your permission, I would like to audio record our discussion, so that I can read the transcript later for better accuracy. The transcribed interview will be transferred into a password-protected, anonymised electronic dataset for analysis. The original questionnaire will be kept locked in an office at the University of the Free State, to which only I will have access. All information will be coded, and your name will never be used at any time throughout the research process. Your participation in the research is completely voluntary. You can withdraw from the study at any time without facing negative consequences. Even if there are certain questions that you do not wish to answer, you may still remain in the study.

If you have any questions or concerns about the research, please feel free to contact me at the following:
Mobile phone number: 0823020259; Email: jvrensburgandre@gmail.com

Alternatively, contact my study supervisor:
Prof Pieter Fourie
Phone number: 021 808 2414
Email: ppfourie@sun.ac.za

RIGHTS OF RESEARCH PARTICPANTS: You may withdraw your consent at any time and discontinue participation without penalty. You are not waiving any legal claims, rights or remedies because of your participation in this research study. If you have questions regarding your rights as a research subject, contact Ms Maléne Fouché [mfouche@sun.ac.za; 021 808 4622] at the Division for Research Development.
You have right to receive a copy of the Information and Consent form.

If you are willing to participate in this study please sign the attached Declaration of Consent and hand it to the researcher

Yours sincerely

André Janse van Rensburg
Principal Investigator

DECLARATION BY PARTICIPANT

By signing below, I …………………………………..………………. agree to take part in a research study entitled "Governance of mental health care integration processes" and conducted by André Janse van Rensburg.

I declare that:

- I have read the attached information leaflet and it is written in a language with which I am fluent and comfortable.
- I have had a chance to ask questions and all my questions have been adequately answered.
- I understand that taking part in this study is **voluntary** and I have not been pressurised to take part.
- I may choose to leave the study at any time and will not be penalised or prejudiced in any way.
- I may be asked to leave the study before it has finished, if the researcher feels it is in my best interests, or if I do not follow the study plan, as agreed to.
- All issues related to privacy and the confidentiality and use of the information I provide have been explained to my satisfaction.

Signed at (*place*) ....…………………….. on (*date*) …………....……….. 2016.

....

Signature of participant

SIGNATURE OF INVESTIGATOR

I declare that I explained the information given in this document to ___________________ [*name of the participant]* *[H*e/she] was encouraged and given ample time to ask me any questions. This conversation was conducted in [*Afrikaans/*English/*Xhosa/*Other*] and [*no translator was used/this conversation was translated into* ____________ by ________________________].

____ _______________

Signature of Investigator **Date**

Addendum D: SNA instrument

MENTAL HEALTH CARE SURVEY

Please complete all questions. Unless otherwise stated, tick only one response to each question. All information will be treated as strictly confidential.

Questionnaire number (office use only):

SECTION A

1. Date:	dd/mm/yyyy
2. Sub-district:	☐ Bloemfontein ☐ Botshabelo ☐ Thaba Nchu
3. Name of facility:	____
4. Address of the facility:	____
5. Contact details of the facility:	Telephone number:____________________________ Fax number:__________________________________ Email:_____________________________________
6. Catchment population of the clinic:	____
7. Details of interviewee:	Name:_____________________________________ Position:___________________________________
8. Does this facility have someone who is trained in the following:	☐ Screening for mental illness _____________ ☐ Diagnosing mental illness_____________ ☐ Treating mental illness (with medication)__ ☐ Counselling/therapy________________ ☐ Appropriate referral _______________
9. Does this facility provide the following mental health services? *Tick all that apply, and add who usually provides the specific services (positions, not names)*	☐ Screening for mental illness __________ ☐ Diagnosing mental illness_______________ ☐ Providing medication______________ ☐ Counselling___________________________ ☐ Treatment adherence support___________ ☐ Refer to appropriate care_______________ ☐ Accept referrals________________________ ☐ Community integration_________________ ☐ Psychological rehabilitation______________
10. During the past month, overall how many patients living with mental illness did you *Note: Last full month*	Provide with treatment ____________ Accept as outpatients who were referred to you _______ Refer for diagnosis________________________________

	Refer for appropriate treatment____________________
11. When referring a patient suffering from mental illness to another governmental facility, how is it communicated? *Tick all that apply*	☐Phone call ☐Fax ☐E-mail ☐Referral form transferred by the patient ☐Other (specify):________________________
12. When a referring a patient suffering from mental illness to a non-governmental facility, how is it communicated? *Tick all that apply*	☐Phone call ☐Fax ☐E-mail ☐Referral form transferred by the patient ☐Other (specify):________________________
13. Please indicate whether you follow up on patients suffering from mental illness whom you have referred to governmental facilities, and state how (via phone, email, fax etc.) *Tick all that apply*	☐Diagnosis______________________________ ☐Clinical treatment_______________________ ☐Psychotherapy/counselling_______________
14. Please indicate whether you receive feedback from governmental facilities to which you have referred patients suffering from mental illness, and state how (via phone, email, fax etc.) *Tick all that apply*	☐Diagnosis______________________________ ☐Clinical treatment_______________________ ☐Psychotherapy/counselling_______________
15. Please indicate whether you follow up on patients suffering from mental illness whom you have referred to non-governmental facilities, and state how (via phone, email, fax etc.) *Tick all that apply*	☐Diagnosis______________________________ ☐Clinical treatment_______________________ ☐Psychotherapy/counselling_______________
16. Please indicate whether you receive feedback from non-governmental facilities to which you have referred patients suffering from mental illness, and state how (via phone, email, fax etc.) *Tick all that apply*	☐Diagnosis______________________________ ☐Clinical treatment_______________________ ☐Psychotherapy/counselling_______________
17. When you are presented with a patient with possible mental illness symptoms, and are uncertain how to manage the situation, who do you call on for advice and support? *Rate from 1 to 4 (1=most important, 4=least important)*	☐A colleague in this facility ☐A colleague in a different facility (specify facility) ____ ☐A district-level manager ☐A non-governmental person (specify) ____
18. Do you have a written mental health policy?	☐Yes ☐No

19. Briefly explain how a mental health referral is made:	____ ____ ____ ____ ____ ____ ____ ____ ____ ___________________________
20. What are you main challenges regarding mental health care?	____ ____ ____ ____ ____ ____

SECTION B

Please indicate 1) which facilities/organisations/people refer patients with mental illness to your clinic, and 2) how often. Please name ALL you know of, including other health facilities, NGOs, churches, social workers, traditional healers, police etc.

Please state the name of the facility/organisation/person, the usual reason for referral, as well as the frequency of referrals

Name of facility/organisation/person	**Usual reason for referral**	**Frequency of referral**
1		☐ Daily ☐ Weekly ☐ Monthly ☐ Less than monthly
2		☐ Daily ☐ Weekly ☐ Monthly ☐ Less than monthly
3		☐ Daily ☐ Weekly ☐ Monthly ☐ Less than monthly
4		☐ Daily ☐ Weekly ☐ Monthly ☐ Less than monthly
5		☐ Daily ☐ Weekly ☐ Monthly ☐ Less than monthly
6		☐ Daily ☐ Weekly ☐ Monthly ☐ Less than monthly
7		☐ Daily ☐ Weekly ☐ Monthly ☐ Less than monthly
8		☐ Daily ☐ Weekly ☐ Monthly ☐ Less than monthly
9		☐ Daily ☐ Weekly ☐ Monthly ☐ Less than monthly
10		☐ Daily ☐ Weekly ☐ Monthly ☐ Less than monthly

Please indicate 1) to which facilities/organisations/people you refer patients living with mental illness, and 2) how often. Please name ALL you know of, including other health facilities, NGOs, churches, social workers, traditional healers, police etc.

Name of facility/organisation/person	**Usual reason for referral**	**Frequency of referral**
1		☐ Daily ☐ Weekly ☐ Monthly ☐ Less than monthly
2		☐ Daily ☐ Weekly ☐ Monthly ☐ Less than monthly
3		☐ Daily ☐ Weekly ☐ Monthly ☐ Less than monthly

4		☐ Daily ☐ Weekly ☐ Monthly ☐ Less than monthly
5		☐ Daily ☐ Weekly ☐ Monthly ☐ Less than monthly
6		☐ Daily ☐ Weekly ☐ Monthly ☐ Less than monthly
7		☐ Daily ☐ Weekly ☐ Monthly ☐ Less than monthly
8		☐ Daily ☐ Weekly ☐ Monthly ☐ Less than monthly
9		☐ Daily ☐ Weekly ☐ Monthly ☐ Less than monthly
10		☐ Daily ☐ Weekly ☐ Monthly ☐ Less than monthly

SECTION C

Please indicate with whom you collaborate in providing mental health services, the nature of the collaboration, the extent to which you depend on and trust these facilities/organisations/people.

Please name ALL you know of, including other health facilities, NGOs, churches, social workers, traditional healers, police etc.

Name of facility/organisation/ person	**Reasons for collaboration** **(ex. Mental health training, referral, promotion etc)**	**Please rate the extent to which do you depend on this facility/ organisation/person** **1** Very little **2** A little **3** A moderate amount **4** A great deal	**Please rate the extent to which you trust this facility/organisation/person** **1** Very little **2** A little **3** A moderate amount **4** A great deal
1			
2			
3			
4			

5			
6			
7			
8			
9			
10			

SECTION D

Please indicate to what degree you agree with the following statements:

Tick only one

1. Mental health outpatient care should be provided at PHC clinics

☐ Strongly agree ☐ Agree ☐ Disagree ☐ Strongly Disagree

2. It is possible to provide mental health services in PHC clinics

☐ Strongly agree ☐ Agree ☐ Disagree ☐ Strongly Disagree

3. Dealing with patients living with mental illness at the clinic makes my job too difficult

☐ Strongly agree ☐ Agree ☐ Disagree ☐ Strongly Disagree

4. Our clinic is able to provide adequate care to patients living with mental illness

☐ Strongly agree ☐ Agree ☐ Disagree ☐ Strongly Disagree

5. Patients seeking HIV and maternal care should be screened for mental illness at the PHC clinic

☐ Strongly agree ☐ Agree ☐ Disagree ☐ Strongly Disagree

6. It is easier to refer a patient with suspected mental illness to another service provider than to treat him/her ourselves

☐ Strongly agree ☐ Agree ☐ Disagree ☐ Strongly Disagree

7. It makes our job much more difficult when patients living with mental illness are referred to us for care from other clinics/hospitals

☐ Strongly agree ☐ Agree ☐ Disagree ☐ Strongly Disagree

8. It is better to refer a patient with suspected mental illness to another service provider than to treat him/her ourselves

☐ Strongly agree ☐ Agree ☐ Disagree ☐ Strongly Disagree

9. Private GPs, psychologists, social workers and therapists can contribute much to the provision of mental health services in PHC clinics

☐ Strongly agree ☐ Agree ☐ Disagree ☐ Strongly Disagree

10. NGOs and churches can contribute much to the provision of mental health services in PHC clinics

☐ Strongly agree ☐ Agree ☐ Disagree ☐ Strongly Disagree

11. Traditional healers can contribute much to the provision of mental health services in PHC clinics

☐ Strongly agree ☐ Agree ☐ Disagree ☐ Strongly Disagree

12. In terms of mental illness, collaborating with GPs, traditional healers, churches and NGOs is better for the patient

☐ Strongly agree ☐ Agree ☐ Disagree ☐ Strongly Disagree

13. Collaborating with GPs, traditional healers, churches and NGOs would make our job easier in providing mental health services

☐ Strongly agree ☐ Agree ☐ Disagree ☐ Strongly Disagree

14. We receive enough support from district management in providing mental health care

☐ Strongly agree ☐ Agree ☐ Disagree ☐ Strongly Disagree

15. We receive enough support from provincial management in providing mental health care

☐ Strongly agree ☐ Agree ☐ Disagree ☐ Strongly Disagree

16. We make suggestions around mental health care in our clinic to the district and provincial managers

☐ Strongly agree ☐ Agree ☐ Disagree ☐ Strongly Disagree ☐ N/A

17. When we complain/make suggestions about mental health care to district/provincial management they respond to our concerns

☐ Strongly agree ☐ Agree ☐ Disagree ☐ Strongly Disagree ☐ N/A

Thank you for completing this questionnaire!

Addendum E: Semi-structured interview schedule, collaborating service providers

Intro

- What types of mental health services do you provide to patients (including co-morbid consultations)
- How often do you refer people presenting with mental illness, who directly come to your facility for help?

Interaction with patients

- When dealing with patients with mental illness, do you feel that you have enough time to care for them?
- What about resources?
- Do you feel confident in managing people with mental illness?
- Are there ways for mental patients or their families to give feedback on their care?
- Do patients discuss challenges with their treatment and care with you or your colleagues?

Interaction with the state (district and provincial health managers)

- How much input do you and your colleagues have in terms of input into mental health policy (for instance, referral, medication, therapy)?
- What kind of mental health information do you send to the district and provincial management?
- Are you happy with the way in which the district and provincial management manage mental health care?
- Do you provide feedback to the district and provincial management on the challenges you face regarding mental health care provision?
- To what extent do the district and provincial management listen and attend to your concerns?

Interaction with non-state service providers

Background

- Do you collaborate with non-governmental/government in any way in providing mental health care?
- Does anyone in the community help you with people with mental illness?

Formal authority

- How did you start working with your collaborator? (who initiated the relationship, reached out)
- Are there things that you or your collaborator cannot do? (such as, why)
- Who is in charge of the collaboration process?
- What do you expect from the collaboration? (are these expectations usually met)?

- How often, if ever, do you meet? (Who initiates meetings, who sets the agenda)
- What do you want to happen in this collaboration?
- Does your collaborator have a legal right to do what they do?

Resources

- How many people do you have providing mental health care compared to your collaborator?
- What expertise do you have compared to your collaborator?
- How is the collaboration funded?
- Is there any information-sharing?
- Do you both understand the problems and issues of the patients with mental illness?

Discursive legitimacy

- How does your status as service provider compare to that of your collaborator?
- Do you think that people with mental illness trust you and your collaborator equally?
- Are you and your collaborator well connected to provide mental health services?
- Do you have ways to get your collaborator to do their part?
- How and how often do you communicate with your collaborator?
- How and who decides what priorities are in providing mental health care?

Recommendations or suggestions

- Do you have any suggestions on how we can strengthen mental health care in South Africa?

Addendum F: Semi-structured interview schedule, health managers

Intro

- What types of mental health services does the DoH provide in Magaung Metro?
- What are the patient loads like?
- Please explain how people with mental illness are managed, from the moment that they come through the facility doors.
- What are the main challenges in providing quality mental health care for those who need it?
- What challenges do patients and their families face?
- What challenges do health facilities face?

Interaction with health facilities

- How do you support health facilities with mental health care?
- Do these facilities have input in the development of mental health-related policy and other guidelines?
- What kind of information is collected on mental health care? (by whom, who manages it, what happens to it, is it communicated back to facilities)
- Do you provide any feedback to health facilities in terms of performance in mental health care?
- Do they provide reporting to you?
- To what extent do you think is mental health care a priority in the DoH?
- To what extent do you think is mental health care a priority nationally?

Interaction with non-state service providers

Background

- Do you collaborate with non-governmental people in any way?
- Private? NGO?
- Does anyone in the community help you with people with mental illness?

Formal authority

- How did you start working with the organisation you collaborate with? (who initiated the relationship, reached out)
- Are there things that you or the organisation cannot do? (such as, why)
- Who is in charge of the collaboration process?
- What do you expect from the collaboration? (are these expectations usually met)?
- How often, if ever, do you meet? (Who initiates meetings, who sets the agenda)
- What do you want to happen in this collaboration?
- Does your partner have a legal right to do what they do?

Resources

- How many people do you have compared to your partner?
- What expertise do you have compared to your partner?
- How is the collaboration funded?
- Is there any information-sharing?
- Do you both understand the problems and issues of the patients with mental illness?

Discursive legitimacy

- How does your status compare to that of your partner?
- Do you think that people with mental illness trust you and your partner equally?
- Are you and your partner well connected to provide mental health services?
- Do you have ways to get your partner to do their part?
- How and how often do you communicate with your partner?
- How and who decides what priorities are in providing mental health care?

Recommendations or suggestions

- Do you have any suggestions on how we can strengthen mental health care in South Africa?
- Do you think that collaboration with other role players would be helpful?
- Who should facilitate such relationships?

Addendum G: Semi-structured interview schedule, non-state stakeholders

Intro

- What types of mental health services do you provide to patients (including co-morbid consultations)
- Please explain how people with mental illness are managed, from the moment that they come through your doors.
- How often do you refer people presenting with mental illness, who directly come to your facility for help?
- How often do you receive referrals from other organisations?

Interaction with patients

- When dealing with patients with mental illness, do you feel that you have enough time to care for them?
- What about resources?
- Do you feel confident in managing people with mental illness?
- Are there ways for mental patients or their families to give feedback on their care?
- Do patients discuss challenges with their treatment and care with you or your colleagues?

Interaction with the state (district and provincial health managers)

- In providing mental health care at your facility, do you feel supported by the government?
- How much input do you and your colleagues have in terms of input into mental health policy (for instance, referral, medication, therapy)?
- What kind of mental health information do you send to the government?
- Are you happy with the way in which the district and provincial management manage mental health care?
- Do you provide feedback to the district and provincial management on the challenges you face regarding mental health care provision?
- To what extent do the district and provincial management listen and attend to your concerns?

Interaction with other service providers

- Do you collaborate with governmental people in any way?
- Other non-state providers?
- Does anyone in the community help you with people with mental illness?

Recommendations or suggestions

- Do you have any suggestions on how we can strengthen mental health care in South Africa?

Addendum H: Semi-structured interview schedule, healthcare workers

Intro

- What types of mental health services do you provide to patients (including co-morbid consultations)
- Please explain how people with mental illness are managed, from the moment that they come through the clinic doors.
- Are these patients usually seen immediately, or do they have to wait in line alongside other patients?
- How often do you refer people presenting with mental illness, who directly come to your facility for help?

Interaction with patients

- When dealing with patients with mental illness, do you feel that you have enough time to care for them?
- What about resources?
- Do you feel confident in managing people with mental illness?
- Are there ways for mental patients or their families to give feedback on their care?
- Do patients discuss challenges with their treatment and care with you or your colleagues?

Interaction with the state (district and provincial health managers)

- In providing mental health care at your facility, how well does the district and provincial management support you?
- How much input do you and your colleagues have in terms of input into mental health policy (for instance, referral, medication, therapy)?
- What kind of mental health information do you send to the district and provincial management?
- Are you happy with the way in which the district and provincial management manage mental health care?
- Do you provide feedback to the district and provincial management on the challenges you face regarding mental health care provision?
- To what extent do the district and provincial management listen and attend to your concerns?

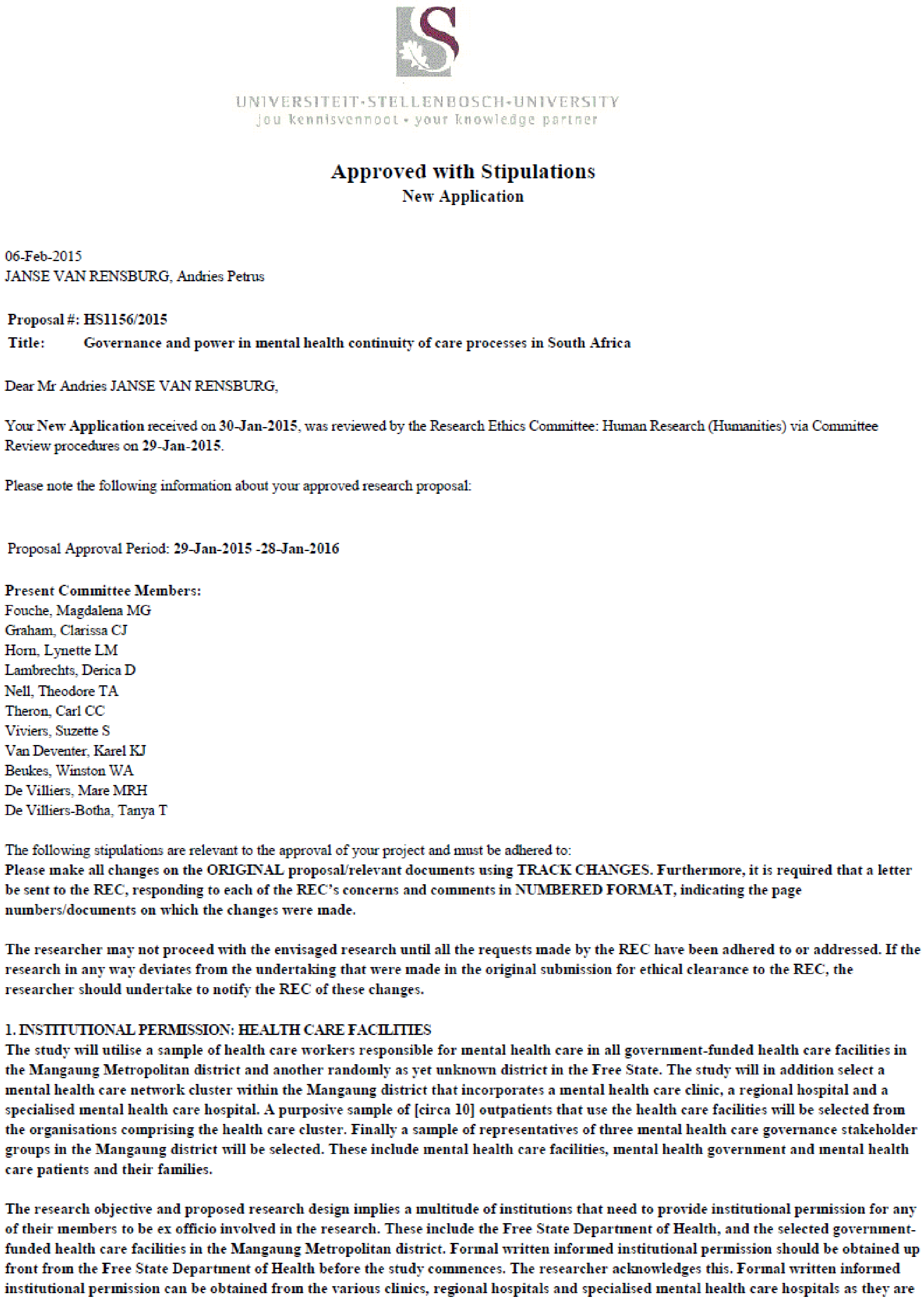
Interaction with non-state service providers

- Do you collaborate with non-governmental people in any way?
- Does anyone in the community help you with people with mental illness?

Recommendations or suggestions

- Do you have any suggestions on how we can strengthen mental health care in South Africa?
- What can national, provincial government do to improve mental health care?

Addendum I: Ethical permission



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Approved with Stipulations

New Application

06-Feb-2015
JANSE VAN RENSBURG, Andries Petrus

Proposal #: HS1156/2015
Title: **Governance and power in mental health continuity of care processes in South Africa**

Dear Mr Andries JANSE VAN RENSBURG,

Your **New Application** received on **30-Jan-2015**, was reviewed by the Research Ethics Committee: Human Research (Humanities) via Committee Review procedures on **29-Jan-2015**.

Please note the following information about your approved research proposal:

Proposal Approval Period: **29-Jan-2015 -28-Jan-2016**

Present Committee Members:
Fouche, Magdalena MG
Graham, Clarissa CJ
Horn, Lynette LM
Lambrechts, Derica D
Nell, Theodore TA
Theron, Carl CC
Viviers, Suzette S
Van Deventer, Karel KJ
Beukes, Winston WA
De Villiers, Mare MRH
De Villiers-Botha, Tanya T

The following stipulations are relevant to the approval of your project and must be adhered to:
Please make all changes on the ORIGINAL proposal/relevant documents using TRACK CHANGES. Furthermore, it is required that a letter be sent to the REC, responding to each of the REC's concerns and comments in NUMBERED FORMAT, indicating the page numbers/documents on which the changes were made.

The researcher may not proceed with the envisaged research until all the requests made by the REC have been adhered to or addressed. If the research in any way deviates from the undertaking that were made in the original submission for ethical clearance to the REC, the researcher should undertake to notify the REC of these changes.

1. INSTITUTIONAL PERMISSION: HEALTH CARE FACILITIES
The study will utilise a sample of health care workers responsible for mental health care in all government-funded health care facilities in the Mangaung Metropolitan district and another randomly as yet unknown district in the Free State. The study will in addition select a mental health care network cluster within the Mangaung district that incorporates a mental health care clinic, a regional hospital and a specialised mental health care hospital. A purposive sample of [circa 10] outpatients that use the health care facilities will be selected from the organisations comprising the health care cluster. Finally a sample of representatives of three mental health care governance stakeholder groups in the Mangaung district will be selected. These include mental health care facilities, mental health government and mental health care patients and their families.

The research objective and proposed research design implies a multitude of institutions that need to provide institutional permission for any of their members to be ex officio involved in the research. These include the Free State Department of Health, and the selected government-funded health care facilities in the Mangaung Metropolitan district. Formal written informed institutional permission should be obtained up front from the Free State Department of Health before the study commences. The researcher acknowledges this. Formal written informed institutional permission can be obtained from the various clinics, regional hospitals and specialised mental health care hospitals as they are

approached for participation in the research. For this purpose an informed institutional permission template can be prepared. The informed institutional permission template should clarify the objective and nature of the research and should explicitly indicate whether the identity of the institutions will be revealed.

The proposal indicated that the identity of the institution will remain unspecified although the province and district will be made known. Due to the limited number of mental health care facilities in the Mangaung district the anonymity of participating institutions might nonetheless be compromised.

The researcher is requested to comment in a note to the REC on the feasibility of the proposed procedure described above and on the voiced concerns. The researcher is requested to file copies of the permission letters once they are received so as to ensure that Stellenbosch University can at all times successfully rebut any allegation of violating institutional privacy rights.

2. INFORMED CONSENT PROCESS

Informed consent will be obtained from all research participants. Three informed consent forms have been prepared [one directed at the health care workers, one directed at outpatients and one directed at the stakeholders responsible for the governance of the mental health care system]. The three forms are largely the same and do not explain with sufficient differential clarity why health care workers, patients and governance stakeholders have been invited to participate in the research and what involvement in the research would entail exactly.

The outpatient informed consent form should reflect the risk that participation might reveal their mental status to community members and health care facility workers [given that the researcher acknowledges this as a risk in the application for ethical clearance]. The informed consent forms otherwise generally provides a sufficiently comprehensive explanation of the objective and the nature of the research to allow the potential participant to make an informed decision whether to participate or not.

The language on the informed consent form for the patients who will participate may need to be simplified to promote understanding of the research and its aims. In addition, there are a few technical and grammatical errors on the informed consent forms that need to be addressed before they are used in the data collection process.
The researcher is requested to amend the informed consent form so that they more clearly delineate the motivation for involving the specific group of participants and what the involvement for the specific group of participants will entail.

3. INVITATION OF PARTICIPANTS

Participants in the study will be health care workers responsible for mental health care in all government-funded health care facilities in the Mangaung Metropolitan district and another randomly as yet unknown district in the Free State, outpatients that utilise the health care facilities comprising a specific health care cluster in the Mangaung Metropolitan district and stakeholder representatives from mental health care facilities, mental health government institutions and mental health care patients and their families.

The proposal and the application for ethical clearance provide relatively little information on the manner in which these individuals will be invited to participate in the study. Mental patients clearly represent a vulnerable group. The proposal and the application for ethical clearance implicitly acknowledge this by stating that outpatients will be selected in consultation with [appropriately qualified] health care workers to make sure that “only patients with adequate levels of willingness, mental ability and comprehension” are invited. The REC assumes that adequate, as it may be interpreted amongst others as the ability to read and comprehend the informed consent form.

Lack of clarity on the recruitment procedure prevents the REC from forming an independent judgment on the ethical risk that participants’ right of voluntary participation might be jeopardised.
The researcher is consequently requested to elaborate on the manner in which participants will be invited in a note to the REC [i.e. who will extend the invitations, via which medium, etc.].

4. CONTINGENCY MEASURES

It should be considered whether the semi-structured interviews conducted with the sample of 10 outpatients hold any risk for the participants, specifically the risk that their mental problem might be aggravated. The researcher acknowledges the risk of stigmatization in the application for ethical clearance. This should be communicated to participants via the informed consent form. The researcher moreover mitigates this risk by having [appropriately qualified] health care workers screen outpatients in terms of their capacity to participate. In addition, the outpatient interview schedule [included in the application for ethical clearance] do not seem to contain questions that will be particularly traumatic.

Nonetheless the REC asks the question whether it would not be more prudent to err on the side of being overly cautious [given the nature of the participant group] by having a formal contingency plan in the [unlikely] case of a participant responding negatively to the interview? Should the contingency plan be communicated via the informed consent form to participants? The researcher is invited to comment in a note to the REC.

The patient interview schedule does ask questions about service quality [e.g.” do you think that nurses give enough time and attention to you when you visit the clinic?” and are you happy with the services?”]”. It is possible that such and other questions might reveal gross incompetence and misconduct. If this is the case, this will be reported in the dissertation. The dissertation will, however, not reveal the identity of participating institutions. The results of the research will be published. Research findings will be disseminated via pamphlets to the Free State mental health task team. Copies of the dissertation might possibly be given to participating organisations [this is not indicated in the application for ethical clearance].

Nonetheless the REC asks the question whether these steps are sufficient to address the problem should gross irregularities be revealed at

any participating facility. What measures are in place to ensure the confidentiality of the health workers and governmental officials who participate in the research? The researcher is invited to comment in a note to the REC.

5. COST-BENEFIT RATIO
Participation in the research will require an investment and commitment from participants. Participation in the research holds no immediate benefit for themselves. The potential benefit and the likelihood of the benefit, both to themselves and to the larger community, however, justifies the investment

6. REC APPLICATION FORM
6.1) The researcher mentions that a participant information sheet is attached. This is not provided as part of the documentation submitted for review. Please confirm whether a participant information sheet will be used in this study, If so, please submit the participant information sheet for review. If not, please correct the REC application form accordingly.
6.2) The researcher states that data will be stored on his computer and archived on an external hard drive, both of which will be password protected. At what point will the data be destroyed? Overall, the issue of data storage and protection requires more thought.
6.3) The researcher must ensure that all study documents are translated into the languages of the participant population.
6.4) The researcher uses the terms ''mental patients'' and ''mental out-patients'' throughout the study documentation submitted. This is highly inappropriate. The REC recommends that a more appropriate term is used i.e. people living with mental illness.

Please provide a letter of response to all the points raised IN ADDITION to HIGHLIGHTING or using the TRACK CHANGES function to indicate ALL the corrections/amendments of ALL DOCUMENTS clearly in order to allow rapid scrutiny and appraisal.

Please take note of the general Investigator Responsibilities attached to this letter. You may commence with your research after complying fully with these guidelines.

Please remember to use your **proposal number** (**HS1156/2015**) on any documents or correspondence with the REC concerning your research proposal.

Please note that the REC has the prerogative and authority to ask further questions, seek additional information, require further modifications, or monitor the conduct of your research and the consent process.

Also note that a progress report should be submitted to the Committee before the approval period has expired if a continuation is required. The Committee will then consider the continuation of the project for a further year (if necessary).

This committee abides by the ethical norms and principles for research, established by the Declaration of Helsinki and the Guidelines for Ethical Research: Principles Structures and Processes 2004 (Department of Health). Annually a number of projects may be selected randomly for an external audit.

National Health Research Ethics Committee (NHREC) registration number REC-050411-032.

We wish you the best as you conduct your research.

If you have any questions or need further help, please contact the REC office at 218089183.

Included Documents:
REC Application form
Interview schedules
DESC Checklist form
Research Proposal
Informed consent forms

Sincerely,

Clarissa Graham
REC Coordinator
Research Ethics Committee: Human Research (Humanities)

Investigator Responsibilities

Protection of Human Research Participants

Some of the general responsibilities investigators have when conducting research involving human participants are listed below:

1.Conducting the Research. You are responsible for making sure that the research is conducted according to the REC approved research protocol. You are also responsible for the actions of all your co-investigators and research staff involved with this research. You must also ensure that the research is conducted within the standards of your field of research.

2.Participant Enrollment. You may not recruit or enroll participants prior to the REC approval date or after the expiration date of REC approval. All recruitment materials for any form of media must be approved by the REC prior to their use. If you need to recruit more participants than was noted in your REC approval letter, you must submit an amendment requesting an increase in the number of participants.

3.Informed Consent. You are responsible for obtaining and documenting effective informed consent using **only** the REC-approved consent documents, and for ensuring that no human participants are involved in research prior to obtaining their informed consent. Please give all participants copies of the signed informed consent documents. Keep the originals in your secured research files for at least five (5) years.

4.Continuing Review. The REC must review and approve all REC-approved research proposals at intervals appropriate to the degree of risk but not less than once per year. There is **no grace period.** Prior to the date on which the REC approval of the research expires, **it is your responsibility to submit the continuing review report in a timely fashion to ensure a lapse in REC approval does not occur.** If REC approval of your research lapses, you must stop new participant enrollment, and contact the REC office immediately.

5.Amendments and Changes. If you wish to amend or change any aspect of your research (such as research design, interventions or procedures, number of participants, participant population, informed consent document, instruments, surveys or recruiting material), you must submit the amendment to the REC for review using the current Amendment Form. You **may not initiate** any amendments or changes to your research without first obtaining written REC review and approval. The **only exception** is when it is necessary to eliminate apparent immediate hazards to participants and the REC should be immediately informed of this necessity.

6.Adverse or Unanticipated Events. Any serious adverse events, participant complaints, and all unanticipated problems that involve risks to participants or others, as well as any research related injuries, occurring at this institution or at other performance sites must be reported to Malene Fouch within **five (5)** days of discovery of the incident. You must also report any instances of serious or continuing problems, or non-compliance with the RECs requirements for protecting human research participants. The only exception to this policy is that the death of a research participant must be reported in accordance with the Stellenbosch Universtiy Research Ethics Committee Standard Operating Procedures. All reportable events should be submitted to the REC using the Serious Adverse Event Report Form.

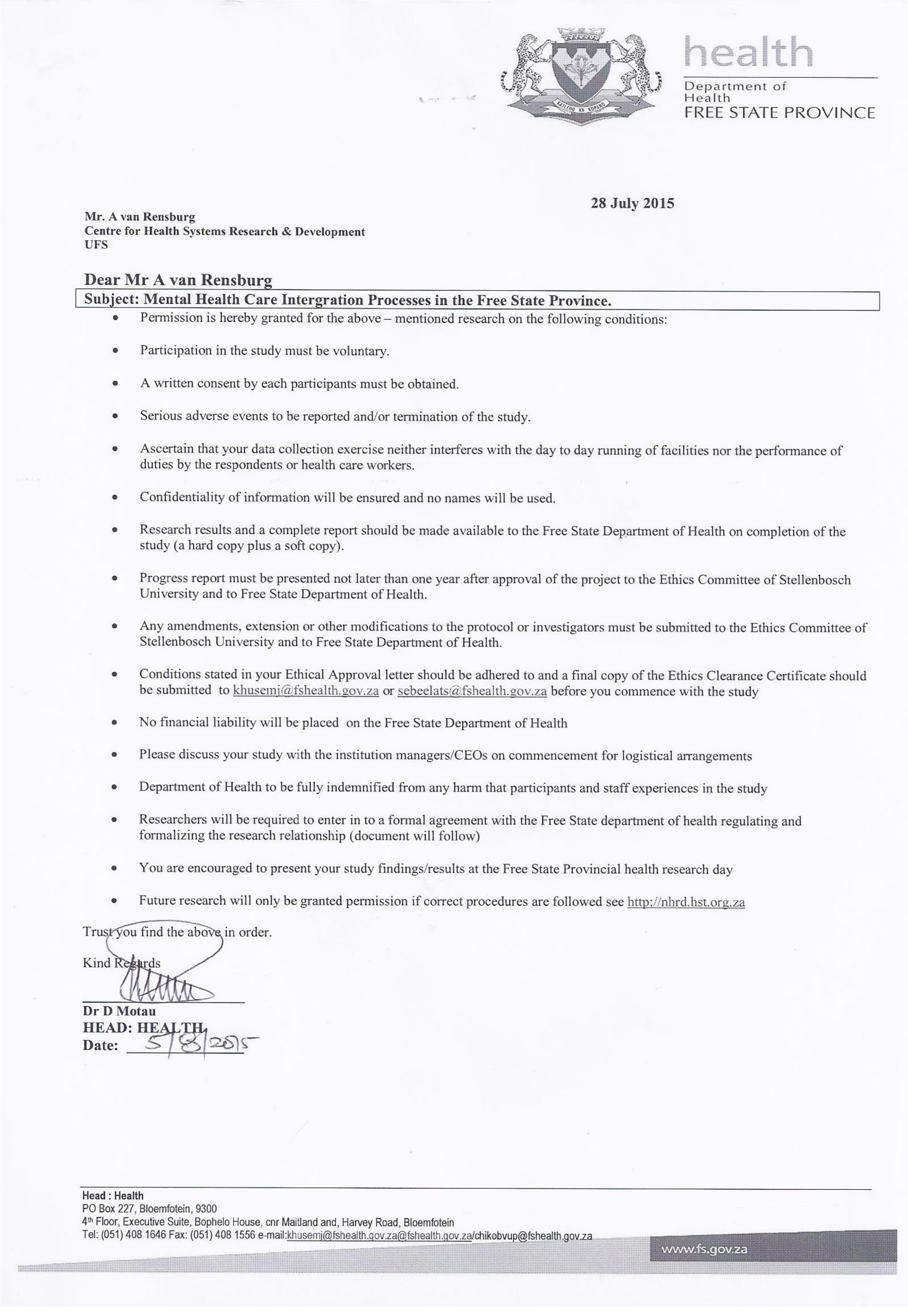
7.Research Record Keeping. You must keep the following research related records, at a minimum, in a secure location for a minimum of five years: the REC approved research proposal and all amendments; all informed consent documents; recruiting materials; continuing review reports; adverse or unanticipated events; and all correspondence from the REC

8.Provision of Counselling or emergency support. When a dedicated counsellor or psychologist provides support to a participant without prior REC review and approval, to the extent permitted by law, such activities will not be recognised as research nor the data used in support of research. Such cases should be indicated in the progress report or final report.

9.Final reports. When you have completed (no further participant enrollment, interactions, interventions or data analysis) or stopped work on your research, you must submit a Final Report to the REC.

10.On-Site Evaluations, Inspections, or Audits. If you are notified that your research will be reviewed or audited by the sponsor or any other external agency or any internal group, you must inform the REC immediately of the impending audit/evaluation.

Addendum J: Institutional permission from Department of Health



health
Department of
Health
FREE STATE PROVINCE

28 July 2015

Mr. A van Rensburg
Centre for Health Systems Research & Development
UFS

Dear Mr A van Rensburg

Subject: Mental Health Care Intergration Processes in the Free State Province.

- Permission is hereby granted for the above – mentioned research on the following conditions:
- Participation in the study must be voluntary.
- A written consent by each participants must be obtained.
- Serious adverse events to be reported and/or termination of the study.
- Ascertain that your data collection exercise neither interferes with the day to day running of facilities nor the performance of duties by the respondents or health care workers.
- Confidentiality of information will be ensured and no names will be used.
- Research results and a complete report should be made available to the Free State Department of Health on completion of the study (a hard copy plus a soft copy).
- Progress report must be presented not later than one year after approval of the project to the Ethics Committee of Stellenbosch University and to Free State Department of Health.
- Any amendments, extension or other modifications to the protocol or investigators must be submitted to the Ethics Committee of Stellenbosch University and to Free State Department of Health.
- Conditions stated in your Ethical Approval letter should be adhered to and a final copy of the Ethics Clearance Certificate should be submitted to khusemj@fshealth.gov.za or sebeelats@fshealth.gov.za before you commence with the study
- No financial liability will be placed on the Free State Department of Health
- Please discuss your study with the institution managers/CEOs on commencement for logistical arrangements
- Department of Health to be fully indemnified from any harm that participants and staff experiences in the study
- Researchers will be required to enter in to a formal agreement with the Free State department of health regulating and formalizing the research relationship (document will follow)
- You are encouraged to present your study findings/results at the Free State Provincial health research day
- Future research will only be granted permission if correct procedures are followed see http://nhrd.hst.org.za

Trust you find the above in order.

Kind Regards

Dr D Motau
HEAD: HEALTH
Date: 5/8/2015

Head : Health
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