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RESEARCH ARTICLE

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At the coalface of collaborative mental health care: A qualitative study of governance and power in district-level service provision in South Africa

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Summary

Globally, there is an urgency to address fragmented mental health systems, especially in low-to-middle income countries. State and non-state mental health service collaboration is a central strategy to strengthen care. The study was undertaken to analyse the power in governance processes of public mental health service provision. Semi-structured interviews were conducted with state and non-state actors in mental health care in a South African district. Transcriptions were thematically analysed using the Framework for Assessing Power in Collaborative Processes. Findings suggested that 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 the service network. Fragmentation between the Departments of Health and Social Development was telling in district forums. Resistance to power structures unfolded, some participants sidestepping traditional hierarchies to leverage funding and support. The paper highlights the complexities and different facets of power in integrated mental health care in a South African district, adding to growing literature on the social mechanisms that influence collaboration.

KEYWORDS

collaboration, governance, mental health services, non-governmental organisations, power

1 | 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).[1] In South Africa's pluralistic, state-driven health system, close collaboration between state and private mental health service providers is a key strategy in addressing the burden of mental illness.[2,3] Private (non-state, non-government, or third-sector) organisations are a core component of local public health service provision, although their presence often goes hand-in-hand with activity overlap, blurred lines of responsibility, and fragmentation in the provision of care.[4] Research on engagement between state and non-state entities in LMICs remains limited.[5] 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.[6] The inclusion of NGOs and other private partners in health care 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.[7,8]

The spectrum of mental disorders cannot simply be addressed with pharmacology and psychotherapy, but requires collaboration across services to effectively address its devastating effects on both individuals and communities.[9-11] This said, people suffering from mental conditions face substantial barriers in negotiating health system compared with people without these conditions.[12] Despite increased global efforts to achieve the ideal of comprehensive mental health care by integrating social and health services, success has been mixed.[13-16] Paradoxically, integrated care initiatives have been plagued by fragmented approaches, across different contexts, health systems, cultural and governance structures, and definitions of key terms.[17-19] Indeed, collaboration and partnership across the structural and cultural boundaries of siloed approaches has become something of a unicorn, both attractive and seemingly unattainable.[20] The division between health and social sectors particularly affects socially marginalised people, with chronic conditions including mental health service users (MHSU).[21] In South African health care, "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 [22(p67)]. 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.[22,23] In such settings, integrated systems of care become even more difficult to achieve.[13]

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.[24] 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.[2,25-30] The dynamics of governance mechanisms in collaborative arrangements are crucial in fostering beneficial partnerships,[31] but evidence of the particularities of the governance processes are lacking,[32] as are questions on how to effectively govern networks geared towards "wicked problems".[33] 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.[34] The governance of service delivery networks requires empirical insight into the processes of power and influence,[35] and herein lies our study focus. Accordingly, the principle aim of this study was to understand the power dynamics in collaborative governance processes of district-level public mental health service provision.

2 | METHODS

The findings were derived from a larger, mixed methods study that involved social network analysis as well as key informant interviews.[36] 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.[37] From October to November 2015, all 66 state 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 state and

non-state service collaboration were identified for further in-depth analysis (see Table 1 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 2 for breakdown). Twenty 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.[38]

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)[39(p596)]. Pre-determined themes were deductively generated from the Framework for Assessing Power in Collaborative Processes.[40] This framework allows for the interrogation of power by considering authority, resources and discursive legitimacy and key sources of power, while the participants, the process design and the content of collaborative governance processes are presented as the arenas for the use of power (see Table 3). 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.

TABLE 1 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 NGO A2 NGO A4 NGO A5 NGO A7	Social/welfare services, psychotherapy Housing/rehab, treatment adherence Housing/rehab Substance abuse rehab and prevention 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 NGO A4	Social/welfare services, psychotherapy 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 2 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

TABLE 3 Framework for assessing power in collaborative processes[40]

		Arenas for Power		
		Formal authority	**Resources**	**Discursive legitimacy**
Process elements	Participants	Participant selection Participant limitations	Number of representatives Representatives' expertise	Status of representatives Use of coalitions
	Process design	Process ownership Process interaction expectations Number, length, and location of meetings	Financing of the process	Frequency of voice Methods of voice Communication about the process
	Content	Agenda-setting Process outcome expectations Use of indirect authority such as legal rights	Information distribution Understanding and analysing the issues Production of meeting records	Prioritisation of issues Framing of the issues to be addressed

3 | RESULTS

The findings are presented as follows: First, the themes derived deductively from Purdy's Framework for Assessing Power in Collaborative Governance Processes[40] 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.

3.1 | Participants

3.1.1 | 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. State 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. State facilities in turn referred MHSU for psychosocial aftercare to NGOs. However, the limited service capacities of NGOs in rural areas were perceived by state 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. In an almost complete absence of state substance abuse rehabilitation facilities, several state 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 holds primary 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)*

3.1.2 | Participants and resources

Participants varied in their access to resources within collaborative arrangements, demonstrated by different forms of professional capital across service providers. The bulk of clinical experts and mental health professionals—including

psychiatrists, psychologists, mental health nurses, and social workers—were situated in state health facilities, particularly in hospitals. 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 state facilities for clinical services, as well as public funding. Well-funded NGOs saw themselves superior to state 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).

The discipline of social work was highlighted as a key point of 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 state 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.

3.1.3 | 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 state officials to lead mental health care, due to concerns related to corruption and political venality. On the other hand, some state 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 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 state 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 work with influential state actors in order to ensure service delivery. For example, an NGO providing housing, treatment adherence, and basic social care to MHSU 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 MHSU can be managed in terms of treatment adherence.

Psychiatrists were identified as particularly powerful in district mental health decision making, due to psychiatry's legitimacy compared with that of social work, psychology, and nursing. In service delivery, the state psychiatric hospital had elevated status, which was amplified by serving as a 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 state 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 state and non-state spheres. A fitting example is the arrangement was seen between the state 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.

4 | PROCESS DESIGN

4.1 | 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 state 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 to extend the scope of care for MHSU. It was expected that NGOs refer patients in need of clinical treatment to state facilities, or in rare cases where patients had appropriate medical insurance, to a private psychiatric institution. State facilities, in turn, were expected to refer patients to relevant NGOs according to geographical access and specific needs. Expectations between state and private service providers generally depended on the specifics of collaborative relationships. In general, the expectation was that state 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 state facilities while accompanying patients in their care, while state participants rarely ventured out of the public service provision sphere. The responsibility to initiate and foster collaboration with non-state service providers was the state's responsibility, both by state and private participants.

Meetings between state and non-state collaborating partners ranged from informal telephonic contact to regular formal face-to-face meetings. The psychiatric hospital organised a yearly catered social event as a way of thanking certain 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 state 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)*

4.2 | Process design and discursive legitimacy

Sectorial fragmentation emerged in state-driven district forums, where several siloed meetings related to mental health were held between state and private participants. Some participants took part in the previously mentioned forum for mental health (driven by the DoH), some in a forum for NGOs (driven by an NGO coalition), some focused on addiction and rehabilitation (driven by the DoSD), and some in a forum focusing on disability (driven by the 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.

5 | CONTENT

5.1 | Content and formal authority

Within one state and non-state relationship, there was a mutual expectation that the NGO would provide 6 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 between them and their state partners. 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 MHSU 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 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—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:

> *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)*

5.2 | 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 state 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 state mental health actors to access the mental health service network. Information shared among state and private participants mostly involved telephone conversations and email. For instance, a participant at the state 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 state 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 South Africa's national mental health policy and therefore did not analyse mental health care according to its strategic parameters.

5.3 | 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 diagnoses based on the Diagnostic and Statistical Manual of Mental Disorders 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 state 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)*

6 | MENTAL HEALTH STEWARDSHIP

6.1 | Mental health financing structures

Public mental health care was funded in two ways. Facilities that provided mental health care in the state sphere received their funding from the DoH, while NGO contracting and disability grant management were managed 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 they 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 the DoH was involved in screening for mental illness, although some were unsure to which extent DoSD funded NGOs provided housing and treatment adherence to MHSU. Funding seemed to be closely tied to the physical dimensions of disability. One NGO commented that they only started to engage with the DoH after self-harm became a problem for clients suffering from addiction. The link between visible infirmity and access to funding streams was 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 levels of care (where most of mental health professionals were concentrated), which weakened funding to community mental health and PHC. MHSU who had medical insurance largely accessed services from a for-profit, private psychiatric hospital. This hospital was established in the context of a post-apartheid expanding private health care sector that neglected psychiatric services. As suggested by one participant, the real "*money spinner*" in general hospitals were 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 hospital in the district. Dissatisfaction was expressed by both state 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)*

6.2 | 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 health care and substance abuse rehabilitation activities ending up significantly down the priority list. One participant remarked that "*mental health drinks out of a large pot, from which many others drink*" (CP_PHCC4), while another mentioned 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). For the DOSD, mental health was "*not generally a passion—their focus is children*" (SW_TH). Local funding priorities were also linked to global health funding priorities. Some NGOs mentioned that they had to frame their mental health work in terms of overlaps with HIV and tuberculosis programmes in order to access funding.

6.3 | Strategic leadership

Senior mental health professionals highlighted that their inputs in policy processes and strategic decisions were routinely ignored in provincial government processes, 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. 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 urgent 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, which frustrated state mental health professionals doing community outreach. One psychiatrist remarked 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)—"an absurdity" (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).

6.4 | Mental health information and monitoring system

Gathering and strategically using health information is a crucial aspect of stewardship, and many gaps emerged in this regard. A senior state official noted that policy objectives should be measured from a national perspective, suggesting that "*by 2020 [target year for the achievement national mental health policy goals] 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 had its own paper-based monitoring systems, state facilities had no mental health registers and minimal mental health indicators overall, little indication that this information is shared or used for strategic decision-making. In many cases, outpatients who stopped their treatment for more than a year had their case histories disposed of by state facilities—this necessitated PHC-level staff to re-create patient records from memory when the MHSU had to access secondary levels of care. The fractured health information system made referrals challenging, especially in referrals between state and non-state providers, where the responsibility to create continuity was often shifted to the MHSU:

> 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)*

6.5 | Resistance

Instances of resistance to existing mental health care 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 government departments rarely led to desired outcomes, and more than one participant stressed the importance of having direct access to the politically elected (and powerful) department head. A mental health nurse

employed by a state hospital had to visit NGOs after work hours in order to sidestep managerial policy that prohibits employees from working outside the state sphere. Some state participants worked with private participants to circumvent referral steps to expedite access to specialist care for MHSU. Normally, someone experiencing symptoms of mental disorders (1) presents to a PHC clinic for screening (which occurs only once a month in some of the more rural clinics); (2) 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 (3) after which referral to a specialist psychiatric hospital and psychiatric assistance may occur. Some state health workers assisted non-state organisations to obtain an order for involuntary admission to the state psychiatric hospital according to the Mental Health Act (even if it is not strictly necessary), providing a quicker route to access specialised mental health care than the formal referral hierarchy.

Sometimes, a MHSU's symptoms were inflated (both by state and non-state participants) in order to secure a disability welfare grant. It was highlighted that "*depression does not qualify*" and that psychotic features can facilitate disability grant access. In this way, schizophrenia and bipolar disorder are more desirable as a diagnosis (PN_PHCC1). 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 resisted the ideals of systems integration, that mental health care should not be unified: "*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).

7 | DISCUSSION

The governance of mental health care in a South African district was found to be fragmented—most strikingly in terms of state and non-state service providers, biomedical and social approaches to care, and a disjuncture between the DoH and DoSD. The schism between state 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 state government in South Africa.[41] 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.[17,42-44]

Themes related to public stewardship of mental health care 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.[45] Strong leadership is a particularly strong mechanism in health system strengthening, and—along with cross-sectoral approaches to health—it forms a protective barrier around public health in the context of competing interests.[46] Indeed, a key feature of stewardship is the building supportive coalitions towards policy-specific outcomes.[47,48] 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"[49(p735)]. 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.[50] Our findings particularly illuminate previous suggestions of poor information systems and monitoring of mental health in LMICs[51] and affirms that provincial government managers hold significant power over programme funding and information.[52] Views from this study district further highlighted the discrepancies between the purported support by state government for frontline health care provisioning and actual resourcing of such services.[53] In our findings state 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[54]—have been suggested elsewhere to be a feature of local health care provision in South Africa.[52]

Further, it seems prudent to ask whose interests are being served within the stewardship and governance dynamic, and how policy subjects are problematised.[55] In this vein, we build on a narrative of competing public health priorities as a stark reality faced by MHSU in LMICs.[51] 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 MHSU. The worst example of this type of prioritisation was illustrated in the Life Esidimeni crisis, where the financial de-prioritisation of serious mental illness in a South African province led to 144 preventable deaths of deinstitutionalised patients suffering from serious mental conditions.[56] It is a strategy employed by a state with neoliberal tendencies, where certain populations are stratified and codified, often to their disadvantage.[57,58]

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.[21,59] Further, contestations among provincial programme managers often echo through to service delivery levels,[52] a phenomenon that emerged in our study. The brain-body Cartesian division of responsibilities between biomedical-oriented and socially oriented mental health care[60]—a persisted global challenge[61]—is particularly salient due to the nature of mental illness, which generally falls at the interface of biomedical health and social services.[62]

Within collaborative contexts, resistance often emerges in relation to power distribution and decision-making structures.[63] 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 state and non-state divide (state mental health care professionals who visit NGOs in order provide care). These "minor and low profile alterations of routines…are contextually bound" to the governance structures that it resists[64 (p907)].

The findings of our study should be interpreted against the background of limitations. Our focus being that of a case study also means a narrow focus on one district in South Africa, prohibiting wider generalisation. The particular strategy that we followed to define the respective partners in the service delivery network was largely based on snowball methodology, and as such the inputs from service providers not connected to the network may well have been neglected. An example is the silence of traditional healers, a drawback that we underlined previously.[36]

8 | CONCLUSION

Mental illness truly represent a "wicked problem" in health planning and management,[65] as its nature necessitates that it "axiomatically transcends a diverse range of professional and organizational boundaries and often at multiple levels"[66(p45)]. Non-state mental health service providers are a real and important component of national health systems in LMICs, and close engagement between state and non-state actors is a key consideration towards achieving universal health coverage.[67] Additionally, governance of this engagement can be strengthened, for example by exploring the introduction of joint coordination and formal shared care plans across state and non-state, health and social care divides.[61] 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 dynamics 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,[68-71] and, importantly, illuminates the role of power in integration and fragmentation of mental health services.[30]

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CONFLICT OF INTEREST

None declared.

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