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Collaborative mental health care in the bureaucratic field of post-apartheid South Africa

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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 dynamics 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. 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 (Gillis, 2012; Jones, 2012; Petersen & Lund, 2011; Sukeri, Betancourt, & Emsley, 2014; Thom, 2000, 2004). 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 of care in South Africa's post-apartheid period. 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. This is important in a period of global mental health care reform that stresses the pertinence of collaboration (Fredheim, Danbolt, Haavet, Kjonsberg, & Lien, 2011; Hickie & Groom, 2002; Unützer & Park, 2012; Woltmann et al., 2012), which, in many countries, means partnership-working across state and non-state divisions (Janse van Rensburg & Fourie, 2016). Here, collaboration refers to voluntary inter-organisational participation that include the balancing of responsibilities and benefits, between state and non-state sectors (Axelsson & Axelsson, 2006; Hill & Lynn, 2003). 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 unfold particularly in mental health care (Fries, 2008; Henderson, 2005; 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 (2009a, 2010) elaboration of field theory. However, we first need to add some context to the discussion.

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 introduction 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.

The state is the steward of health care in South Africa, with the official responsibility for strategic leadership in mental health care provision (Coovadia, Jewkes, Barron, Sanders, & McIntyre, 2009). State-managed health facilities provide health care to the (uninsured) bulk of the South African population. 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, p. 200). We draw from the bureaucratic field, where the state is a "culmination of a process of concentration of different species of capital" and the power dynamics that it elicits (Bourdieu, 1994, p. 5). Within the bureaucratic field, 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, van Niftrik, Beira, Mapham, & Tienie, 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-profit organisation (NPO) 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 NPO 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 NPOs (Wolvaardt et al., 2008).

Structure of mental health care in post-apartheid South Africa

Much has been written about South Africa's health system re-structuring during its post-apartheid period (Coovadia et al., 2009; Harrison, 2009; Jobson, 2015; Mayosi et al., 2012; Van Rensburg & Engelbrecht, 2012), and the structure of the country's mental health system has similarly been well-described (Janse van Rensburg, 2018; Lund, Kleintjes, Kakuma, & Flisher,

2010; Petersen & Lund, 2011; Thom, 2000, 2004). Briefly, South Africa's health system is pluralistic, in that it contains both socialist and free market modes of health service delivery (Van Rensburg, 2012). Following the attainment of democracy, South Africa's macroeconomic and health policy environment was conducive for the proliferation of a strong private for-profit health care sector (Van Rensburg & Engelbrecht, 2012). It mirrors persisting inequalities in contemporary South Africa, a historical legacy of centuries of colonial and apartheid rule (Coovadia et al., 2009). Socioeconomic inequalities are especially telling in the grossly inequitable distribution of resources between private for-profit and public health services (Harris et al., 2011).

[TABLE 1 HERE]

Following the attainment of democracy in 1994, the newly-elected African National Congress (ANC) government launched several initiatives of sweeping reform. Significant and important strides were made towards health system improvement for a population buckling under burdens of an obstinate human immunodeficiency virus/acquired immunodeficiency syndrome (HIV/AIDS) and tuberculosis (TB) co-epidemic; high levels of interpersonal violence and injury; and poverty and vast inequalities in terms of access to high quality health care and the job market. These included the adoption of key legislation and policy regarding the provision of free primary health care (PHC) and choice of termination of pregnancy, as well as improvements in health systems management (Harrison, 2009; Van Rensburg & Engelbrecht, 2012) (see Table 1). In addition, it launched the largest antiretroviral programme in the world, and presently drives the introduction of a National Health Insurance scheme. In terms of mental health care, similar strides have been made, though in a more limited and piecemeal fashion.

During apartheid and up until the 1990s, South Africa had no coherent, national mental health policy, and relied on the provisions of the Mental Health Act of 1973. The result was that the state had no official mandate to provide appropriate mental health care for the public. Along with racial discrimination and fragmentation of approaches, the strategic focus of the Act fell on institutionalisation (Pillay & Freeman, 1996). There were exceptions; a model of community-based psychiatric care was developed in the Free State province, with good rates of success (Fourie & Gagiano, 1988; Gagiano, 1990). Despite mental health care featuring in many of South Africa's health policies that drove the transition to a district-based health system with a rapid expansion of PHC, and several efforts to create a dedicated mental health policy, little coherence and consensus remained on how to reform mental health care (Pillay & Freeman, 1996). Nonetheless, some headway was made. The introduction of a 1997 mental health policy – although relatively ineffective – and the adoption of the Mental Health Care Act (17 of 2002) allowed for a foothold in future reforms (Draper et al., 2009; Petersen & Lund, 2011). Ultimately, after almost two decades of democracy, and on the back of the Global Mental Health movement, the Mental Health Policy Framework and Strategic Plan 2013 – 2020 (South African National Department of Health, 2013) was introduced. The primary objectives include the provision of district-based and PHC-level mental health services, fostering collaboration, and promoting institutional capacity and innovation (Stein, 2014). The relative success of this policy will be evaluated in coming years; it must contend with hospital-centric care, heavily differentiated between provinces due to decentralisation efforts. Furthermore, there is wide inconsistency between provinces in the nature and availability of assessment and treatment protocols for mental health (Lund et al., 2010; WHO, 2007).

Mental health care has been subsumed under the stewardship of the Department of Health (DoH), but many overlaps occur with the Department of Social Development (DoSD). The DoH, DoSD and the non-state sector intertwine to provide mental health care, along several paths (see Figure 1) (Janse van Rensburg, 2018). To the bulk of the population, who cannot afford private medical insurance, the DoH provides mental health care according to primary (screening and referral in clinics, community health centres and small hospitals), secondary (treatment and counselling in larger hospitals) and tertiary (treatment, care and institutionalisation in specialised hospitals) levels of care. The DoH uses public-private partnership (PPP) agreements to access more specialised services in the private for-profit sector, while private service providers refer patients back to the public sector when they cannot afford out-of-pocket payments, or when their medical insurance funds become depleted. Regarding the non-state, non-profit sector, the DoH uses community-based NPOs to provide basic care, housing, and in limited instances, basic psychotherapy. NPOs have been especially instrumental in the provision of residential/institutionalisation services for people living with mental illness (World Health Organization, 2008). In the relative absence of psychiatrists, psychologists and mental health nurses generally and particularly in the public sector, NPOs 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). NPOs 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, & Merson, 2008). NPOs refer patients in need of medical intervention to public sector health facilities. The DoSD is in control of social welfare distribution, and process monthly disability stipends to people

suffering from serious mental disorders. They intervene in legal and forensic matters and regulate the NPO sector. Important ruptures between the DoH, DoSD and non-state sectors exist and have persisted since the inception of this post-apartheid system, underlined by clinical (DoH) and social (DoSD) approaches to care (Janse van Rensburg 2018.; Petersen, 1998, 2000). These ruptures have been amplified in strong neoliberal undercurrents, exemplified by the Life Esidimeni tragedy, where 144 people with serious mental conditions died from neglect during a botched state-driven deinstitutionalisation attempt (Makgoba, 2017).

[FIGURE 1 HERE]

The bureaucratic field and its internecine struggles

We draw from Bourdieu's concept of *the field* to situate the actors, institutions and their relationships in mental health care 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; Hilgers & Mangez, 2015; Müller, 2014). 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, p. 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 dynamics 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 & Mangez, 2015). "The field of power is a field of forces structurally determined by the state of the relations of power among forms of power, or different

forms of capital", which includes economic, cultural, social and symbolic capital (Bourdieu, 1996, p. 264). The success of different parties in the field depends on the distribution of various forms of capital within the relations among players (Kurunmäki, 1999). 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 to 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). These conflicts 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 – 144 patients suffering from severe mental conditions died from negligence (Makgoba, 2017). The incident was rooted in a mental

health care PPP 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 by no means a recent feature of collaborative mental health care provision. The roots of Life Healthcare lie in the Smith Mitchell Company, an apartheid-era chartered accountancy firm contracted by the then-government to operate mental health institutions. At one point, the Company operated more than 40 percent of the country's psychiatry beds, and it ultimately changed its name to Life Healthcare (Jones, 2012). At present, Life Healthcare is one of South Africa's largest private hospital groups, operating 60 facilities. It provides privately insured mental health services in six facilities throughout the country, the country's largest provider of private mental health care (Life Healthcare, 2013). This capacity has been used towards building the largest PPP with the DoH. 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 publicly-funded health systems, politicians have significant means of economic capital, by having the power to change resource consumption and deciding how to distribute funds among service providers (Kurunmäki, 1999). 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 need for community-based care was underscored, and the GDoH aimed to move 2 378 people suffering from serious mental disorders from Life Healthcare facilities to NPOs. This required lateral engagement and coordination between the state spheres of the DoH and the DoSD; the patients were moved to 27 different

NPOs, none of which were regulated by the DoSD. Following initial reports of patient deaths during the transfer process, an investigation by the Office of Health Standards Compliance (OHSC) was commissioned by the national minister of health (Makgoba, 2017). The findings of the report were widely reported and discussed, and much attention was drawn to the circumstances of the deaths. To date, 144 patients have died of neglect – causes of death included hunger, dehydration and hypothermia – while a substantial amount of patients remain missing. Worryingly, deceased and missing patients' welfare grants are still being claimed by NPOs on part of the beneficiaries (Bornman, 2017).

The Life Esidimeni tragedy echoes a similar event that unfolded more than four decades earlier, also involving collaboration between the state and a previous version of Life Healthcare. In 1975, UK and South African news media alleged that thousands of black people with severe mental disorders were living in inhumane conditions, without medical supervision, in Smith Mitchell Company facilities. The Smith Mitchell Company facilities were described as "human warehouses, rendering only custodial care", and due to apartheid segregation laws, the Company rented derelict buildings for black patients and used the patients to renovate the buildings (West, 1979, p. 11). The incident sparked an investigation by the American Psychiatric Association, and by the Church of Scientology (Jones, 2012). In its profiteering to the detriment of vulnerable populations, the corrupt structures and practices of the apartheid government were also laid bare (West, 1979).

In the bureaucratic field – as in any field of power – there are constant contestations and tensions over different types of capital. In the Smith Mitchell Company case, several points of power emerge: the cultural capital of the Church of Scientology at the time, in opposition to the professional capital of global psychiatry; with a range of different types of capital wielded by the

apartheid government, most prominently, economic capital. The similarities between the Smith Mitchell Company and the Life Esidimeni tragedies speak to the power of a type of symbolic capital, persisting as part of the deeper facets of the social fabric. It suggests a laissez faire, market-driven dispositif in the relations between the state and its non-state counterparts. The GDoH argued that the amount of US$24 million being spent on 2 378 patients during the 2014/2015 financial year was unaffordable, and stated that those funds would be reprioritised (Mahlangu, 2015b). It highlights "the brutal fact of universal reducibility to economics", where "economic capital is at the root of all the other types of capital" (Bourdieu, 1986, p. 24).

Government officials that represent the right hand of the state (financial technocrats with substantial economic capital) dominated the left hand of the state (government officials tasked with carrying the social struggles of the past). This victory has been cemented in post-apartheid policy shifts, where South Africa's re-integration into global capitalism opened it up for external pressures, against the need to address centuries of social injustice (Nattrass, 1996; Seekings & Nattrass, 2015; Terreblanche, 1999). The DoSD, by governing the distribution of social welfare and regulating NPOs (the champions of the poor) took in the position of the left hand, though their part in Life Esidimeni is completely silent. In fact, in the official government report, no mention is made of the DoSD. What we essentially have here is the DoSD on the left hand, providing social assistance to people suffering from debilitating mental conditions by giving them cash grants (in itself an ideological form of power) or by contracting NPOs to care for them. On the other, we have the right-handed DoH, applying a market-driven rationality by de-prioritising investment in a vulnerable population with very little social, economic, cultural or symbolic capital (Bourdieu, 1986).

A key element in the GDoH's decision-making was the significant symbolic capital captured in legislation. Chapter Two of the Mental Health Care Act (17 of 2002) was used to legitimise the deinstitutionalisation strategy: "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 a quintessential strategy in the bureaucratic field, a "neoliberal Leviathan" – the management of a vulnerable population by applying legal tools to its management (Wacquant, 2009b, p. 73). After all, "economic coercion is often dressed up in juridical reasons" (Bourdieu, 2000, p. 20). Furthermore, the decision presumed 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, 2011; Krüger & Lewis, 2011; Moosa & Jeenah, 2008). Rochefort (1997, p. 236) notes 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 & Chipps, 2012). If anything, the Life Esidimeni tragedy laid bare a group of NPOs woefully short of the capital required to care for people with complex mental, physical and social needs. It is here that the second struggle in the bureaucratic field is exemplified.

Struggles between higher and lower state nobility

The Life Esidimeni tragedy illustrated the shifting of responsibility for people with serious and chronic mental disorders away from the state (via its private partner) to the community, where

NPOs were pointed out as successors in the caring task (Mahlangu, 2015b). Tensions have emerged within the relationship between NPOs (as lower state nobility) and state government departments (higher state nobility) during the past decade, typified by a recent court case between an NPO coalition and the state. In 2008, the Free State provincial government announced that 48 NPOs 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 NPOs (Legalbrief, 2010). The dispute concerned the amount of funding an NPO can (or rather, should) receive from the provincial government, especially within the limits of budgetary constraints.

Contrary to private for-profit actors such as Life Healthcare, NPOs are far less independent from the state. Contemporary shifts in aid, along with the conditions set under advanced liberalism, have rendered NPOs as subcontractors of the state; their reliance on external funding agencies have make NPOs increasingly *governmental*, significantly influencing their autonomy and accountability (Habib & Taylor, 1999; Habib, 2005). Especially in Southern African contexts, global funding shifts and economic rationalities have led NPOs to have been subsumed into the state (Ferguson, 2015), and in South Africa, the traditional values of NPOs as representatives of advocacy and social justice have been significantly curtailed (Habib & Taylor, 1999; Adam Habib, 2005). We therefore must break with the conception of NPOs as strictly “non-state”, described at the beginning of the paper. As agents of the state, NPOs 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 & Curran, 2012). The Life

Esidimeni tragedy vividly illustrated how NPOs receive little to no financial, human resource or other support from the state (Makgoba, 2017), and suggests that the “higher state nobility” of South African policy-makers stand in opposition to the “lower state nobility” of NPOs as service providers, in that market-oriented reforms undermine “the traditional missions of government” (Wacquant, 2010, p. 201). This particular conflict played out more fully when the National Association of Welfare Organisations and Non-profit Organisations (NAWONGO) took the state to court. Many provincial governments rely to a considerable degree on NPOs to provide public services, especially social welfare, to vulnerable populations that include people suffering from debilitating mental conditions. In order to access the economic capital wielded by the state, NAWONGO turned to the judicial system, a perceivably neutral authority whose powers are “special” and “socially granted” (Bourdieu, 1987, pp. 837, 843). Given the burden of people who were served by the NPOs on behalf of the state, it was argued that the government subsidies should be increased, or the NPOs faced closure. In response, the Free State High Court (2014) noted that NPOs 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 NPOs 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 NPOs 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 & Soltau, 2014).

This particular rift between the South African state and NPOs 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 NPOs, culminating in legal processes to force the implementation of antiretroviral treatment and mother-to-child prevention (Fourie, 2006; Kim, 2015; Nattrass, 2008). 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 (Fourie, 2009; Posel, 2008). Unfortunately, as a social challenge, HIV/AIDS hold significantly more symbolic capital than mental illness. This was underlined in the NAWONGO case, when a list of public priorities was submitted to the court, with the rank of mental illness not being entirely clear (Free State High Court, 2014). Importantly, the list was compiled by a global, private auditing company, bringing in a distinct economic rationality into the judicial process. Although the relations of power that played out here had to unfold according to judicial rules of the game (Bourdieu, 1987), the tenets of ethics, logic and reason were somewhat replaced by the calculating capital of economic rationality. This capital also occupied the NAWONGO coalition, whose social capital was threatened by competition for limited funds. This undermined the NPO collective as well as organisational fidelity to social needs. Ultimately, the subsuming of NPOs within the state sphere by way of the power of economic power brings into sharp focus the struggles between market-led agents and those who carry out government tasks.

Concluding remarks

The story of mental health care provision has been one rife with contestations, contradictions, and dynamics of power, particularly persisting dynamics between pro-market forces and

frontline care. 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 dynamics inherent in collaborative mental health care. Against a growing recognition of the centrality of power in health care and health policy (Erasmus & Gilson, 2008; Gilson, 2016; Nkosi, Govender, Erasmus, & Gilson, 2008), 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, p. 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 & Engelbrecht, 2012, p. 178). Importantly, the two cases discussed speaks to a certain degree of moral malaise, in that the incommensurable values of caring for those needing care stand in opposition of free market principles (Lukes, 2008); essentially, symbolic power is firmly tethered to the politics of universal values (Siisiäinen, 2000).

Crucially, it appears as though bureaucratic field conditions significantly shaped the practices of NPOs, who “attach themselves to new procedures designed to meet the disciplinary demands of the neoliberalising bureaucratic field” (Woolford & Curran, 2012, p. 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 NPOs were structured (Habib, 2005). Further, the global hegemony of ‘poverty reduction’ within international development (Ferguson, 2015), with significant resource support from international agencies to NPOs, created a system that insisted on measurement and indicators – reigning in and depoliticising NPOs’ strategizing capabilities (Mitlin, Hickey, & Bebbington, 2007). Market-led relations and increasing commercialisation may threaten the core values of the NPO sector: corporate human resourcing rather than volunteerism; financial accountability rather than community accountability; and dependence rather that autonomy. These symbolic forms of capital assume an ideological function, by legitimising forms of distinction and classification as facts and by concealing the distribution of forms of capital throughout society (Siisiäinen, 2000). 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.

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Table 1: Major health system gains in post-apartheid South Africa (Harrison, 2009)

Figure 1: The structure of mental health care in contemporary South Africa (Janse van Rensburg, 2018)