Collaborative Care for Mental Health in South Africa: A Systematic Review

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DECLARATION

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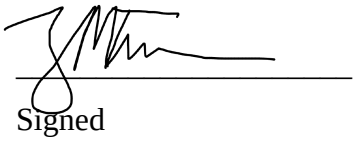

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ABSTRACT

Collaborative care (CC) is a strategy that restructures the roles of health care providers, and sectors outside of health care provision, to encourage a team-based approach to the management of mental illness. CC models involve, amongst others, non-governmental organisations, community health workers, and traditional healers, and, therefore, have been proposed as a strategy to make mental health care (MHC) more accessible and culturally appropriate. Despite the strong recognition of the need for CC models in policies and research initiatives promoting such accessible care, research on a CC strategy for mental health in South Africa is scarce. Failed attempts towards CC, such as the Life Esidimeni tragedy, have highlighted the urgent need to generate more evidence about this approach and improve collaboration.

The aim of this study was to systematically review the available literature to produce a summary of CC in the context of mental health in South Africa. This study further aimed to identify strategies to facilitate the implementation of CC models on micro- (community) and macro- (national) levels, and to make recommendations for future collaborative efforts.

This study was conducted in accordance with PRISMA guidelines. South African studies published in English between 2002 and April 2018 were considered for inclusion. Sixteen studies with heterogeneous study designs were included in this review. Using the Critical Appraisal Skills Programme tool, all included studies were found to be of high quality. Included studies were summarised and analysed using a thematic synthesis approach.

Six dominant themes and 25 subthemes were identified. The dominant themes included: (1) The context of CC in South Africa, (2) barriers to the implementation of CC models, (3) detrimental outcomes of CC, (4) facilitative factors in the implementation of CC models, (5) proposed strategies to improve the implementation of CC models, and (6) beneficial outcomes of CC.

From this review it is evident that CC models hold promise for closing the mental health treatment gap and providing culturally appropriate MHC in South Africa. However, despite progress made, several challenges remain in the implementation of collaborative policies. Considering the specific barriers highlighted in this review, four main strategies to improve the implementation of CC models in South Africa were identified. These included (1) redirecting resources and improving infrastructure, (2) formalising roles and relationships and improving

leadership, (3) improving communication and supervisory structures, and (4) improving training and education. This review offers valuable recommendations for South African MHC policy that might also be useful for other resource-constrained countries.

Keywords: *collaborative care, explanatory models, integrated care, mental health care, task-sharing, team-based approach*

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Chapter 1: Introduction

Accompanying the end of Apartheid in 1994, South Africa's health system faced major challenges resulting from inequities in the old dispensation's allocation of resources, many of which continue to exist (Coovadia, Jewkes, Barron, Sanders, & McIntyre, 2009). One particular challenge is the lack of access to mental health care (MHC) services in previously disadvantaged and marginalized populations (Janse van Rensburg, 2009; Petersen, 2000), especially in rural areas (Jack et al., 2014; Lund et al., 2015). South Africa is challenged with a large mental health treatment gap, i.e. the gap between the number of people who need, and those who receive, treatment (Lund et al., 2015). It is estimated that between 70% to 75% of South Africans with mental illness do not receive treatment (SACAP, 2018; Williams et al., 2008). Untreated mental illness contributes to a high burden of disease, as such patients typically experience diminished quality of life and disability, stigma and discrimination, poverty (Hanlon et al., 2014), and co-morbidity with a variety of chronic diseases including HIV/AIDS (Prince et al., 2007). According to the World Health Organisation (WHO) (2011), mental health specialists will most likely not be able to close this treatment gap as there are approximately 0.04 psychiatrists, 0.2 psychiatric nurses, and 0.05 psychologists per 100 000 people in Africa. Likewise, the South African psychologist to population ratio is about 1.4:100 000 (PsySSA, 2017). Given these and other constraints, researchers have argued for a transformation in the quality of MHC in South Africa (Bartholomew, 2016; Macleod, 2004).

A second challenge for MHC delivery in post-apartheid South Africa is the shift away from imposed systems of Western psychology to culturally-appropriate and culturally-meaningful care for diverse populations of individuals (Bartholomew, 2016; Campbell-Hall et al., 2010). Adopting a universalistic perspective in mental health fails to explain culturally driven presentations of psychological distress (Laher, 2014), tends to suppress cultural beliefs about mental health and culturally derived treatments, pathologises culturally normative behaviour (Bartholomew, 2016), and could be a reason for the high levels of non-adherence to Western treatment regimes in South Africa (Bhagwanjee, Petersen, Akintola, & George, 2008).

In response to these challenges, various researchers and policy-makers have proposed a collaborative care (CC) model for mental health service delivery in South Africa (Brooke-Sumner, Lund, & Petersen, 2016; Campbell-Hall et al., 2010; Jack et al., 2014; Shidhaye, Lund, & Chisholm, 2015; Van Rooyen, Pretorius, Tembani, & Ten Ham, 2015). A CC model refers to a strategy which "restructures the roles of health care providers and sectors outside of health care

provision and introduces a team-based approach to the management of chronic medical conditions" (Ngo et al., 2013; p.2). The research focus for this study was on CC for the management of mental illness. Specific research aims and research questions are discussed below.

1.1 Research Rationale

Various local and international policy documents support the implementation of a multi-level CC model approach towards mental health service delivery in South Africa. In 2008 the World Health Organization launched the mental health Gap Action Programme (mhGAP) which aims to strengthen access to MHC through integration into primary health care (PHC) (WHO, n.d.). Integration of MHC into PHC requires collaboration amongst treating professionals, including nurses and psychiatrists, working at the PHC level. In South Africa, the Mental Healthcare Act was instituted in 2002 (Department of Health, 2013). The Act addressed the need for more collaborative and community-based care and in July 2013 the Department of Health adopted The National Mental Health Policy Framework and Strategic plan (2013-2020) (Department of Health, 2013). The National Mental Health Policy Framework and Strategic Plan (2013-2020) promotes intersectoral collaboration and a team approach to community-based rehabilitation programmes (Department of Health, 2013; Schneider, et al., 2016). Since 1978, the WHO has advocated for traditional healers to be more involved in general health care, and, in 2004, the service of traditional healers was recognized for the first time in South Africa with the institution of the Traditional Health Practitioners Bill. The Traditional Health Practitioners Act (35 of 2004) replaced the Witchcraft Suppression Act (3 of 1957) and aims to provide for the registration, training, and practice of traditional healers (Janse van Rensburg, 2009; South African Government, 2005).

Policy goals and objectives in favour of CC models are reflected in international research initiatives. The Mental Health Innovation Network (MHIN) consists of researchers, practitioners, and policy-makers from all over the world working together to facilitate the development and uptake of effective mental health interventions. They focus on creating high-quality research evidence and have launched the PRIME (PRogramme for Improving MHC) and EMERALD research projects ('Mental Health Innovation Network', n.d.). Both PRIME and EMERALD aim to generate evidence on how to best implement and expand the coverage of mental health treatment programmes in low-resource settings through integration of MHC into primary care. In addition, The Mental Health and Poverty Project (MHaPP), led by the Alan J. Flisher Centre for Public Mental Health, conducted an analysis of existing mental health policies in low- and middle-income countries, including Ghana, South Africa, Uganda, and Zambia. The focus of this

work is on providing interventions to assist the implementation of mental health policies in these countries and to make MHC more accessible to poor communities (‘Mental Health & Poverty Project (MHaPP)’, n.d.).

Despite the strong recognition for the need for a CC model in MHC services and policies, and research initiatives promoting this approach, evidence on the use of a CC strategy for mental health is scarce (Ameermia, 2009; El Ansari, Phillips, & Hammick, 2001; Gureje et al., 2017; Lund et al., 2015). Although some research has shown that CC is positively received by patients, rewarding for community members to deliver, and can be sustained at a low cost (Abas et al., 2016), other researchers are critical of this stance (Janse van Rensburg, 2009; Thornicroft, Deb, & Henderson, 2016). Furthermore, the majority of research on CC models has been conducted in high-income countries, and less evidence is available from low and middle-income countries (Diminic et al., 2015; Ngo et al., 2013). South African research regarding collaborative efforts in service provision has focused mostly on the prevention and treatment of HIV/AIDS and MHC has received little attention (Van der Watt et al., 2017). Brooke-Sumner et al. (2016) concluded that existing levels of collaboration in South Africa are inadequate. Likewise, Mutsago, Marmetja, McGee and Hattingh (2017) argue that inadequate intersectoral collaboration contributed to the Life Esidimeni tragedy in Gauteng, where more than 118 patients died after being “wrongly” deinstitutionalised[1] in May/June 2016.

In sum, there seems to be an urgent need to focus on, and improve, collaboration, and to make MHC more accessible and culturally appropriate for all South Africans. Before it is possible to make recommendations regarding how to implement an effective CC model, there is a need to explore and understand the current context of CC in South Africa. The first step in this process requires the gathering of knowledge about existing efforts towards collaboration in South Africa, and reviewing how collaboration could occur in culturally sensitive ways. Such a review would enable documentation of good practices, highlight barriers and challenges, and identify guidelines for collaborative efforts in the future.

1.2 Research Aims

The aim of this study was to systematically review the available literature to produce a summary of CC in the context of MHC in South Africa. Furthermore, I aimed to identify strategies to facilitate the implementation of CC models on an inter-professional, community, intersectoral,

[1] In October 2015 The Gauteng Department of Health terminated an outsourced care contract with Life Esidimeni (a private health care provider) in order to save money and give effect to a policy to "deinstitutionalise" psychiatric patients. Patients were transferred from Life Esidimeni to the care of their families, non-governmental organisations (NGOs), and other hospitals. Causes of death included starvation and neglect.

and healing paradigm level, and to ultimately make recommendations for future efforts to utilise this approach. I discuss definitions of these different levels of CC in Chapter 2 (2.2 Defining Collaborative Care).

1.3 Research Questions

In line with the aforementioned aims, I addressed the following research questions within the context of MHC in South Africa:

1. What are the proposed strategies for collaboration?
2. What are the barriers to collaboration?
3. What are the costs and benefits of collaboration?
4. How do different stakeholders' (eg. community members, PHC workers, psychologists, traditional healers, MHC users) perspectives on collaboration affect the implementation of CC models?
5. Where have CC models been used and what were the outcomes?

1.4 Outline of the Report

This research report has four chapters following Chapter 1. Chapter 2 defines the different levels of CC and provides an overview on existing literature in the field of CC. Chapter 2 also introduces the theoretical framework I used to make sense of my findings. Chapter 3 describes the methodology that guided the review procedures. Chapter 4 reports the findings of this review, and, more specifically, the results of the research process, the sample characteristics, and the dominant themes identified across included studies. In Chapter 5, I discuss the findings of this study by drawing on other existing literature in the field and present strategies that could address identified barriers to CC in South Africa. Chapter 5 concludes with a discussion of the strengths and limitations of this study and includes recommendations for practice and future research.

Chapter 2: Literature Review

2.1 Introduction

In this literature review, I first define the term collaborative care (CC) and describe how collaboration can occur on multiple levels to make mental healthcare (MHC) more accessible and culturally appropriate. I also describe some of the critiques which have been levelled against these approaches, as identified in the literature. Thereafter, I highlight what researchers consider to be necessary components of effective collaboration across disciplines, including business, educational, and, importantly, health systems. I discuss some of the barriers to, and suggested pathways for, the implementation of CC models. I conclude this background literature review with an overview of Kleinman's explanatory model theory as the theoretical framework for this study.

2.2 Defining Collaborative Care

In the South African literature, the term CC has been used to refer to collaboration between different stakeholders on the facility, community, sectoral, and healing paradigm levels. In this section I provide definitions of CC on each of these levels.

2.2.1 Inter-Professional Collaboration

Primary health care (PHC) is "a fundamental component of a health care delivery platform since it serves as the first level of care within the formal health care system" (Shidhaye et al., 2015; p.3). The services provided at this level are usually affordable, accessible, and acceptable for individuals, families, and communities (World Health Organisation, 2005). In South Africa, PHC occurs by means of PHC clinic care and district hospital level care (Department of Health, 2013). These services are primarily offered by PHC nurses, while some PHC sites may employ other staff such as a general practitioner and/or social workers (South African Nursing Council, 2018).

PHC workers can be trained and supervised by mental health specialists (psychologists or psychiatrists) to identify common mental illnesses in patients with HIV and other chronic health conditions who are at risk for mental illness, manage these, and refer where appropriate (Jack et al., 2014; Petersen & Lund, 2011). Thus on the facility level, PHC workers can collaborate with specialist health care workers to integrate MHC services at a PHC level (Petersen, 2000). For

example, in Cape Town, the Perinatal Mental Health Project (PMHP) trains PHC nurses to screen pregnant women for psychosocial risk and depression and, in turn, to offer them counselling services. PHC nurses in this project are supervised by a clinical psychologist (Schneider, et al., 2016). In this way, mental health problems can be identified and treated at an early stage, and this can reduce the burden on the already limited number of specialist health care providers (Honikman, van Heyningen, Field, Baron, & Tomlinson, 2012). This may also prevent the high costs generally associated with specialist care (Abas et al., 2016; Petersen, Lund, Bhana, & Flisher, 2012).

Indeed, collaboration amongst professionals at a facility level has shown to be a cost-effective approach to improve access to mental health services in South Africa (Jack et al., 2014; Mutiso, 2016; Petersen & Lund, 2011) and to strengthen MHC service systems in rural areas (Ngo et al., 2013). In addition, Shidhaya et al. (2015) illustrated how receiving MHC at a primary health care level might reduce mental health stigma and thereby possibly motivate more individuals to seek MHC. Offering MHC in primary care settings can further offer support to the chronically ill, and complement general health care by, for example, improving the outcomes of HIV care via improved medication adherence (Joska & Sorsdahl, 2012). Inter-professional collaboration acknowledges the reciprocal relationship between mental illness and other chronic diseases, and is aligned with the notion of *no health without mental health* (Docrat, Lund, & Chisholm, 2019).

Despite the available body of research evidence arguing for the implementation of inter-professional CC models to help close the mental health treatment gap, concerns regarding the feasibility and sustainability of this approach remain. According to Schneider, et al. (2016), MHC services at PHC settings primarily involve dispensing medication for severe mental disorders. These authors are concerned about the limited number of evidence-based treatment protocols to detect and treat common mental disorders, such as depression and anxiety, at PHC settings (Schneider et al., 2016). Petersen (2000) further cautions that adding MHC to PHC might result in a biomedically-oriented approach to primary MHC which will compromise the delivery of comprehensive, integrated primary MHC. Although research projects including PRIME, EMERALD, and MhAPP all aim to develop effective evidence-based interventions involving the integration of MHC into PHC and thus inter-professional collaboration, these remain largely at the testing phase and their feasibility has not been adequately assessed.

2.2.2 Community-Level Collaboration

At the community level, collaboration refers to the training and involvement of community members, such as peers, family associations, and lay people (World Health Organisation, 2005) to assist in screening, the promotion of mental health, and the facilitation of self-help groups in a PHC setting (Abas et al., 2016; Shidhaye et al., 2015). Mutiso (2016) specified that the roles of community health workers (CHW) are to provide psychosocial support, adherence support for chronic conditions, and referral support to social, psychological, and health services in PHC settings. In South Africa, CHWs are also trained to provide homebased care through a home visitation programme (Petersen, Ssebunnya, Bhana, Baillie, & MhaPP Research Programme Consortium, 2011). While some CHWs in South Africa are volunteers, others work under a contract with a non-governmental organisation (NGO) and receive a stipend (Petersen et al. 2011). This type of collaboration is often called task-sharing, or task-shifting, where MHC is provided by non-specialists to improve access in resource-scarce areas (Mendenhall et al., 2014) and to lighten the workload of PHC workers (Ngo et al., 2013; Petersen & Lund, 2011). Compared to treatment as usual in public and private primary care clinics, community-level CC has shown to be a cost-effective strategy (Patel et al., 2010).

International evidence has illustrated the effectiveness of such community collaboration initiatives to improve MHC in other low- and middle-income countries (Araya et al., 2003; Chatterjee, Pillai, Jain, Cohen, & Patel, 2009; Ginneken et al., 2017, 2013; Padmanathan & De Silva, 2013; Schneider, Baron, et al., 2016) although most of the task-shifting literature comes from India and Pakistan (Chowdhary et al. 2014; Patel et al. 2010; Rahman et al. 2008). For example, Sangath is considered a leading mental health institution committed to improve access to MHC in India through training and supervising CHWs to deliver evidence-based psychosocial treatments (Patel, 2015; ‘Sangath’, n.d.). Sangath has completed projects which involved the systematic development of such interventions and subsequent randomised controlled trials of them, the latter of which showed significant benefit in terms of social and clinical outcomes (Patel, 2015).

A systematic review of community-level CC in South Africa (Petersen, Fairall, Egbe, & Bhana, 2014) indicated that trained lay counsellors, under the supervision of a mental health specialist, can effectively screen, and provide psychosocial interventions for, common mental illnesses at PHC level. Spedding, Stein, and Sorsdahl (2014) provide an overview of South African task-shifting interventions for the treatment of such common mental illnesses including anxiety,

depression, and substance abuse. Other South African task-sharing interventions include the VUKA family program, which involved a family-based psychosocial intervention to promote health and mental health among adolescents living with HIV in Durban. Lay counsellors were supervised by a Clinical Psychologist, as they facilitated discussions about coping with family loss, identity, and peer relationships within families (Bhana et al., 2014). The results of this study and other similar South African studies (MhaPP Research Programme Consortium, Petersen, Bhana, & Baillie, 2012) showed a significant reduction in depressive symptoms and increased coping skills.

Additionally, a CC approach at the community level can enable community participation and empowerment (Ameermia, 2009; Hanlon et al., 2014) and the promotion of culturally congruent care by striving to overcome class, language, and racial barriers (Petersen & Lund, 2011). For this reason, patients in Myers et al.'s (2018) study indicated a preference for lay counsellors, rather than existing professionals, to help patients develop adaptive coping strategies to deal with negative emotions in the Western Cape. In addition to patient satisfaction (Thornicroft et al., 2016), task-sharing has been found to be viewed positively by health managers and PHC staff in South Africa (Petersen & Lund, 2011). Conversely, in one study, Indian participants were found to have confidentiality concerns, which resulted in lay counselling services being viewed as less acceptable (Chatterjee et al., 2009).

Other researchers have questioned the overall efficacy of community-level CC. Although there is a growing body of evidence indicating that CHWs are able to provide effective psychosocial interventions, Ginneken et al. (2013) conducted a Cochrane review and concluded that a large part of the data coming from low-to-middle income countries (LMICs) were subject to selection bias, small samples and high drop-out rates, making the findings inconclusive. Patel (2015) concurs in that task-sharing interventions have not been scaled-up significantly in any country, and researchers can therefore not conclude on the real-world effectiveness of this approach. Findings regarding the cost-effectiveness of this approach are also inconclusive. While Patel et al. (2010) demonstrated community-level CC to be a cost-effective strategy, Thornicroft et al. (2016) found no significant difference between overall costs of community-based versus hospital-based care.

2.2.3 Intersectoral Collaboration

On an intersectoral level, collaboration refers to “a relationship between the health sector and other sectors which is necessary to improve health outcomes more effectively, efficiently, or

sustainably, than would be achieved by the sole action of the health sector" (Brooke-Sumner et al., 2016; p. 1). Sectors outside of the health sector may include Departments of Education, Social Development, Labour, Criminal Justice, Human Settlements, and NGOs (Brooke-Sumner et al., 2016; Diminic et al., 2015). Together, these sectors could address the social and economic factors that influence the mental health of a population (Mitchell & Pattison, 2012) through an exchange of resources, including staff, information, grants, equipment, skills, and expertise (Gazley, 2014).

Brooke-Sumner et al. (2016) asserts that intersectoral collaboration is especially important for the provision of psychosocial rehabilitation for those diagnosed with a severe mental illness that causes serious functional impairment. Collaboration across sectors could provide such patients with, amongst others, long-term medical care, empower him/her economically, and strengthen support structures and living situations to ultimately prevent patients from being repeatedly hospitalised (Brooke-Sumner et al., 2016). Intersectoral collaboration therefore aims to address the distal determinants of mental illness including poor social development, unemployment, and poverty (Plagerson, 2015; Skeen et al., 2010). A recent study by Van de Water, Rossouw, Yadin, and Seedat (2017) demonstrated how Government Departments of Health and Education collaborated to provide school-based psychotherapy through task-shifting, involving nurse counsellors and school personnel in Cape Town. Skeen et al. (2010) provides other examples of intersectoral collaboration in South Africa. Even so, (Saraceno et al., 2007) concluded that large-scale programmes addressing the social and economic determinants of mental health in LMICs are scarce.

There is growing evidence supporting the effectiveness of intersectoral collaboration in improving health and psychosocial outcomes and various countries have recognised its importance in their mental health policy documents (Diminic et al., 2015). However, policy details on how to approach intersectoral collaboration, specifically appropriate funding models and adequate resources, have not been systematically examined. This is noteworthy, given that Whiteford et al. (2014) identified resource constraints as the most commonly described blockade to intersectoral collaboration.

2.2.4 Collaboration Between a Western/Biomedical and Traditional/Faith Healing Paradigm

A biomedical or Western paradigm uses a scientific knowledge lens while a healing paradigm uses an indigenous knowledge lens when treating mental health concerns (Moshabela, Thembelihle, & Gaeda, 2016). According to Campbell-Hall et al. (2010), Western psychology

and psychiatry are generally regarded as the dominant models to understand and treat mental illness, but numerous researchers have advocated for syntheses between Western care providers (WPs) and complementary and alternative care providers (CAPs) in looking after the mental health of South Africans (Gureje et al., 2017; Janse van Rensburg, 2009; Kahn & Kelly, 2001; Van der Watt et al., 2017). CAPs include traditional healers [eg. 'diviners' (amagqira), 'herbalists' (ixhwele) and 'faith healers' (umthandazeli)'in the Xhosa culture] (Kahn & Kelly, 2001) and other faith healers such as Muslim or Christian healers (Moshabela et al., 2016). Models for collaboration between care paradigms include the establishment of referral systems between WPs and CAPs, CAPs as part of a multidisciplinary team, or CAPs visiting hospitals as consultants (Ṛreeman & Motsei, 1992).

Engel's (1977) seminal paper on the biopsychosocial model of health care represented a paradigmatic shift from the predominant biomedical model, which lacked a framework for exploring the impact of a patient's psychosocial and cultural characteristics on their mental health. Yet, Sulmasy (2002) has called for a broadening of this model to recognise the patient's spirituality and proposed a biopsychosocial-spiritual approach. Since then, the integration of Western and traditional indigenous treatment practices is becoming an accepted and more widely used model in health care systems across the world (Gyasi et al., 2017; Salan & Maretzki, 1983).

Various rationales have been proposed for collaboration on this level. First, culture and spirituality tend to influence the construction and understanding of psychological distress and mental illness (Gone, 2011; Janse van Rensburg, Myburgh, Szabo, & Poggenpoel, 2013; Laher, 2014). Landman (2013), writing from a theological perspective, conducted empirical research in a South African peri-urban settlement, and underscored the importance of spirituality and religion in the identities of young South Africans. Landman (2013) asserted that the collaboration between health care providers and faith healers is therefore a moral and ethical responsibility of care work. Many South Africans interpret their own mental distress within indigenous explanatory models of mental illness (Campbell-Hall et al., 2010). These models of illness incorporate spiritual understandings of causation such as upsetting the ancestors by failing to compare certain rituals, compared to physiological and psychological factors in Western models (Ensink & Robertson, 1999; Laher, 2014). While Western approaches are seen as useful in providing treatment, traditional healers are particularly valued for their skills in identifying the cause of illness (Crawford & Lipsedge, 2004). Furthermore, some patients view certain mental experiences as specific to African cultures, and believe that such illnesses can only be understood and treated from an indigenous healing framework (Crawford & Lipsedge, 2004; Van der Watt et

al., 2018). When patients experience their cultural beliefs to be validated by their treating professionals, this seems to give them a greater sense of control over their illness(Incayawar, Wintrob, Bouchard, & Bartocci, 2009). For this reason, patients may be more comfortable to self-disclose towards someone with a similar world-view (Chu, Leino, Pflum, & Sue, 2016; Kahn & Kelly, 2001). In support of this stance, researchers reported that approximately 80% of South Africans seek care from CAPs in addition to receiving treatment from WPs (Hopa, Simbayi, & du Toit, 1998). A similar trend was reported amongst MHC seekers in Indonesia (Salan & Maretzki, 1983). As a result, the provision of MHC by CAPs has a positive impact on individual and community mental health, specifically for common mental disorders such as depression and anxiety (Campbell-Hall et al., 2010; Hassim, 2013).

Second, since there seems to be more CAPs than WPs in especially rural areas in South Africa (Meissner, 2004), involving CAPs to assist with care of common mental disorders could help to narrow the mental health treatment gap (Saraceno et al., 2007). According to the WHO 2001 report, there are approximately 200,000 traditional healers practicing in South Africa (World Health Organisation, 2001). In other words, there is about one traditional healer to every 250 people compared to the psychologist to population ration of 1.4: 100 000 (PsySSA, 2017).

Several studies support the potential efficacy of collaborative models across healing paradigms. A review which included 16 studies on the perceived efficacy of traditional and faith healing to treat mental illness concluded that stakeholders perceived such treatment models to be most efficacious when used in combination with biomedical treatment (Van der Watt et al., 2018). Likewise, receiving traditional healing parallel to biomedical treatment led to improvements in treatment outcome amongst patients with psychosis in Uganda (Abbo, Okello, Musisi, Waako, & Ekblad, 2012) as well as treatment compliance and treatment outcome amongst Maori patients in New Zealand (Incayawar et al., 2009).

Conversely, some researchers cautioned against the inclusion of CAPs in treating mental illness. For example, contrary to the findings of Abbo et al. (2012), other researchers questioned CAPs ability to effectively deal with more severe mental illness such as psychotic disorders (Ensink & Robertson, 1999; Nortje, Oladeji, Gureje, & Seedat, 2016). Gureje et al. (2017) and Kale (1995) further noted that CAPs often engage in harmful practices which could violate human rights. Another documented concern is toxic drug-herb interactions when patients use biomedicine and traditional medicine simultaneously (Kale, 1995; Van Rooyen et al., 2015). Importantly, Sorsdahl et al. (2009) noted the lack of placebo-based trials supporting the efficacy of traditional herbal

medicine in treating mental illness. Perhaps this is why collaboration across healing paradigms in Rwanda is not considered beneficial to patients and patients who seek help from a traditional healer are cautioned by biomedical staff not to do so (Schierenbeck, Johansson, Andersson, Krantz, & Ntaganira, 2018). Lastly, although a number of researchers argue that the commonalities between different cultures' understandings of the self and illness may support a common ground between indigenous and Western healing paradigms (Hopa et al., 1998; Laher, 2014), Arias, Taylor, Ofori-Atta, and Bradley (2016) are sceptical of this stance and illustrated how deeply held beliefs and routine practices of WPs and CAPs are difficult to reconcile.

2.3 Models for Effective Collaboration

In line with existing models and frameworks outlining effective collaboration (American Psychiatric Association, 2016; Bosch & Mansell, 2015; Canadian Interprofessional Health Collaborative, 2010), researchers identified some conditions which may be necessary to promote a CC model in South Africa. In writing this section, I drew on literature published in various domains apart from health, including business and education, discussing models and frameworks proposed for effective collaboration.

First, Mendenhall et al.'s (2014) analysis of stakeholders' perceptions regarding CC suggests that the availability of resources, including finances, trained health workers, and access to medications, are basic requirements for CC. Mugisha et al. (2017) conducted a situational analysis of the health system contexts in Ethiopia, India, Nepal, Nigeria, South Africa and Uganda to assess readiness for the implementation of CC models. They concluded that before CC can be implemented, more resources, including health budgets spent on mental health, human resources and health facilities for mental health service, need to be allocated.

Second, according to Mitchell and Pattison (2012) stakeholders must share values and norms in favour of collaboration and believe that joint working has the potential towards purposive change. Stated otherwise, stakeholders' perceived benefits must exceed their perceived risks for collaboration (El Ansari et al., 2001). Consequently, partners will be more willing to compromise as the decisions in a collaborative approach will not always fit the preferences of each actor perfectly (Mattessich & Monsey, 1992). Where there is a history of competitiveness amongst stakeholders, potential collaborators can be educated regarding the benefits and processes of collaboration (Mattessich & Monsey, 1992). Governance and leadership can also help to enforce such values and norms through policies that support collaboration (Patel, Pettitt, & Wilson, 2012; Roberts, Van Wyk, & Dhanpat, 2017).

Third, ongoing relationships and supportive supervision structures seem to be another requirement for CC (Abas et al., 2016). Given that effective collaboration is based on the development of relationships, open discussions and regular contact are necessary to improve communication, enhance cohesiveness (Bronstein, 2003; Mattessich & Monsey, 1992; Roberts et al., 2017) and to build trust (Schneider, et al., 2016). Regular monitoring and feedback between stakeholders also help to establish achievement of collaborative goals (Roberts et al., 2017). For example, Bronstein's (2003) model for interdisciplinary collaboration for social workers introduced that meetings should involve a "reflecting on process" component which refers to collaborator's thinking and talking about their process of working together and finding ways of strengthening collaborative relationships. Particularly, supportive supervision by specialist mental health professionals seems to be crucial for the sustainable integration of MHC into PHC (Hanlon et al., 2014).

Lastly, the multidisciplinary literature on collaboration identifies the collective ownership of attainable goals as a key component for successful collaboration. In addition to a clearly agreed upon vision or goal, collaborative partners should have a clear understanding of their specific roles and responsibilities and be confident in fulfilling their roles (Agbiji & Landman, 2014; Mattessich & Monsey, 1992; Roberts et al., 2017). Bronstein (2003) argues that when the agreed-upon vision is to place the patient at the centre of care, this allows stakeholders to take collective ownership to provide best quality of care. Additionally, this fosters interdependence which refers to the reliance on interactions among stakeholders whereby each is dependent on the other to accomplish his/her specific tasks.

2.4 Measuring Levels of Effective Collaboration

International researchers have developed several instruments to measure levels of effective collaboration (eg. Roberts et al., 2017; Valentine, Nembhard, & Edmondson, 2015). Such measures include items based on abovementioned requirements for collaboration. For example, instruments would measure the frequency of communication and whether team members are informed about their specific roles and responsibilities. In my literature search for South African research, however, I have found a lack of consensus around an operational definition for CC und no evidence of an existing collaboration measure in South Africa. Roberts et al. (2017) seems to be the first to validate an international collaboration measure in the South African context. A comprehensive discussion about collaboration measurement instruments is beyond the scope of this study.

2.5 Barriers and Pathways for Collaborative Care

According to Hanlon, Wondimagegn, and Alem (2010) many African countries struggle to implement policy strategies for CC. Existing literature highlighted a number of stumbling blocks regarding the implementation of CC in South Africa and elsewhere and made recommendations for future efforts (Jack et al., 2014; Janse van Rensburg, 2009; Ned, Cloete, & Mji, 2017; Petersen & Lund, 2011; Van der Watt et al., 2017). Some of the identified barriers and suggested pathways on an inter-professional, community, intersectoral, and paradigm level respectively are discussed below. These barriers and pathways will be elaborated on in the findings of this review (see Chapter 4 and 5) and the section below aims to provide some background for the reader.

2.5.1 On an Inter-Professional Level

Shidhaye et al. (2015) identified poor supervision structures between PHC workers and mental health specialists, and the scarcity of mental health workers to support PHC workers to provide MHC, as barriers to inter-professional collaboration. Studies have shown that high workloads and time pressures, accompanied with the emotional work of dealing with patients with mental disorders, could lead to PHC worker burnout, further underscoring the need for PHC worker support (Hanlon et al., 2014; Jenkins et al., 2013; Mendenhall et al., 2014). In response to this challenge, Hanlon et al. (2014) proposed the use of innovative methods, such as remote supervision using telemedicine, to achieve adequate levels of supervision.

Furthermore, numerous studies reported that PHC workers, including nurses and doctors, were insufficiently trained to screen and manage mental illness (Hanlon et al., 2010; Petersen & Lund, 2011; Shidhaye et al., 2015). Hanlon et al. (2014) found that comprehensive information regarding treatment for mental disorders were unavailable at PHC facilities in the Dr Kenneth Kaunda District, North West. To assist PHC workers in screening for depression, Cholera et al., (2014) sought to validate the Patient Health Questionnaire-9 (PHQ-9) as a depression screening tool at a high HIV-burden primary care clinic in Johannesburg.

Another challenge for inter-professional collaboration seems to be a lack of communication across health care platforms and poor referral strategies. Studies done in the psychiatry outpatient departments of the Pelonomi Provincial Hospital in Bloemfontein (Struwig & Pretorius, 2009) and the Chris Hani Baragwanath Academic Hospital in Johannesburg (Tenea, 2016) found that referrals to secondary level care had inadequate information and that referral pathways were often

bypassed. Consequently, higher levels of care tend to become overburdened which may further impact on the quality of care (Petersen & Lund, 2011; Tenea, 2016).

2.5.2 On a Community Level

Limited levels of community mental health awareness and high levels of stigma seem to be a challenge for CC initiatives involving community members (Hanlon et al., 2014). Thom (2003) highlighted the difficulty of maintaining motivation amongst community members when they have a marginalised status, are stigmatised in the community, and are not remunerated for their work. According to a systematic review on lay counsellor services in South Africa, the implementation of standardised training and a clear definition of the scope of practice of CHWs could assist with such status and remuneration challenges (Petersen et al., 2014). Recently, however, some community level interventions could not be implemented in South Africa as CHWs were not sufficiently trained to deliver certain interventions (Hanlon et al., 2016). Other researchers commented on the lack of financial resources and poor information systems to monitor transitions to community-based care (Abas et al., 2016; Petersen & Lund, 2011).

2.5.3 On an Intersectoral Level

Brooke-Sumner et al. (2016) conducted interviews with representatives from the Department of Health, Department of Social Development, and NGO's regarding intersectoral collaboration for psychosocial rehabilitation in South Africa. Similar to the challenges identified on an inter-professional level, Brooke-Sumner et al. (2016) noted poor communication and support amongst sectors, a lack of leadership structures, and unclear roles as challenges to intersectoral collaboration. Furthermore, Jack et al. (2014) pointed out that commitments towards a CC model are not reflected in current health budgets and system designs while researchers concur that a public sector resource-constrained environment in South Africa typically fosters competition rather than collaboration between sectors (Brooke-Sumner et al., 2016; Hanlon et al., 2014; Jenkins, Baingana, Ahmad, McDaid, & Atun, 2011).

Participants in Brooke-Sumner et al.'s (2016) study identified some strategies to address these challenges, such as drawing up appropriate written agreements to formalise intersectoral relationships and identifying a focal person who could coordinate collaboration between sectors. A further area of improvement, identified in a review of intersectoral policies for severe and mental illness in a sample of high-income countries, was to provide more information on how intersectoral collaboration initiatives could be monitored and evaluated (Diminic et al., 2015).

Diminic et al.'s (2015) review also highlighted examples of collaboration in these policies which serve as a useful reference for South Africa.

2.5.4 On a Paradigm-Level

Various researchers noted that distrust, perceptions of superiority, and unclear roles and responsibilities are all barriers to collaboration between WPs and CAPs (Ae-Ngibise et al., 2010; Osafo, 2016; Shields et al., 2016; Van der Watt et al., 2017; Van Rooyen et al., 2015). In turn, these barriers complicate referral practices or the integration of CAPS into existing multidisciplinary MHC teams in South Africa (Janse van Rensburg, 2014).

Although some research illustrated that WPs acknowledge CAPs' skills and knowledge as important resources (Addis, Abebe, Genebo, & Urga, 2002), other researchers found WPs to engage in limited collaboration by demanding biomedical services to control, regulate, and supervise CAPs (Campbell-Hall et al., 2010; Kahn & Kelly, 2001). On the other hand, CAPs seem to be more willing to collaborate with WPs (Addis et al., 2002; Hanlon et al., 2010) but also expressed a need for more respect from WPs and recognition from government (Van der Watt et al., 2017). Additional concerns amongst CAPs include beliefs surrounding the inability of WPs to treat the effects of witchcraft or the "real cause" of mental illness (Awodele, Agbaje, Ogunkeye, Kolapo, & Awodele, 2011), beliefs that psychiatric medication simply mask such underlying spiritual causes of illness (Arias et al., 2016) and the potential exploitation of their herbal knowledge (Campbell-Hall et al., 2010). Weak institutional support for the integration of Western and traditional approaches to MHC was identified as a major inhibitor to the implementation of such policies in Ghana (Gyasi, 2018).

According to researchers, collaboration could be facilitated by building mutual understanding and respect in educating both WPs and CAPs about each other's discipline and clinical approaches (Gureje et al., 2017; Van der Watt et al., 2017). In support of this, psychiatrists in South Africa seem to be willing to share information and learn from traditional healers (Janse van Rensburg, 2014). Nurses who are also traditional healers have shown to be a worthwhile avenue for integration (Van Rooyen et al., 2015). In addition, certification and registration from government may help to protect, recognise, and foster respect for CAPs (Janse van Rensburg, 2014).

2.6 Theoretical Framework

I will use Kleinman's explanatory model theory as the theoretical lens for my study (Kleinman, 1978, 1980). Kleinman defines explanatory models (EM) as the "notions of an episode of sickness and its treatment that are employed by all those engaged in the clinical process" (Kleinman, 1980, p. 105). Stated otherwise, EMs offer explanations of the aetiology, onset of symptoms, pathophysiology, and the course of sickness, which can be used to guide treatment of the individual patient (Kleinman, 1978). Although Kleinman's explanatory models were primarily designed in the context of physical illness, I will apply his theory to the understanding and treatment of mental illness.

According to Kleinman, the central component of health care is the interaction between practitioners' EMs and the individual patient's EM of a certain physical or mental illness. Different sectors in the health care system, however, tend to have separate EMs or "clinical realities" of mental illness, which may align with or differ from the individual patient's EM (Kleinman, 1978). Health care systems, according to Kleinman (1978), typically contain "three social arenas" within which mental illness are experienced and reacted to, namely the professional, folk, and popular sectors (Figure 2.1). Stakeholders in the multi-level collaboration model mentioned in this review can be placed in the three social arenas of Kleinman's model: Mental health workers in a PHC setting tend to employ a biomedical understanding of mental illness (professional sector), the beliefs and practices of CAPs may fit a more indigenous knowledge framework (folk sector), and CHWs may endorse more common-sense ideas (popular sector).

Kleinman (1978) noted that EMs linked to the three social arenas are not simply systems of meaning and norms which stand alone, but, that such meanings and norms are influenced by larger political, economic, and social determinants. Although EMs in the professional sector, popular sector, and folk sector may inform treatment of a certain mental illness, treatment often involves sectors outside of health care provision. For example, in South Africa, MHC treatment may be controlled by available resources provided by the Department of Health (Brooke-Sumner et al., 2016). These three sectors could therefore be conceptualised as embedded within a broader context of MHC (Figure 2.1). For the purpose of this study, I will therefore add a fourth component, "the broader context of MHC", to Kleinman's EM theory (Figure 2.1).

Researchers, however, have stated the need for a framework that goes beyond meaning-making, and includes a model that could be translated to serve a more practical purpose in MHC delivery

(Bhui & Bhugra, 2002). For example, when EMs in the different social arenas conflict, research suggests that such conflicts impede health care while effective communication across social arenas, on the other hand, has shown to be associated with patient compliance and satisfaction (Abas et al., 2016). This study, therefore, sought ways to understand and improve collaboration across the different social arenas of the health care system, including the professional, folk, and popular sector, and the broader context of MHC.

Figure 2.1 Structure of the Health System embedded within the Broader Context of MHC

Figure 1 The three social arenas of the health system (circles representing professional, folk, and popular sector) embedded within the broader context of MHC (dark grey circle).

2.7 Conclusion

In this literature review, I have provided some background, which may allow the reader to understand the origin and relevance of CC models in South Africa. Additionally, I have defined the different levels of CC, discussed how CC on these levels could make MHC more accessible and culturally appropriate, and highlighted some of the critiques of these CC models. I summarised some of the proposed requirements for effective collaboration across disciplines and introduced ways to measure levels of effective collaboration. A brief overview of current barriers to, and pathways for, the implementation of CC models in South Africa was provided. I concluded this chapter with a discussion of Kleinman's explanatory model theory as the theoretical framework for this study. In the next section, I discuss the methods I used in this study.

Chapter 3: Methodology

3.1 Introduction

This chapter presents the methods I followed in conducting this study. First, I discuss and explain my choice of using a systematic review as research design. I then provide an overview of my review procedures, followed by a more in-depth explanation of how I approached the five steps of the review process, namely; formulating review aims and questions, designing a search strategy to select included studies, assessing the quality of selected studies, extracting data from the included articles and lastly the analysis and synthesis of data in this review. The Results chapter (Chapter 4) reports the outcomes of this review procedure. I conclude this chapter with a brief ethical statement and a reflection on my role as the researcher in this study.

3.2 Research Design

This study was conducted using a systematic review method. Systematic reviews use rigorous and explicit methods to identify, select, and critically appraise relevant research, and to combine and analyse the findings of included primary research to provide reliable answers to specific questions (Moher et al., 2015). The researcher follows clearly pre-defined steps to increase transparency and limit bias, both of which improve the validity of reported findings (Uman, 2011) to provide a high quality form of evidence on a particular topic (Cook, Mulrow, & Haynes, 1997; Higgins & Green, 2008). Such findings are important to identify evidence-based recommendations to inform decision-making (Dixon-Woods, Agarwal, Jones, Young, & Sutton, 2005).

The systematic review for this study was conducted according to the PRISMA (Preferred Reporting Items for Systematic Reviews and Meta-Analyses) guidelines (Liberati et al., 2009; Moher et al., 2015). The PRISMA Statement aims to help researchers improve the reporting of systematic reviews and consists of a 27-item checklist (Appendix A) and a four-phase flow diagram (Appendix B). The checklist includes items considered essential for transparent reporting of a systematic review, while the flow diagram illustrates the flow of information through the different phases of a systematic review. Recent studies conducted within the South African health context support the application of PRISMA guidelines in favour of other available guidelines for systematic reviews (Ellapen, Hammill, Swanepoel, & Strydom, 2017; M'kumbuzi & Myezwa, 2016; Ssewanyana, Mwangala, van Baar, Newton, & Abubakar, 2018).

3.3 Review Procedures

Prior to conducting the review, I did a preliminary literature search, also known as a scoping search, to gain an overview of the range and depth of existing research in the field of collaborative care (CC) in South Africa, and to determine the viability of my topic for a review (Boland, Cherry, & Dickson, 2017). I then used the 5-step structured framework proposed by Ten Ham-Baloyi and Jordan (2016) to guide the systematic review process. The first step involved the formulation of the review aim and question. The second step was searching for literature, which included selecting sources of evidence, designing a search strategy, search terms, inclusion and exclusion criteria, and the documentation of the search. Third, included studies were critically appraised to determine the strength of the evidence. The fourth step was data extraction, i.e. "the process by which researchers obtain the necessary information about study findings from the included studies," (Ten Ham-Baloyi & Jordan, 2016, p.124). The final step was the data synthesis; the process in which I summarised and analysed the included studies, using a thematic synthesis approach (Thomas & Harden, 2008), to arrive at the outcome of the systematic review. In the following sections, I describe in more detail how I approached these five steps of the systematic review process.

3.3.1 Step 1: Formulation of Review Aims and Questions

The aim of this study was to systematically review the available literature to produce a summary of CC in the context of mental health care (MHC) in South Africa. Furthermore, I aimed to identify strategies to facilitate the implementation of CC models on an inter-professional, community, intersectoral, and paradigm level, and to make recommendations for future efforts. In light of this, this study attempted to answer the following research questions within the context of MHC in South Africa:

1. What are the proposed strategies for collaboration?
2. What are the barriers to collaboration?
3. What are the costs and benefits of collaboration?
4. How do different stakeholders' (eg. community members, PHC workers, psychologists, traditional healers, MHC users) perspectives on collaboration affect the implementation of CC models?
5. Where have CC models been used and what were the outcomes?

Guidance related to systematic reviews advocates that the review question should narrow down the research participants (P), interventions (I), comparative interventions (C), outcomes of interest (O), and the context to be investigated (C). This is known as the widely used PICOC guideline for formulating systematic review questions (Higgins & Green, 2008). In contrast to traditional guidance that advocates for concise and narrow review questions (Bambra, 2005; Higgins & Green, 2008), my research was concerned with understanding the current context of CC for MHC in South Africa and a review question that was fairly broad in scope was therefore appropriate.

3.3.2 Step 2: Search Strategies and Study Selection

The search for relevant literature was conducted on three levels. I indicate the months in which each respective step took place in parentheses to provide a timeline for the review process. First, I searched databases using specific search terms to identify potentially relevant studies (April 2018). All citations, abstracts, and eventually full text articles were downloaded into a reference manager software, Zotero, for ease of data management (Ahmed & Al Dhubaib, 2011). The databases I accessed for this review allowed me to export citations directly into Zotero. Second, after deleting duplicates using a Zotero function, I screened titles and abstracts using the inclusion and exclusion criteria (June – August 2018). Third, I screened the full-text articles of those studies that I identified for possible inclusion in the review based on the abstract screening (September – October 2018). Below, I explain and provide rationales for the different sources of evidence I accessed, the search terms I used, and how I applied specific inclusion and exclusion criteria.

Sources of evidence. Research was accessed using six electronic databases, available through the online WITS Library website, which provided access to relevant research in the field of mental health and well-being. Hence, PsycInfo and PubMed were used. More general, but bigger databases, such as EBSCO and Science Direct were also used. Africa-Wide and Sabinet were used primarily as they increased the chances of locating studies in South Africa, which often do not appear in databases from the West. Table 3.1 below summarises the databases used and the specific reasons for selecting these databases.

Table 3-1

Databases used and reasons for selection

Database	Reason for Selection
PsycInfo	Provides access to relevant research in the field of mental health
PubMed	Provides access to relevant research in field of general and mental health
EBSCO	Provides a broad multidisciplinary search of scholarly literature globally
Science Direct	Provides a broad multidisciplinary search of scholarly literature globally
Africa-Wide	Provides access to interdisciplinary publications which are relevant to Africa
Sabinet	Provides access to literature from African electronic journals as well as African Digital Repository (includes theses & dissertations)

I used citation chaining, also known as reference mining, to identify potentially relevant studies that were not identified through the database search (Boland et al., 2017; Bronson & Davis, 2011). I employed two types of citation chaining – backward searching and forward searching. During the backward searching process, I examined the reference lists of included studies and during the forward searching process I used the "cited by" function on the Google Scholar search engine to see which papers subsequently published the key reference (Boland et al., 2017). Additionally, when two or more potentially relevant studies were published by the same author, I examined a list of the author's publications to identify other potentially relevant studies. According to Bronson and Davis (2011), using alternative sources of data, such as the reference mining process, assists in reducing the publication bias introduced by the search strategy and inclusion criteria.

Search terms and search strategy. I used the following search terms: "Collaboration", "care", "mental health", "psychology", "psychiatry", and "South Africa". I made use of Boolean phrases to link my keywords with Boolean operators (AND, OR) and a wild card (*) which added power to the search and increased the efficiency thereof in terms of specificity (identifies relevant papers) and sensitivity (does not identify too many irrelevant papers) (Boland et al., 2017). I used the following Boolean phrase to optimise my search strategy: Collaborat* care AND (mental OR psych*) AND "South Africa". I searched the titles, abstracts, and full texts of all articles for the presence of these key words in published studies with abstracts and full texts in English. On the

online WITS Library, I ticked boxes “apply related words”, “search within full texts of articles” and “apply equivalent subjects” when searching the different databases using the Boolean phrase.

CC on an inter-professional level is often used synonymously with the term “integrative care”. Integrative care is a multi-layered concept and can be used to describe the linking of services on primary, secondary, and tertiary health care levels to increase access to psychiatric care (Van Rensburg & Fourie, 2016). Other terms related to the concept of CC include “multidisciplinary care” and “task-shifting approach”. The focus of this report, however, was on the factors impacting collaboration in order to provide such care and thus articles containing the terms “integrative care”, “multidisciplinary care”, and “task-shifting”, but not the term “collaboration”, were not considered for inclusion.

Inclusion and exclusion criteria. First, I screened titles and abstracts of studies identified through the database search to assess eligibility. Studies that were incompatible with the inclusion criteria and those that satisfied the exclusion criteria, were excluded. Second, I examined the full texts of the remaining citations to confirm or disprove their eligibility.

To be eligible for inclusion in the review, the studies must have satisfied all the following criteria: (1) They explored collaboration on either an inter-professional, community, intersectoral, or paradigm level, (2) they were conducted in the context of MHC in South Africa, (3) they contained primary research, and (4) they were published from 2002 onwards. The time criterion is based on the Mental Healthcare Act that was promulgated in 2002. I considered all study designs, including quantitative and qualitative designs, for inclusion in this review.

Studies which met one or more of the following criteria were excluded: (1) They were review articles, policy documents, or commentaries on policy documents, (2) they only studied collaboration between the patient and professional(s) in the form of case studies or reflections, to improve the quality of MHC, (3) they studied collaboration in the context of general health care in South Africa and (4) they were published in a language other than English. During every stage of the review process, I documented reasons for exclusion of studies. I will mention the most common exclusion reasons and provide citations as examples under Process Results in the Results chapter. Given that my search strategy yielded a large sample of relevant published peer-reviewed articles, and considering time constraints and that I had limited access to full texts of all theses from other universities, grey literature (i.e. literature that is unpublished or published in non-commercial form, including conference papers and research reports) (Kugley et al., 2017) were also excluded.

3.3.3 Step 3: Quality Assessment

Studies found to be eligible following the full-text screening process underwent a quality assessment. Quality assessment is an important part of a systematic review to reduce biases in the review process as well as biases in the primary research which the review contains (Hannes, Lockwood, & Pearson, 2010; Thomas & Harden, 2008). I used two different quality appraisal tools for eligible quantitative and qualitative studies.

I assessed the quality of the eligible qualitative studies using the Critical Appraisal Skills Programme (CASP) Qualitative Checklist Tool (Appendix C). The CASP Qualitative Checklist Tool consists of a 10 question checklist and was designed in the context of systematic reviews to assess the quality of qualitative studies (Critical Appraisal Skills Programme, 2017). In brief , the 10 questions review the clarity of the research aims, the appropriateness of the chosen methodology, the suitability of the research design, the choice of recruitment strategy, whether methods of data collection are aligned with the research aims, the extent to which the influence of the researcher was critically examined, consideration of ethical issues, the rigour of data analysis, the clarity of findings presented, and lastly the value of the research to the existing body of knowledge and understanding. Furthermore, various researchers have used the CASP Qualitative Checklist Tool for systematic reviews conducted in the Sub-Saharan African health context (see Colvin et al., 2013; Gourlay, Birdthistle, Mburu, Iorpenda, & Wringe, 2013; M'kumbuzi & Myezwa, 2016), and so it was deemed suitable for the present work.

I used an adapted version of the CASP Qualitative Tool to assess eligible quantitative studies (Appendix D). Available quantitative quality assessment tools, such as the Cochrane Risk of Bias Tool (Higgins & Altman, 2008), were designed specifically for randomised control trials whereas the CASP Tool is user friendly and could easily be adapted to assess a variety of quantitative study designs.

Included studies were given a score on a range of 0-10 and classified as either 'low risk', 'high risk', or 'unclear risk'. The threshold score for inclusion was set at 7/10. Under Process Results in the following chapter, I provide a table which summarises the quality of each study under the main criteria of aims, method, research design, recruitment strategy, data collection, researcher role, ethical issues, data analysis, findings, and value of research contribution (see also National Institute and Care Excellence, 2012).

3.3.4 Step 4: Data Extraction

For every included study, I first extracted relevant data from the included studies and recorded the data on self-constructed data extraction tables. The purpose of the data extraction step was to provide an overview on the study characteristics and the extracted texts were then subjected to analysis (Boland et al., 2017). I used Microsoft Excel to capture and structure data electronically and to assist me in the process of data management and synthesis.

I used three data extraction tables, each with different subsections, to record relevant extracted data. The first table was "General Description" and the subsections included: Author(s), publication date, title of article, journal of publication, geographical context of study, and how the study defined Collaborative Care. The second table was "Methodological Appraisal" and its subsections were: Research aims, research design, participants, sampling methods, methods of data collection, and methods of data analysis. The third table was "Results and Recommendations" and included the subsections: Findings, conclusions, recommendations, and limitations. The completed tables are provided in summarised format under Study Characteristics in the Results chapter.

3.3.5 Step 5: Data Analysis and Synthesis

Even though a review of quantitative articles typically involves statistical analysis (Higgins & Green, 2008; Moher et al., 2015), I employed a qualitative approach in analysing the included studies. Whereas quantitative methods are focused on making generalisations based on statistical analyses, qualitative methods are concerned with understanding phenomena and peoples' experiences and how these are described in words (Silverman, 2013). In other words, compared to meta-analyses that investigate the efficacy of certain interventions, the value of qualitative systematic reviews is to inform us *why* and *how* interventions can be effective (Hannes & Macaitis, 2012). The purpose of this systematic review was to describe different stakeholders' perspectives on CC and to identify strategies to facilitate the implementation of CC models, and a qualitative approach was therefore deemed acceptable.

I analysed the data using a thematic synthesis of the qualitative research. A thematic synthesis method has been applied within other systematic reviews that focused on health promotion and public health (Thomas & Harden, 2008). Thematic synthesis is based on more established methods used in primary research, particularly thematic analysis (Braun & Clarke, 2006). Thomas and Harden (2008) proposed three steps for the thematic synthesis of qualitative

systematic reviews: (1) Line-by-line coding of the text, (2) the development of descriptive themes, and (3) creation of analytical themes. Descriptive themes summarise and describe the original findings of the included studies while analytical themes go beyond the original content to generate additional concepts, understandings, or hypotheses (Thomas & Harden, 2008). Drawing on these analytical themes, I aimed to make recommendations to improve CC efforts for MHC in South Africa. Although I present the steps in a linear fashion below, during my process of analysis I followed a cyclical route by constantly reviewing and refining the themes.

First, I read and re-read the included articles several times to develop a good understanding of the data, after which I could systematically identify key issues across articles to generate initial codes. Second, I categorised phrases or statements containing key issues to compile a list of codes from the data. Codes are referred to as the building blocks of qualitative data analysis (Braun & Clarke, 2006). I then used comparative analysis where I continuously compared the article data to my newly identified codes and subsequently applied codes from the existing code list or generated new codes where necessary. I created a code list in Microsoft Excel to document the prevalence of codes in the included studies. Third, I looked at the similarities and differences between my identified codes, to collate similar codes into themes. For example, I grouped “lack of clinic spaces”, “lack of finances”, and “scarcity of human resources” under a theme “resources shortage”. I made diagrams to assist me in creating themes that were organised around a central concept in the data. Fourth, I unpacked every potential theme separately. I used the Microsoft Excel table, indicating the presence of codes in each included article, to revisit specific articles and to extract what each article discussed pertaining to the identified theme. Once this had been completed for each theme, I wrote up the descriptive themes under Results.

Although I coded the data with my specific review questions in mind, I was cognisant of not imposing an *a priori* framework implied by my review questions onto the study findings without allowing for the possibility that a different framework may be a better fit (Dixon-Woods, 2011; Thomas & Harden, 2008). In this review, as will be seen in the Results chapter, the primary studies were directly concerned with the review questions and it was therefore not necessary to go beyond the contents of the original studies to answer the research question (Thomas & Harden, 2008).

3.4 Ethical Statement

Prior to collecting data, I obtained permission to conduct the study from the Higher Degrees Committee of the Faculty of Humanities at the University of the Witwatersrand. This study

systematically reviewed published papers in the public domain. Hence, no special permissions and/or access was required, and no ethical clearance was necessary.

3.5 Reviewer Reflexivity

As the researcher in this study, I played an active role in the study selection, presentation and synthesis of the findings, which according to Anney (2014) makes investigator biases inescapable. Investigator bias occurs when the researcher's own experiences and background influence the content of findings (Rees, Sutcliffe, Dickson, & Thomas, 2017). Reviewer reflexivity is therefore crucial and refers to the exploration of one's own perspectives and a consideration of how these might influence the research process (Pillow, 2003; Rees et al., 2017). Hence, I strived to "bracket" or put aside my own experiences, biases, and preconceived notions during the study selection and qualitative synthesis stage (Tufford & Newman, 2012). I employed the following strategies to assist me in this bracketing process.

First, I used a reflexive journal to record my thoughts and reflections about my research process which helped me to be constantly aware of how my own biases and preconceptions could possibly influence the research process and findings (Rees et al., 2017). Second, I consulted an academic librarian at the University of the Witwatersrand, who has experience in conducting systematic reviews, to help ensure a comprehensive search and to minimise bias during the information retrieval phase. Further, to ensure the validity of this study, I followed a thoughtful, systematic research process, carefully documented every step of the review process and provided examples for every step of the process. I kept a detailed audit trail and provided a rich description of the context in which the study is based. Careful documentation, in turn, allows other to be able to replicate, or elaborate, on this study (Bless, Higson-Smith, & Sithole, 2013). Lastly, I discussed my process and reflections consistently with my research supervisor.

The contribution of my supervisor built in a level of investigator triangulation. Methodological verification refers to the process by which more experienced researchers verify the logic and implementation of each step in the methodology. For example, my supervisor inspected the internal coherence of the key themes I identified.

3.6 Conclusion

In this chapter, I discussed the systematic review method of this study and how it aligned with my research aims. This review was conducted according to the PRISMA guidelines. I gave a detailed

account of the five steps of my review process including the formulation of review aims and questions (1) and the design of my search strategy to select included studies (2). I used the CASP tool to assess the quality of selected studies (3) and made use of Microsoft Excel to assist me in the extraction of data from the included studies (4). I carefully documented my application of a thematic synthesis approach to analyse and synthesise the data in this review (5). I concluded this chapter with a brief ethical statement and a reflection on my role as the researcher in this study. The purpose of the last section was to illustrate how I aimed to increase the validity of the study and to reduce biases in the review process.

In the next section, I discuss the results of the review process, the sample characteristics, and the themes and subthemes that I identified from the data.

Chapter 4: Results

4.1 Introduction

This chapter presents the results obtained from the systematic review of collaborative care (CC) for mental health in South Africa. The chapter is divided into three sections: (1) Process results, (2) sample characteristics, and (3) thematic analysis. The section on process results reports the findings of the review process, steps taken to identify included studies, and a discussion of the quality appraisal of included studies. Under sample characteristics, I provide summary tables of the included studies and a brief overview of the extracted data under three headings namely general description, methodological appraisal, and results and recommendations. In the final section I present the themes and subthemes that I identified in the data.

4.2 Process Results

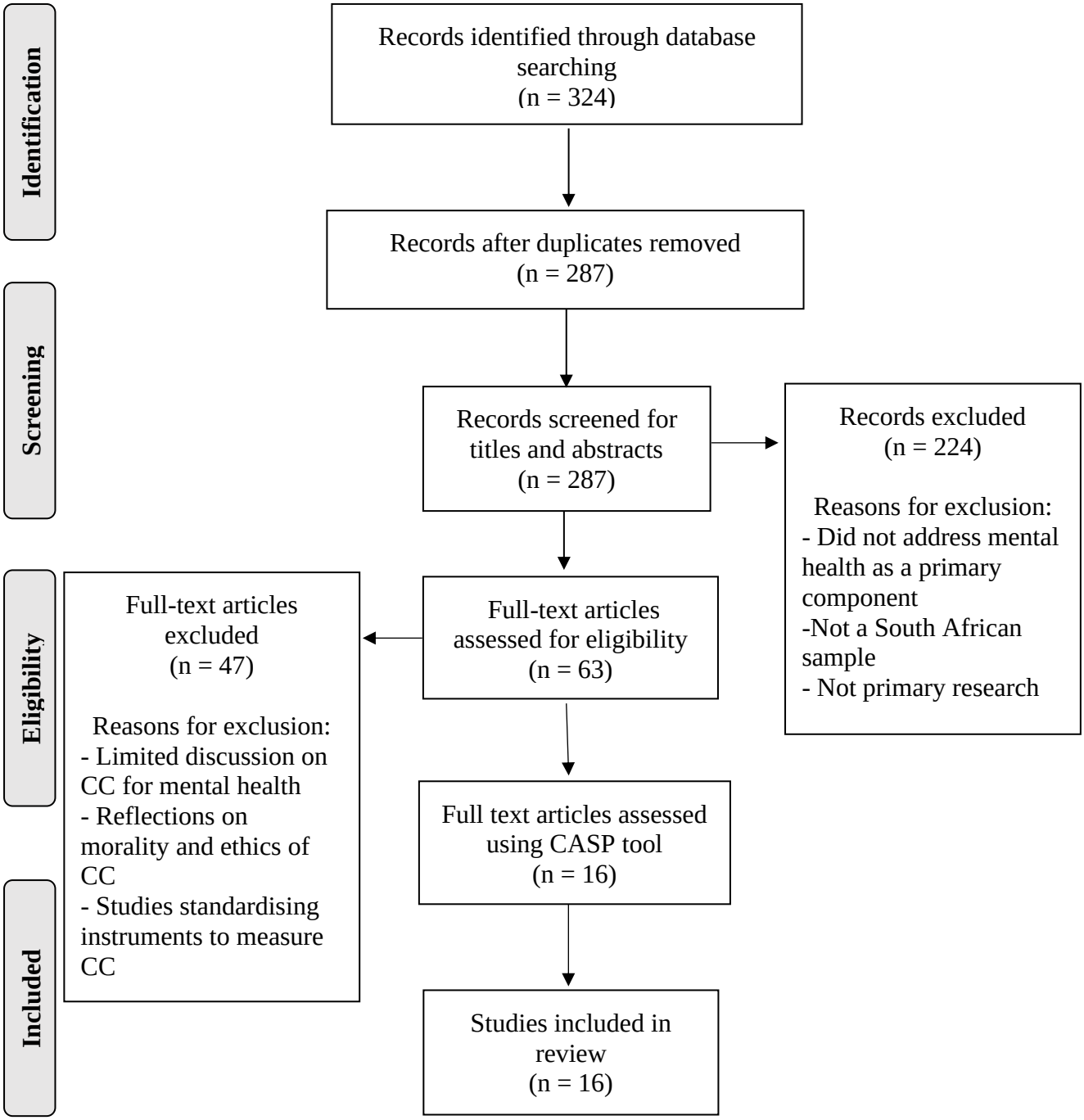
4.2.1 Study Selection

Figure 4-1 depicts a flow diagram as a visual representation of the results of the review process (adapted from Prisma flow chart; Moher et al., 2009). The search across all databases yielded a search result of 324 documents. Identification of articles in this search were based on the presence of keywords in the title, abstract, or full text of each article. After removal of duplicates the number dropped to 287 studies. During the title and abstract review, the most common reason for exclusion was articles that investigated collaboration for general health and HIV/AIDS (eg. (Chetty & Maharaj, 2013; Loeliger, Niccolai, Mtungwa, Moll, & Shenoi, 2016; Mills, 2005; Ngunyulu, Peu, Mulaudzi, Mataboge, & Phiri, 2017) or health care education (eg. Chambers, Clouder, Jones, & Wickham, 2013) rather than mental health as a primary component of the study. Other reasons for exclusion were articles not containing any primary research (i.e. policy documents, reviews, commentaries, conceptual articles) (eg. Faydi et al., 2011; Ngo et al., 2013; Petersen et al., 2014), and studies not using South African samples (eg. January & Sodi, 2006; Luitel et al., 2015; Van der Feltz-Cornelis & Huijbregts, 2008; Van der Watt et al., 2017).

It is possible that there might have been articles that would be relevant but if their abstracts did not accurately reflect their content, such articles were excluded. Following the screening of titles and abstracts, I assessed 63 full-text articles for eligibility. As I read the full texts, I realised that some articles did not meet the inclusion criteria and I accordingly excluded 47 articles. Reasons for exclusion at this stage included articles that mentioned collaboration but contained limited

discussion (eg. Alburquerque-Sendín et al., 2018; Bhana et al., 2014; Sorsdahl, Stein, & Flisher, 2013), articles focussing on the moral and ethical considerations of collaboration in health care (eg. Paphitis & Kelland, 2015; Yen & Wilbraham, 2003), and studies standardising instruments to measure CC (eg. Roberts et al., 2017). Following the assessment of 16 articles using the critical appraisal tool (CASP), all 16 studies were included in the review.

Figure 4-1. Flow-diagram of Review Process Results



4.2.2 Quality Assessment of Sample

I assessed the quality of articles using the CASP tool (Critical Appraisal Skills Programme, 2017)[2]. Table 4-2 below summarises the results of the quality assessment and how the included studies performed on the 10 CASP questions. I assessed all 16 studies to be of a high quality and classified them as low risk and I therefore included all 16 studies in the review. The lowest score obtained was a 7/10, followed by one study that scored 8/10 while the rest all scored either a 9/10 or 10/10. The subsection in which most articles scored low was "(6) Researcher Role" which indicated that studies did not adequately consider the relationship between the researcher and participants nor critically examined how they might have contributed to potential bias in the study. Despite this, the studies met the quality criteria and achieved scores equal to or higher than 7/10.

[2] Refer to Methodology chapter, p. 24, for a discussion on the CASP tool

Table 4-2

Performance of Included Articles on the CASP Questions

Article	1. Aims	2.Method	3.Research Design	4.Recruitment Strategy	5.Data Collection	6.Researcher Role	7.Ethical Issues	8.Data Analysis	9.Findings	10.Value	Total
Brooke-Sumner et al. 2016	Y	Y	Y	Y	Y	M	Y	Y	Y	Y	**9**
Burgess 2016	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	**10**
Campbell-Hall et al. 2010	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	**10**
Gerber 2018	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	**10**
Hanlon et al. 2017	Y	Y	Y	Y	Y	N	Y	Y	Y	Y	**9**
Janse van Rensburg et al. 2018[b]	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	**10**
Janse van Rensburg et al. 2018[a]	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	**10**
Marais & Petersen 2015	Y	Y	Y	Y	Y	N	Y	Y	Y	Y	**9**
Mendenhall et al. 2014	Y	Y	Y	Y	Y	M	Y	Y	Y	Y	**9**
Petersen et al. 2016	Y	Y	Y	N	Y	N	Y	M	Y	Y	**7**
Petersen et al. 2009	Y	Y	Y	Y	Y	N	Y	Y	Y	Y	**9**
Petersen et al. 2011	Y	Y	Y	Y	Y	M	Y	Y	Y	Y	**9**
Petersen et al. 2012	Y	Y	Y	Y	Y	N	Y	Y	Y	Y	**9**
Schierenbeck et al. 2018	Y	Y	Y	Y	Y	M	Y	M	Y	Y	**8**
Skeen et al. 2010	Y	Y	Y	Y	Y	N	Y	Y	Y	Y	**9**
Sorshdal et al. 2010	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	**10**

Y=Yes; N= No, M=Maybe/Can't tell

4.3 Sample Characteristics

A total of 16 studies met inclusion criteria for the review. I have synthesised the sample characteristics under three headings: General Description, Methodological Appraisal, Results and Recommendations. Below the extracted data is summarised in table format followed by a brief discussion. Some of the included studies investigated different aspects apart from collaboration such as policy design (Petersen et al., 2016) or examined CC in other African countries (Hanlon et al., 2014; Petersen et al., 2011). For these studies, only relevant data on CC in the South African context were extracted and are discussed below.

Table 4-3

General Description of Included Studies

Author	Date	Title	Journal	Context	Define Collaborative Care
Brooke-Sumner et al.	2016	Bridging the gap: Investigating challenges and way forward for intersectoral provision of psychosocial rehabilitation in South Africa	International Journal of Mental Health Systems	PRIME study district, Dr. Kenneth Kaunda District, North West Province (mostly urban and some rural)	Intersectoral collaboration between government sectors Health and Social Development and nongovernmental organisations (NGOs) *(intersectoral level)*
Burgess	2016	Policy, power, stigma and silence: Exploring the complexities of a primary MHC model in a rural South African setting	Transcultural Psychiatry	MHaPP study district, Hlabisa sub-district of the Umkhanyakude district in northern KwaZulu-Natal (rural)	Collaboration amongst treating professionals to provide integrated primary mental health care *(inter-professional level)*
Campbell-Hall et al.	2010	Collaboration between traditional practitioners and primary health care staff in South Africa: Developing a workable partnership for community mental health services	Transcultural Psychiatry	MHaPP study district, Hlabisa sub-district of the Umkhanyakude district in northern KwaZulu-Natal (rural)	Collaboration between traditional healers and western biomedically trained mental health professionals *(healing paradigm level)*
Gerber	2018	Practitioners' experience of the integration of mental health into primary health care in the West Rand District, South Africa	Journal of Mental Health	PHC clinic in the West Rand District Johannesburg, Gauteng (urban)	Collaboration amongst treating professionals to provide integrated primary mental health care *(inter-professional level)*
Hanlon et al.	2014	Challenges and opportunities for implementing integrated MHC: A district level situation analysis from five low- and middle-income countries	PLOS	PRIME study district, Dr. Kenneth Kaunda District, North West Province (mostly urban and some rural)	Collaboration amongst treating professionals to provide integrated primary mental health care *(inter-professional level)*

Janse van Rensburg et al.	2018[b]	State and non-state mental health service collaboration in a South African district: A mixed methods study	Health Policy and Planning	Mangaung Metropolitan District, Free State, South Africa (rural and urban)	State (clinics, hospitals) and non-state (NGOs) mental health service collaboration *(intersectoral level)*
Janse van Rensburg et al.	2018[a]	At the coalface of collaborative MHC: A qualitative study of governance and power in district-level service provision in South Africa	International Journal of Health Planning and Management	Mangaung Metropolitan District, Free State, South Africa (rural and urban)	State (clinics, hospitals) and non-state (NGOs) mental health service collaboration *(intersectoral level)*
Marais & Petersen	2015	Health system governance to support integrated MHC in South Africa: Challenges and opportunities	International Journal of Mental Health Systems	PRIME study district, Dr. Kenneth Kaunda District, North West Province (mostly urban and some rural)	Collaboration amongst treating professionals to provide integrated primary mental health care *(inter-professional level)*
Mendenhall et al.	2014	Acceptability and feasibility of using non-specialist health workers to deliver MHC: Stakeholder perceptions from the PRIME district sites in Ethiopia, India, Nepal, South Africa, and Uganda	Social Science and Medicine	PRIME study district, Dr. Kenneth Kaunda District, North West Province (mostly urban and some rural)	Collaboration amongst treating professionals, including CHWs, to provide MHC on PHC and community level *(inter-professional and community level)*
Petersen et al.	2016	Integrating mental health into chronic care in South Africa: The development of a district mental healthcare plan	The British Journal of Psychiatry	PRIME study district, Dr. Kenneth Kaunda District, North West Province (mostly urban and some rural)	Collaboration amongst treating professionals to provide integrated primary mental health care *(inter-professional level)*
Petersen et al.	2009	Planning for district mental health services in South Africa: A situational analysis of a rural district site	Health Policy and Planning	MHaPP study district, Hlabisa sub-district of the Umkhanyakude district in northern KwaZulu-Natal (rural)	Collaboration amongst treating professionals to provide integrated primary mental health care *(inter-professional level)*
Petersen et al.	2011	Lessons from case studies of integrating mental health into primary health care in South Africa and Uganda	International Journal of Mental Health Systems	MHaPP study district, Hlabisa sub-district of the Umkhanyakude district in northern KwaZulu-Natal (rural and peri-urban areas)	Collaboration amongst treating professionals, including CHWs, to provide integrated primary mental health care *(inter-professional and community level)*

Petersen et al.	2012	Understanding the benefits and challenges of community engagement in the development of community mental health services for common mental disorders: Lessons from a case study in a rural South African subdistrict site	Transcultural Psychiatry	MHaPP study district, Hlabisa sub-district of the Umkhanyakude district in northern KwaZulu-Natal (rural)	Mental health professionals collaborating with CHWs to provide MHC *(community level)*
Schierenbeck et al.	2018	Collaboration or renunciation? The role of traditional medicine in MHC in Rwanda and Eastern Cape Province, South Africa	Global Public Health	Nelson Mandela Bay (semi-urban) and Kirkwood areas (rural) of Eastern Cape	Collaboration between traditional healers and western biomedically trained mental health professionals *(healing paradigm level)*
Skeen et al.	2010	'Mental health is everybody's business': Roles for an intersectoral approach in South Africa	International Review of Psychiatry	MHaPP study district, Hlabisa sub-district of the Umkhanyakude district in northern KwaZulu-Natal (rural)	Intersectoral collaboration between Health sectors and Education, Employment, Housing, Welfare, and Criminal Justice sectors *(intersectoral level)*
Sorsdahl et al.	2010	Traditional healer attitudes and beliefs regarding referral of the mentally ill to western doctors in South Africa	Transcultural Psychiatry	Queenstown area of the Eastern Cape Province (rural)	Collaboration between traditional healers and western biomedically trained mental health professionals *(healing paradigm level)*

4.3.1 General Description of Sample

Table 4-3 describes the principal author(s), publication date, article title, journal of publication, geographical location, and the level of CC addressed in every included study. The publishing dates of the included studies ranged from 2009 to 2018, while most studies (n=10) were published in the last five years. Studies were located in both urban and rural contexts. Rural areas investigated were considered representative of rural areas in South Africa as they were resource poor and geographically removed from specialist services which are more concentrated in urbanised areas (Burgess, 2016; Janse van Rensburg et al., 2018[b]). Combining all the included studies, a total of six different geographical locations were investigated. Figure 4-4 highlights the six different areas on a map of South Africa. Six studies were located in the MHaPP study district, namely the Hlabisa sub-district of the Umkhanyakude district in northern KwaZulu-Natal (rural and peri-urban areas) (Burgess, 2016; Campbell-Hall et al., 2010; Petersen et al., 2009; Petersen, Baillie, & Bhana, 2012; Petersen et al., 2011; Skeen et al., 2010). Five studies were located in the PRIME study district, namely the Dr Kenneth Kaunda district in the North West Province (mostly urban and some rural)(Brooke-Sumner et al., 2016; Hanlon et al., 2014; Marais & Petersen, 2015; Mendenhall et al., 2014; Petersen et al., 2016). Furthermore, two studies were located in the Mangaung Metropolitan District, Free State, South Africa (rural and urban)(Janse van Rensburg et al., 2018[ab]), one in the West Rand District of Johannesburg, Gauteng (urban)(Gerber, 2018), one in the Nelson Mandela Bay (semi-urban) and Kirkwood areas (rural) of the Eastern Cape(Schierenbeck et al., 2018), and one in the Queenstown area of the Eastern Cape (rural)(Sorsdahl et al., 2013).

Figure 4-4. Map of South Africa indicating study locations of included studies

Included studies investigated different levels of CC. Most of the studies defined CC on an inter-professional level (n=8) and examined how primary health care (PHC) nurses, psychiatric nurses, mental health specialists including psychiatrists and psychologists, and general doctors could collaborate to integrate mental health care (MHC) on a PHC level. Next, four studies explored intersectoral collaboration between the departments of health and other government sectors (including Social Development, Education, Housing, Welfare, Criminal Justice) and nongovernmental organisations (NGOs). Three studies focussed on collaboration between healing paradigms – i.e. between traditional healers and western biomedically trained mental health professionals while three studies considered collaboration on a community level in studying how CHWs could contribute towards integrating mental health on a PHC level or providing psychosocial care in the community (see Table 4-3).

Table 4.5

Methodological Appraisal of Included Studies

Author	Research Aims	Research Designs	Participants	Sampling	Data Collection	Data Analysis
Brooke-Sumner et al. 2016	Provide recommendations for intersectoral collaboration to strengthen psychosocial rehabilitation for severe mental illness	Qualitative	16 key informants from the South African Department of Health, 2 key informants from the Department of Social Development, 4 key informants from the NGO sector and 1 key informant from a service user organisation at national level	Purposive	24 in-depth semi-structured interviews	Framework analysis
Burgess 2016	Identify factors that shape the everyday delivery and outcomes of a primary mental health care model in resource-poor settings	Qualitative	Observations of hospital clinics, satellite clinics, and an NGO. Interviews with health professionals	Purposive	Motivated ethnography, case study method 76 hours formal/structured observations, daily informal observations over 5 weeks, semi-structured interviews	Grounded thematic analysis
Campbell-Hall et al. 2010	Explore perceptions of service users and providers of current interactions between the two systems of care (Western and Traditional) and ways in which collaboration could be improved in the provision of community mental health services	Qualitative	Stakeholders from the formal health sector (9 interviews, 6 focus groups); NGO sector (1 interview); traditional practitioners (2 interviews; 4 focus groups); and mental health service users (15 interviews)	Purposive	27 semi-structured qualitative individual interviews and 9 focus group (6-8 participants) interviews	Framework analysis
Gerber 2018	To explore and describe primary health practitioners' experience of the integration of mental health into primary health care	Mixed methods	Primary health care practitioners: For quantitative part: 87 nurses, 4 medical doctors, 4 social workers For qualitative part: 9 nurses, 2 medical doctors, 2 social workers	Purposive	95 structured questionnaires and 12 semi-structured interviews	Mixed-method data analysis and thematic content analysis

Hanlon et al. 2014	Compare the baseline context, challenges and opportunities in districts in five low-to-middle income countries (including SA). The purpose was to inform development and implementation of a comprehensive district plan to integrate mental health into primary care	Qualitative	Information in public domain: Health facility and system records, health surveillance data, research publications, governmental and non-governmental reports, supplemented with personal communication with key service coordinators	NA	Largely relied upon resourcing information available in the public domain and personal communication with key officials and service heads	Cross-sectional situation analysis using uniquely designed situation analysis tool
Janse van Rensburg et al. 2018[b]	Explore the extent and nature of state and non-state mental health service collaboration using Social Network Analysis (SNA) and interviews with key stakeholders	Mixed methods	66 collaborating state and non-state mental health service providers: 41 PHC facilities, 3 district hospitals, 1 regional hospital, 1 specialist psychiatric hospital, 20 NGOs.	Purposive	Social network analysis (SNA) and semi-structured interviews	Descriptive network analysis for SNA data and thematic analysis of interview data
Janse van Rensburg et al. 2018[a]	Explore the power dynamics in collaborative governance processes of district-level public mental health service provision	Qualitative	State and non-state actors in MHC. This included a psychologist, psychiatrist, and 2 mental health nurses on state level, and a case worker and director from NGOs.	Snowball	20 Semi-structured interviews	Thematic analysis using the Framework for Assessing Power in Collaborative Processes
Marais & Petersen 2015	Identify systemic factors within institutional and policy contexts that are likely to facilitate or impede the implementation of integrated MHC in South Africa	Qualitative	Policy makers at the national level in the Department of Health, provincial coordinators and planners in primary health care and in mental health, and district-level managers of primary health care and MHC services	Purposive	17 qualitative semi-structured interviews	Framework analysis using Siddiqi et al.'s governance framework principles
Mendenhall et al. 2014	Investigate the acceptability and feasibility of task-sharing MHC in low-to-middle income countries (including SA) by examining perceptions of primary care service providers (physicians, nurses, and community health workers), community members, and service users	Qualitative	11 primary care service providers (physicians, nurses, and community health workers), 10 community members, 53 service users, 10 specialists/policy makers	Purposive and snowball	5 focus groups and 87 in-depth individual interviews	Framework analysis

Petersen et al. 2016	To develop a district mental healthcare plan (MHCP) in South Africa that integrates mental healthcare at PHC level and to design feasible collaborative care packages for depression, alcohol use disorder, and schizophrenia to be integrated into existing service delivery platforms. Process evaluation interviews were conducted at 3-month follow-up. The purpose of the qualitative process evaluation interviews was to gain an understanding of individuals' experience of delivering and receiving the interventions as well as bottlenecks that emerged and reasons for these.	Qualitative	4 Primary healthcare nurses, 4 lay counsellors, 2 auxiliary social workers, 6 patients who received counselling for depression, 6 patients who attended psychosocial rehabilitation groups and 4 caregivers of patients attending psychosocial rehabilitation groups	Unclear	Qualitative interviews	Framework analysis
Petersen et al. 2009	Assess progress in South Africa with respect to deinstitutionalization and the integration of mental health into primary health care, with a view to understanding the resource implications of these processes at district level	Mixed methods	Various stakeholders in government health sector (nurses, doctors, hospital managers etc.) and community level (nurses, teachers, social worker, traditional healer)	Purposive	34 semi-structured interviews and 14 focus group interviews Quantitative questionnaire	Situational analysis and framework analysis based on qualitative interviews Simple descriptive statistical analysis for quantitative data
Petersen et al. 2011	Examine how the use of a common implementation framework could assist in the integration of mental health into primary healthcare in Ugandan and South African district sites	Qualitative	South African sample: 15 CHWs, 9 service users of the counselling groups, 4 PHC nurses, 2 psychiatric nurses, the mental health counsellor, a specialist cadre of mental health worker with a four-year B.Psych qualification, health managers including the provincial community mental health coordinator and the sub-district director, 2 community	Unclear	A qualitative post-intervention process evaluation using focus groups and individual interviews	Framework analysis

			representatives on the community collaborative multi-sectoral forum			
Petersen et al. 2012	To understand the benefits and challenges of community participation beyond that of scaling up – especially promoting culturally competent MHC and greater community control of mental health	Qualitative	15 CHWs, 29 participants from psychosocial groups offered by CHWs, 4 PHC clinic nurses, 2 psychiatric nurses, a mental health counsellor, the provincial and district mental health coordinators, 2 community representatives on the community collaborative multi-sectoral forum	Purposive	Qualitative process evaluation using individual interviews and focus group interviews	Thematic Analysis
Schierenbeck et al. 2018	Explore how MHC stakeholders, responsible for managing and implementing policies on MHC, comprehend and relate to the intersection and tension between traditional medicine and biomedicine in the cases of Rwanda and the Eastern Cape Province in South Africa.	Qualitative	12 MHC stakeholders including 3 psychiatrists, 4 PHC nurses, 5 administrators responsible for mental health coordination at regional and district level	Purposive	Semi-structured interviews	Qualitative content analysis
Skeen et al. 2010	Assess progress in intersectoral collaboration for mental health, and provide recommendations for intersectoral collaboration to generate lessons for other low- and middle-income countries	Mixed methods	64 national and provincial stakeholders, including politicians, public sector policy makers and planners (from the Departments of Health, Education, Social Development, Housing, Labour, Justice and Constitutional Development, South African Police Services and Correctional Services), NGO programme managers, MHC users, religious leaders, and members of development agencies, professional associations, unions, universities and research institutions.	Purposive	Qualitative data were collected using 33 semi-structured interviews and 12 focus groups Quantitative data were collected using the World Health Organisation's Assessment Instrument for Mental Health Systems (WHO-AIMS)	Thematic analysis

Sorsdahl et al. 2010	Use the constructs of the Theory of Planned Behaviour (TPB) to gain an understanding of traditional healer referral practices of their patients with a mental illness	Qualitative	24 traditional healers	Convenience	3 focus groups	Framework analysis

4.3.2 Methodological Appraisal

Table 4-5 summarises the research aims, methodological approach, participants, sampling method, data collection methods and method of data analysis for every included study. Of these studies, 12 were qualitative in nature, while four employed a mixed method (qualitative and quantitative) methodological approach. As can be deduced from the summarised research aims, all studies were exploratory or descriptive in nature and contained no correlational nor explanatory research.

The sample of studies covered a wide range of participant views. Study participants ranged from policy makers at the national level, provincial coordinators and district managers of MHC, key informants from various governmental departments (Health, Education, Social Development, Housing, Labour, Justice and Constitutional Development, South African Police Services and Correctional Services) and non-governmental organisations, health professionals (including medical doctors, psychiatrists, psychologists, social workers, PHC nurses, psychiatric nurses), CHWs, traditional healers and herbalists, community members, caregivers, and MHSUs. The most common type of sampling across the studies was a purposive sampling method (n=11). Other sampling methods used included snowball (n=2) and convenience (n=1) sampling, while two studies did not explicitly state the sampling method used.

Given the predominantly qualitative methodological approaches employed across included studies, the most common means of data collection were semi-structured individual interviews (n=14) and focus group interviews (n=7). In one study, data was collected by means of observations of hospital clinics, satellite clinics, and an NGO (Burgess, 2016) and another study drew on information from the public domain, including health facility and system records, health surveillance data, research publications, and governmental and non-governmental reports (Hanlon et al., 2014). Included studies analysed qualitative data using thematic analysis or framework analysis. In contrast to thematic analysis where the researcher identifies themes that emerge from the data, framework analysis involves the development of an *a priori* coding framework based on the specific research questions (Petersen et al., 2016).

Studies that employed a mixed methods approach collected quantitative data using structured quantitative questionnaires (Petersen et al., 2009), SNA-structured interviews (Janse van Rensburg et al., 2018[b]), or the World Health Organisation's Assessment Instrument for Mental Health Systems (WHO-AIMS) (Skeen et al., 2010). Included studies analysed quantitative data

using simple descriptive statistical analysis and descriptive network analysis was conducted for SNA data to explore, describe, and analyse inter-organizational linkages among health-oriented organizations (Janse van Rensburg et al., 2018[b]).

Table 4-6

Results and Recommendations of Included Studies

Author	Findings	Conclusions	Recommendations	Limitations
Brooke-Sumner et al. 2016	3 themes: (1) Views on current levels of collaboration: Inadequate, absent at district level, some evidence on intersectoral level (2) Challenges to intersectoral collaboration: Lack of communication between sectors, problems delineating roles, and each sector's perception of lack of support from other sectors (3) Strategies for addressing challenges: Improve communication between sectors, promote leadership from all levels and formalise intersectoral relationships	This study has outlined several directions for progress to address challenges for intersectoral collaboration for psychosocial rehabilitation (PSR) in South Africa.	Participant-identified strategies: Improve communication between sectors; promote leadership from all levels and formalise intersectoral relationships through appropriate written agreements; create mental health coordination role and case management role; suggested outlines for roles of DOH, NGO, DOSD; ensure that the available resources for PSR are effectively re-directed to district level	Focus was skewed towards perceptions of DOH stakeholders compared to DOSD and NGO views. The interview schedule was not designed to capture positive perceptions related to intersectoral collaboration.
Burgess 2016	Three key symbolic (intangible) factors that impact on the efficacy of the primary MHC model: (1) Power dynamics, which shaped relationships within multidisciplinary teams (2) Stigma, which limited the efficacy of task-shifting strategies (3) The silencing of women's narratives of distress within services	This study illuminated often "unseen" issues in mental health services – i.e. relational dynamics such as power and stigma in multidisciplinary teams	Training programmes that focus on sensitising practitioners to issues of gender, alongside safe spaces for practitioners to tackle their own stigma mHealth to ensure access to support for lower tiered staff	Not addressed
Campbell-Hall et al. 2010	Shifting between traditional and Western treatment modalities caused problems with treatment adherence. Traditional healers expressed a lack of appreciation from Western health care practitioners but were generally open to training in Western biomedical approaches and establishing a collaborative relationship in the interests of improving	This study highlighted the need for and pathways towards formalising collaboration between traditional healers and western health care practitioners for MHC	Interventions to acquaint traditional practitioners with Western approaches to the treatment of mental illness. Orientation of Western practitioners towards a culture centred approach to MHC.	Service users were accessed through DOH PHC clinics which may have generated responses that privileged the DOH

	patient care. Western biomedically trained practitioners were less interested in such an arrangement.		The establishment of forums to facilitate the negotiation of respectful collaborative relationships between the two systems of healing.	
Gerber 2018	Identified challenges regarding mental health integration on PHC level: (1) limited knowledge and skills; (2) increased work load and work pressure; (3) limited child psychiatric resources; (4) resistance from MHCUs; (5) MHCU files being inaccessible;(6) challenges with follow-up reviews; and (7) inadequate training and support. Progress toward integration was also evident: (1) reduced stigma and improved socialization and holistic treatment for users; (2) training and experience yielding improved confidence for practitioners; (3) access to support from MHC practitioners; and (4) practitioners feeling comfortable with stable MHCUs who were down referred.	Despite progress made, several challenges remain to integrate mental health into primary care. This study identified challenges that may contribute to inconsistent care, unidentified symptoms, defaulting treatment, and the revolving-door phenomenon	Improve communication and coordination between National, Provincial and District levels regarding the South African Mental Health Framework Policy of South Africa to promote consensual understanding on the application of the policy. Increase human resources at PHC level. Promote sustainability of integration by providing ongoing training, supervision, support and access to clinical protocols	A homogenous specific population limits generalisation of findings. Participants were mostly nurses with little information obtained from PHC doctors, social workers, and psychologists.
Hanlon et al. 2014	Many health service organisational requirements for MHC were absent. This included specialist mental health professionals to support the service and reliable supplies of medication. Community mental health literacy was low and there were no models of multi-sectoral working or collaborations with traditional or religious healers. Health system opportunities were apparent. For example, the potential to apply existing models of care for tuberculosis and HIV or non-communicable disorders, which have established mechanisms for detection of	This study elucidated the low levels of baseline health system preparedness for CC models and suggested that interventions should focus on the level of health care organisation, health facility and community to promote sustainable delivery of quality MHC integrated into primary care	Improve recording and reporting of service utilisation to monitor the impact of initiatives and scale-up MHC Design more effective interventions to train PHC workers to deliver MHC Increase numbers of specialist MHC workers	Accuracy of situation analysis tool questionable given poor information systems regarding treatment coverage for mental disorders

	drop-out from care, outreach and adherence support. The extensive networks of community-based health workers and volunteers provide opportunities to expand MHC.			
Janse van Rensburg et al. 2018[b]	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 dynamics as an important consideration in the mental health service network.	The fostering of a well-integrated system of care requires inter-institutional arrangements that include both clinical and social facets of care, and improvements in local governance	Develop more efficient health information and referral systems. Ensure reliable and appropriate transportation of MHSUs. Improve infrastructure and increase mental health professionals.	Cross-sectional design may limit possibility of valid claims. Isolated mental health service providers were under-represented and the identified network is therefore not all-inclusive. Network referral linkages could not be determined due to absence of coordinated and valid monitoring data.
Janse van Rensburg et al. 2018[a]	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.	This paper highlights complexities and different facets of power in integrated MHC in a South African district, adding to the growing literature on social mechanisms that influence collaboration.	Joint coordination and formal shared care plans across state and non-state service providers	Narrow focus of case study method prohibits wider generalisation

	Resistance to power structures unfolded, some participants sidestepping traditional hierarchies to leverage funding and support.			
Marais & Petersen 2015	Facilitative factors included: (1) The recent MHC policy framework and national action plan, (2) the roll out of the integrated chronic disease service delivery platform that can be leveraged to increase access and resources as well as decrease stigma; and (3) the presence of NGOs that can assist with service delivery. Challenges included: (1) The low prioritisation and stigmatisation of mental illness, (2) weak managerial and planning capacity to develop and implement MHC plans at provincial and district level, (3) poor pre-service training in MHC and weak orientation to integrated care, (4) high staff turnover, (5) weak intersectoral coordination, (6) infrastructural constraints, and (7) no dedicated mental health budget	This study identified strategies to support and improve integrated MHC in primary health care services	Capacity building at all levels of the health system Greater coordination and collaboration in planning and service provision Training and supervision for PHC workers Infrastructural improvements including streamlined delivery systems of drugs and treatment protocols Implementation of quality improvement programmes Better indicators for mental health in the health information system Advocacy and awareness raising campaigns	Not addressed
Mendenhall et al. 2014	5 Themes: (1) Views on acceptability of task-sharing services, (2) benefits, (3) systemic, social and educational challenges, (4) views on feasibility, (5) logistical challenges	By recognizing the systemic challenges and sociocultural nuances that may influence task-sharing MHC, locally situated interventions could be more easily planned to provide appropriate and acceptable MHC in LMICs.	Task-sharing mental health services are perceived to be acceptable and feasible in these LMICs as long as key conditions are met: (1) Increased numbers of human resources and better access to medications; (2) ongoing structured supportive supervision at the community and primary care-levels; and (3) adequate training and compensation for health workers involved in task-sharing.	Preliminary study – participants were interviewed before collaborative efforts were implemented
Petersen et al. 2016	Potential barriers to the feasibility of implementation at scale were identified from the pilot study. Bottlenecks included:	This pilot study identified bottlenecks and suggested modifications which	Need for cost-benefit studies to show cost savings and impact of	Traditional healers not included in sample despite a large number of people in

	(1) Paucity of referrals by PHC nurses to lay counsellors, (2) minimal identification of alcohol use disorders, (3) poor follow-up of counselling referrals made by counsellors, (4) a high default rate of patients receiving follow-up medications for mental illness at the primary healthcare clinic which limited the number of patients who could be accessed for psychosocial rehabilitation groups, and (5) poor uptake of the psychosocial rehabilitation intervention by caregivers of patients with schizophrenia. Reasons for these bottlenecks: (1) poor mental health literacy, (2) low self-confidence in ability to diagnose mental health disorders, (3) marginalised status and unclear roles, (4) high patient loads and space constraints that limited consultation	strengthened the potential for integrated MHC	integrated mental health on improved health outcomes Increase resources and improve infrastructure	this area consulting traditional healers for mental health
Petersen et al. 2009	Integrating MHC on PHC level was hampered by (1) a lack of resources and inefficient use of existing mental health resources, (2) PHC nurses experienced a lack of support and supervision from mental health specialists, (3) stigma associated with mental illness, which appears to still be pervasive amongst general health care workers, (4) lack of special shelters or housing, supported employment, support groups, and other forms of psychosocial rehabilitation in the community	The decentralization process remains largely limited to emergency management of psychiatric patients and ongoing psychopharmacological care of patients with stabilized chronic conditions	More efficient use of specialist and community-based human resources Injection of trained CHWs to provide psychosocial rehabilitation and mental health promotion and prevention Use traditional healers more effectively and establish mutual referral systems between traditional and western healing paradigms	Not addressed
Petersen et al. 2011	The establishment of community collaborative multisectoral forums assisted in improving political will to strengthen mental health services. Task shifting using community health workers emerged as a promising strategy	Common implementation framework incorporating a community collaborative multi-sectoral, task shifting and self-help approach to integrating	Identified a need for formal collaborative agreements between sectors to help ensure sustainable commitments from sectors other than health.	Not addressed

	for improving access to services and help seeking behaviour. To varying degrees, community-based self-help groups showed potential for empowering service users and carers to become more self-sufficient and less dependent on overstretched healthcare systems. They also showed potential for promoting social inclusion and addressing stigma, discrimination and human rights abuses of people with mental disorders.	mental health into primary healthcare holds promise for closing the treatment gap for mental disorders. However, a minimum number of mental health specialists are still required to provide supervision of non-specialists as well as specialized referral treatment services.	Identified a need for adequate infrastructure and a specialist referral and supervisory support structure.	
Petersen et al. 2012	CHWs did not feel respected by members from the health service department and community members. Most CHW are women and imposing stressful caregiving efforts on them can negatively impact their mental health. Involving CHWs can assist in mobilising resources for MHC through strengthening awareness and holds promise for culturally competent care via promoting dialogue between western and traditional practitioners	Involving CHWs in the provision of MHC on PHC level holds promise for culturally appropriate care and the scaling up of mental health services in resource-strained areas	Increase recognition of training and roles of CHWs through symbols of power (uniforms, badges, remuneration) Reorientation of roles of specialist staff to provide support to CHWs Reflect on power relations inherent in healthcare system that are disempowering CHWs	Not addressed
Schierenbeck et al. 2018	Collaboration between traditional healers and western practitioners was considered a strategy to improve access and utilisation of biomedical services The ‘double competence’ of some nurses and psychiatrists is recognised as helpful in bridging the two belief systems, since they serve as ‘translators’ between traditional medicine and biomedicine Respondents mentioned that referrals from traditional healers to health care clinics occur. This is also seen as a way to enhance the collaboration between the two	Closer collaboration between biomedicine and traditional medicine may result in a better promotion of the right to highest attainable standard of mental health	Promote intercultural competence amongst staff, which helps to provide culturally appropriate and successful treatment for the patients. A more organised and structured collaboration with traditional medicine practitioners was suggested as one way of supporting such developments	Small sample limits generalisability

	systems. Psychiatrists displayed a willingness to interact with traditional healers to improve the quality of MHC.			
Skeen et al. 2010	There are formal collaborations between the government department responsible for mental health (national and provincial Departments of Health) and other departments/agencies at provincial levels. For example, there is a national forum on forensic psychiatry, convened by the Department of Health, with the South African Police Service (SAPS), the Department of Justice and the Department of Correctional Services. Some provinces have attempted to establish intersectoral forums for mental health although the extent to which these groups meet regularly, and function is variable. Despite these developments, stakeholders who were interviewed strongly felt that South Africa's current level of intersectoral action for mental health is limited.	This study identified a wide range of sectors that have a role to play in mental health promotion. Governments should initiate the development of formalised processes to facilitate an intersectoral response to mental health, led by health sector	Increase high-level political commitment and use leadership from the health sector. Outline roles and responsibilities for various sectors including transport, local government housing, justice, correctional services, police service, social development and education. These include developing programmes alongside legislation, employing targeted awareness-raising to engage sectors, and developing a structured approach to intersectoral action.	Purposive sampling did not capture all perspectives
Sorsdahl et al. 2010	Traditional healer referral to Western care is considered a temporary measure or as a last resort. Traditional healers feel that allopathic physicians do not treat traditional healers with the respect that they feel their contribution to the health of the community warrants.	Designing interventions that are theory-based and effective may provide traditional healers with the information and skills to act as a valuable and referral resource for mentally ill patients	Train traditional healers to identify potential cases of mental illness in their communities. Encourage dialogue between traditional and allopathic physicians regarding MHC.	Limited generalisability given convenience sample of traditional healers in the Eastern Cape Principal investigator was unfamiliar with the language in which study was conducted (isiXhosa) and some concepts were difficult to translate between languages isiXhosa and English.

4.3.3 Results and Recommendations

Table 4-6 summarises the relevant findings, conclusions, recommendations, and limitations discussed in every included study. Common themes identified in the findings were; different stakeholders' views on current levels of collaboration and the feasibility of CC models, factors that facilitate and hinder the implementation of CC models, strategies to address such challenges, and the beneficial and detrimental outcomes following the implementation of collaborative efforts. The relevant findings are organised into themes and discussed in detail in Section 4.4.

Recommendations were made concerning both practice and research. The most common recommendations for practice were to promote the sustainability of collaborative efforts by providing ongoing training to health professionals working in PHC settings, increasing the amount of mental health specialists and putting supervisory and support structures in place, improving infrastructure and leadership and formalising collaborative agreements. Regarding recommendations for research, studies identified a need for cost-benefit studies to show cost savings and the impact of CC initiatives on improved health outcomes.

Commonly reported limitations were a lack of generalisability of the study, a lack of diversity among samples or a sample being skewed towards the perceptions of a certain group, and a poor mental health information system complicated the collection of valid data in some studies. Five articles did not report the limitations of the study.

4.4 Thematic Analysis

In the present review, I identified six dominant themes and 25 subthemes in the literature. The dominant themes were: (1) The context of CC in South Africa, (2) barriers to the implementation of CC models, (3) detrimental outcomes of CC, (4) facilitative factors in the implementation of CC models, (5) proposed strategies to improve the implementation of CC models, and (6) beneficial outcomes of CC. Table 4-7 provides a thematic map for themes and relevant subthemes that will be discussed in this section.

Table 4-7

Thematic map of Themes and Subthemes

Theme	Subthemes
(1) The context of CC in South Africa	• Inter-professional collaboration • Community-level collaboration • Intersectoral collaboration • Healing paradigm collaboration
(2) Barriers to the implementation of CC models	• Resource shortage and poor infrastructure • Perceptions of a lack of support and trust • Poor information and referral systems • Inadequate education and training • Low prioritisation and stigmatisation of mental illness • Power dynamics • Problems delineating roles
(3) Detrimental outcomes of CC	• Poor treatment adherence and high relapse rates • Non-detection of common mental disorders
(4) Facilitative factors in the implementation of CC models	• Supporting policy documents • Available network of CHWs and NGOs • Dual competence of some nurses and psychiatrists • Positive attitudes amongst stakeholders
(5) Proposed strategies to improve the implementation of CC models	• Formalise relationships and improve leadership • Redirect resources and improve infrastructure • Improve training and education • Improve communication and supervisory structures

(6) Beneficial outcomes of CC	• Reduced stigma and improved socialisation • Culturally appropriate care • CHWs engaging in health-promoting initiatives • Improved ability to manage MHCUs

4.4.1 Theme 1: The context of Collaborative Care in South Africa

Several studies discussed the implementation of CC models on an inter-professional, community, intersectoral and healing paradigm level; what such interventions entailed; and where CC models were limited or absent. In this theme, I discuss the current context of CC on these four levels.

Studies provided evidence of CC occurring on an inter-professional level to integrate MHC as part of the basic PHC care package in the North West Province (Dr KK district) (Hanlon et al., 2014; Marais & Petersen, 2015; Mendenhall et al., 2014; Petersen et al., 2016), rural northern KwaZulu-Natal (Umkhanyakude district) (Burgess, 2016; Petersen et al., 2009; Petersen, et al., 2011) and in Gauteng (West Rand) (Gerber, 2018). A mental health coordinator was appointed, screening tools and intervention guidelines were provided for mental illnesses, and staff supervisory structures were put in place (Hanlon et al., 2014). Mental health specialists back-referred patients from specialist care to PHC and supervised PHC workers to give follow-up care for people with chronic and severe mental illness through continuing their prescription of medication and providing them with counselling and psychoeducation (Hanlon et al., 2014).

Mental health services offered at the primary level, however, remain primarily focussed on the emergency management of psychiatric patients and ongoing psychopharmacological care rather than on providing access to care for common mental illnesses (Petersen et al., 2009). The high default rate of patients receiving follow-up medications for mental illness at the PHC clinic also limited the number of patients who could be assessed for psychosocial rehabilitation groups (Petersen et al., 2016).

Contrary to the body of evidence indicating the presence of CC occurring on an interprofessional level, only two studies reported on CC efforts occurring on a community level in northern KwaZulu-Natal (Petersen et al., 2012; Petersen, et al., 2011) while one study investigated perspectives' on the acceptability and feasibility of CC on a community level before collaboration occurred (Mendenhall et al., 2014). Some researchers accounted for the low levels of collaboration on this level by suggesting that CHWs felt overburdened with the demands of caring for other illnesses, such as HIV/AIDS and tuberculosis, and therefore felt unable to take

part in psychosocial rehabilitation and mental health prevention and promotion (Hanlon et al., 2014; Petersen et al., 2009). In cases where collaboration was evident, researchers concluded that collaborating with CHWs constitutes a promising strategy to increase access to MHC, to promote social inclusion and address stigma on the community level, and to provide culturally-appropriate care (Petersen, Baillie, et al., 2012; Petersen, et al., 2011). CHWs were trained and supervised by mental health specialists to identify, manage, and refer patients with common mental illnesses (i.e. anxiety, depression, substance use disorders) and some dedicated CHWs were supervised to provide manualised interpersonal group therapy at a PHC clinic. CHWs also formed and led community-based self-help groups that focussed on providing supportive counselling and initiating income generating projects to address unemployment as a social determinant of poor mental health (Petersen, et al., 2012; Petersen, et al., 2011).

Intersectoral collaborative efforts for mental health occurred in the North West Province (Dr KK district) (Brooke-Sumner et al., 2016), the Free State (Mangaung Metropolitan District) (Janse van Rensburg et al., 2018[ab]) and rural northern KwaZulu-Natal (district Umkhanyakude district) (Skeen et al., 2010). Researchers, however, concurred that existing levels of intersectoral collaboration are inadequate on provincial level and apparently non-existent on district level. A social network analysis (SNA) by Janse van Rensburg et al. (2018[b]) elucidated the hospital-centric nature of intersectoral collaboration and the especially low levels of collaboration between government and non-government sectors in the Free State. Stakeholders from the Department of Health (DOH), Department of Social Development (DOSD) and non-governmental organisations (NGOS) described efforts by individual staff members to initiate collaborations with other sectors in an unstructured manner, but this was not supported by formal organisational structures (Brooke-Sumner et al., 2016; Janse van Rensburg et al., 2018[a]). Likewise, studies reported that NGOs and community-based organisations worked with MHCUs despite a lack of formal collaborative agreements and directives from sectors other than the DOH (Hanlon et al., 2014; Petersen, et al., 2011). For example, a SNA showed how focal hospital staff members forged informal relationships with NGO members to refer patients to NGOs for basic needs, treatment adherence, and housing (Janse van Rensburg et al., 2018[a]). Meetings organised to address collaboration by the DOH were described as ineffective, having no clear structure, aims or outcomes, and no minutes were circulated (Janse van Rensburg et al., 2018[a]).

Despite several calls for greater collaboration between healing paradigms, numerous studies coincide that there has been little progress in this regard (Campbell-Hall et al., 2010; Hanlon et al., 2014; Janse van Rensburg et al., 2018[b]; Petersen et al., 2009; Schierenbeck et al., 2018;

Sorsdahl, Stein, & Flisher, 2010). Studies indicated that that some referrals happen from CAPs to WPs (Campbell-Hall et al., 2010; Sorsdahl et al., 2010) and from traditional healers to health care clinics (Schierenbeck et al., 2018) while the establishment of a multisectoral community collaborative forum facilitated meetings between western and traditional practitioners (Petersen et al., 2012). Other studies noted a complete absence of collaboration between traditional or religious healers and PHC services (Hanlon et al., 2014; Janse van Rensburg et al., 2018[ab]). All of these studies agreed that this absence of formal collaborative arrangements between CAPs and WPs is a particular concern.

4.4.2 Theme 2: Barriers to the implementation of Collaborative Care models

Although progress has been made towards implementing CC models for MHC in South Africa, several challenges remain. Table 4-8 presents a summary of the different barriers to CC identified in the sample and the distribution of articles within which such barriers have been reported. I will discuss the seven barriers as different subthemes. The most commonly occurring barrier was the shortage of resources and an inadequate infrastructure to support the implementation of CC models.

Table 4-8

Ranking of Barriers to CC

Barrier	Number of Studies	Ranking	References
Resources shortage and poor infrastructure	12	1	(Brooke-Sumner et al., 2016, 2016; Burgess, 2016; Gerber, 2018; Janse van Rensburg et al., 2018[ab]; Marais & Petersen, 2015; Mendenhall et al., 2014; Petersen et al., 2009; Petersen, et al., 2011; Skeen et al., 2010)
Perceptions of a lack of support and trust	10	2	(Brooke-Sumner et al., 2016; Burgess, 2016; Campbell-Hall et al., 2010; Janse van Rensburg et al., 2018[ab]; Mendenhall et al., 2014; Petersen et al., 2009, 2016; Petersen, et al., 2012; Sorsdahl et al., 2010)
Poor information and referral systems	9	3	(Brooke-Sumner et al., 2016; Burgess, 2016; Campbell-Hall et al., 2010; Gerber, 2018; André Janse van Rensburg et al., 2018[a]; Marais & Petersen, 2015; Petersen et al., 2016; Petersen, et al., 2012; Skeen et al., 2010)
Education and training	9	3	(Burgess, 2016; Campbell-Hall et al., 2010; Gerber, 2018; Hanlon et al., 2014; Janse van Rensburg et al., 2018[a].; Marais & Petersen, 2015; Petersen et al., 2009, 2016; Sorsdahl et al., 2010)
Low prioritisation and stigmatisation of mental health	8	4	(Burgess, 2016; Gerber, 2018; Janse van Rensbrug et al., 2018[b]; Marais & Petersen, 2015; Mendenhall et al., 2014; Petersen et al., 2009, 2016; Skeen et al., 2010)

Power dynamics	6	5	(Brooke-Sumner et al., 2016; Burgess, 2016; Campbell-Hall et al., 2010; Janse van Rensburg et al.,2018[ab]; Petersen, et al., 2012)
Problems delineating roles	4	6	(Brooke-Sumner et al., 2016; Marais & Petersen, 2015; Petersen et al., 2016; Skeen et al., 2010)

4.4.2.1 Resources shortage and poor infrastructure

Inadequate resources and facilities impeded the implementation of CC policies. More specifically, studies identified a lack of human resources, especially specialist MHC workers, a lack of finances, and poor infrastructure in terms of inadequate spaces to provide psychosocial care, and an unreliable supply of psychotropic medication.

A scarcity of specialist mental health workers in the Dr KK district (Hanlon et al., 2014), rural areas in KwaZulu-Natal (Burgess, 2016; Petersen et al., 2009), and the Mangaung Metropolitan District (Janse van Rensburg et al., 2018[b]) hindered the implementation of CC models on a PHC level. Psychiatric nurses reported that visiting psychologists and psychiatrists were overburdened with responsibilities and despite their best efforts could not always be reliable in providing care for certain patients or supervising PHC workers (Burgess, 2016). Similarly, social workers also felt overburdened and were at risk for burnout (Brooke-Sumner et al., 2016; Marais & Petersen, 2015). A particular lack is child psychiatrists and child psychiatric resources (Gerber, 2018; Petersen et al., 2009; Skeen et al., 2010). In turn, due to work overload and burnout, specialists tend to leave state services while finding suitable staff willing to join mental health teams in remotely rural areas was a challenge (Marais & Petersen, 2015). Several researchers questioned the feasibility of CC and the integration of MHC on a primary level if appropriately skilled and mental health specialists are not available to oversee and supervise PHC workers and CHWs (Hanlon et al., 2014; Marais & Petersen, 2015; Petersen et al., 2009; Petersen et al., 2011).

Studies also reported a shortage of PHC workers and CHWs dedicated to MHC in primary health settings (Marais & Petersen, 2015; Mendenhall et al., 2014; Petersen et al., 2016, p. 201; Petersen, et al., 2011). PHC workers feel unable to provide MHC as they are already overburdened and barely manage to cope with the current burden of physical illness (Petersen, et al., 2011). Despite there being more psychiatric nurses than the suggested estimate (SA has 7.5 psychiatric nurses per 100 000 population compared to a median of 5.3 per 100 000 for other upper middle-income countries), psychiatric nurses were not providing MHC and were rather being used for general health care services due to overall shortages in the system (Petersen et al., 2009). In turn, the increased burden of emotional labour has been shown to increase their risk for burnout, especially considering the lack of supervisory support structures (Petersen et al., 2016).

For example, Gerber (2018) found that nurses and medical doctors were resistant to the integration of MHC into primary care because they felt overburdened and struggled to cope with their already high work load. Another factor contributing towards CHWs leaving the mental health workforce was that they are required to take on new roles but were not receiving recognition nor remuneration for it (Marais & Petersen, 2015).

Considering that mental health shares a budget pool with other health programmes, funding for mental health is inadequate (Marais & Petersen, 2015; Petersen et al., 2009) and poorly budgeted (Skeen et al., 2010). A lack of financial resources to create and sustain posts increased the burden on existing staff, specifically specialised mental health professionals, psychologists and psychiatrists, working in PHC contexts which, subsequently, contributed to specialists leaving state services (Marais & Petersen, 2015).

CC efforts are further hampered by an inadequate quantity and quality of existing infrastructure for mental health service provision. Several studies highlighted the paucity of community or residential centres to provide psychosocial care for patients who were discharged from the hospital back into the community (Brooke-Sumner et al., 2016; Hanlon et al., 2014; Janse van Rensburg et al., 2018[ab]; Marais & Petersen, 2015; Petersen et al., 2009; Skeen et al., 2010). A lack of confidential spaces for counselling services and observation in PHC facilities emerged as another challenge related to inadequate infrastructure (Brooke-Sumner et al., 2016; Janse van Rensburg et al., 2018[b]; Marais & Petersen, 2015; Mendenhall et al., 2014; Petersen et al., 2016). In some smaller community-based NGOs, poor communication infrastructure (i.e. telephone, fax, internet) complicated access to the mental health service network (Janse van Rensburg et al., 2018[a]).With regards to the availability of medicine, a reliable supply of the full range of psychotropic medication was available at the Dr KK district (Hanlon et al., 2014) and northern rural area of KwaZulu Natal (Petersen et al., 2009) while participants on PHC level reported drug stock-outs in the Mangaung Metropolitan District in the Free State (Janse van Rensburg et al., 2018[b]) and in the Dr KK district (Marais & Petersen, 2015).

4.4.2.2 Perceptions of a lack of support and trust

Perceptions of a lack of support from other sectors or stakeholders to work collaboratively towards a mutual goal and a sense of mistrust in other stakeholders' competencies to do their part hampered efforts towards collaboration.

On an intersectoral level, participants from the Department of Health (DOH), Department of Social Development (DOSD) and Non-Governmental Organisations (NGO) sectors all held perceptions of a lack of support from and trust in other sectors to fulfil their roles. Participants from the DOH struggled to access social workers from the DOSD assigned to health facilities (Brooke-Sumner et al., 2016; Petersen et al., 2016) and NGO participants highlighted an ongoing struggle for funding from the DOSD to provide ongoing care (Brooke-Sumner et al., 2016; Janse van Rensburg et al., 2018[ab]). Tension was also present between state and non-state sectors. Key stakeholders working in state MHC voiced suspicion and contempt regarding mental health services provided by NGOs and as such did not see the necessity to collaborate (Janse van Rensburg et al., 2018[b]). Concerns included lack of clarity regarding the extent to which NGOs are regulated and conditions at these sites (Janse van Rensburg et al., 2018[a]). In turn, NGO representatives reported that some of their clients were neglected when they sought care in state facilities. Especially, well-funded and established NGOs regarded themselves as superior to state service providers in terms of quality, cost-effectiveness, and efficiency (Janse van Rensburg et al., 2018[a]). Overall distrust in state officials to lead MHC was due to concerns related to corruption and political venality and a sense of unfairness that the state was shifting responsibility towards NGOs (Janse van Rensburg et al., 2018[a]). In a similar line, there was a general sense of mistrust amongst PHC workers, CHWs, and mental health specialists in government stewardship to provide quality mental health services (Mendenhall et al., 2014).

PHC workers had poor trust in community lay counsellors' competency to counsel patients effectively and to follow-up on referrals while lay counsellors had poor trust and confidence in their own abilities (Mendenhall et al., 2014; Petersen et al., 2016). This resulted in low referrals by PHC nurses to lay counsellors (Petersen et al., 2016).

Some traditional healers were reluctant to collaborate with Western practitioners as they feared that their methods and indigenous knowledge would be exploited (Campbell-Hall et al., 2010). Traditional healers who were against collaboration typically considered themselves to be herbalists(Sorsdahl et al., 2010). Herbalists believed in the efficacy of their practices and that Western medicine was not only ineffective in treating the mentally ill, but was also a source of potentially harmful side effects (Sorsdahl et al., 2010). Despite a reported willingness to collaborate with WPs, CAPs tended to view WPs as harbouring feelings of mistrust towards them, not respecting their profession, believing that their practices are harmful or ineffective, and that WPs were therefore reluctant to collaborate with CAPs (Sorsdahl et al., 2010).

Lower tiered staff did not feel adequately supported by higher tiered staff and PHC workers complained about a lack of support and supervision from mental health specialists(Burgess, 2016; Petersen et al., 2009; Petersen, et al., 2012). A lack of support from mental health specialists hampered PHC nurses' capacity to provide adequate care to psychiatric patients (Burgess, 2016; Petersen et al., 2009). Likewise, increasing community participation caused CHWs, comprising mostly economically marginalised women, emotional stress as they remained unsupported by specialist staff (Petersen, Baillie & Bhana, 2012). PHC staff also reported a lack of support from general doctors, due to stigmatising attitudes, to support provision of MHC at primary level and indicated that general doctors were often absent at meetings scheduled to address collaboration (Burgess, 2016).

4.4.2.3 Poor information and referral systems

Overall, formal agreements for partnerships and collaboration were lacking and referral between services and professionals occurred in an informal fashion (Janse van Rensburg et al., 2018[a]; Skeen et al., 2010). Referrals and communication between health professionals were further complicated by the absence of a unified mental health information system.

Onward referrals occurred more often than back-referrals (Brooke-Sumner et al., 2016; Marais & Petersen, 2015; Petersen, et al., 2012) and rather than using outlined pathways of PHC clinics for screening and referral, patients often entered services directly through emergency care and 72 hour observation (Burgess, 2016). This lack of established referral pathways between different systems and levels of care negatively affected already overburdened hospitals and specialist care settings. For example, PHC nurses referred patients to higher levels of care but generally did not get back referral information to assist in the management of psychiatric patients (Marais & Petersen, 2015). Likewise, studies documented a paucity of referrals from PHC nurses to lay counsellors (Petersen et al., 2016) and general poor referral systems to CHWs (Petersen, et al., 2012). Traditional healers who referred patients to western practitioners complained about not getting feedback from hospitals or clinics. On the other hand, although western practitioners did not prevent mental health patients from seeking treatment from traditional healers, they were mostly not in favour of referring patients (Campbell-Hall et al., 2010).

The absence of a unified mental health information system led to little information shared among service providers (Brooke-Sumner et al., 2016; Gerber, 2018; Janse van Rensburg et al., 2018[a]; Marais & Petersen, 2015; Petersen et al., 2016). This complicated the follow up of patients referred from DOH to DOSD, from district social workers to community social workers, and

patients admitted to hospital and down-referred to PHC clinics (Brooke-Sumner et al., 2016; Marais & Petersen, 2015). When patients were down referred from psychiatric hospitals to NGOs, NGO workers lacked access to important patient information due to confidentiality concerns (Brooke-Sumner et al., 2016). Similarly, MHCU files were kept separate from chronic files in a PHC clinic in the West-Rand, Gauteng and nurses therefore struggled to access information regarding patient treatment plans which negatively impacted on the effectiveness and quality of mental health treatment (Gerber, 2018). Additionally, the absence of a unified mental health information system contributed to scripts for MHC treatment often being lost or rewritten without review by medical doctors (Gerber, 2018).

4.4.2.4 Inadequate education and training

Poor understanding and awareness of existing mental health policies, sporadic training for PHC workers in how to care for mental health, and a general lack of knowledge regarding mental illness were barriers to implementing effective CC models on all levels.

Although the majority of participants in Gerber's (2018) study knew what collaboration meant on a PHC level, more than half did not understand the Mental Health Policy and did not think that integration was working, while Janse van Rensburg et al.'s (2018[a]) study showed that most of the participants working in the non-state/private sector had no knowledge of the existence of the policy. Marais and Petersen (2015) demonstrated that policy information was poorly communicated from national down to provincial and district levels resulting in PHC managers being insufficiently trained in the Mental Health Act.

Although a situational analysis indicated that pre-service training of PHC workers in MHC formed a substantial percentage of training time (20%), training in mental health for PHC nurses was experienced as sporadic and incomprehensive (Gerber, 2018; Hanlon et al., 2014; Marais & Petersen, 2015; Petersen et al., 2009, 2016). For example in one study only half of the nurse participants reportedly received some form of undergraduate training or in-service training on how to screen, detect, and intervene in mental disorders (Gerber, 2018). As a result, nurses felt ill-equipped and incompetent to deal with and manage MHCUs (Gerber, 2018; Petersen et al., 2009). Likewise, poor role clarification and inadequate training of existing lay counsellors resulted in a lack of confidence and hesitancy to take on additional counselling duties (Petersen et al., 2016).

A general lack of knowledge about mental illness translated into different interpretations of the causes, meanings, and approaches to mental illness. Several health service providers, including medical doctors, reportedly had an inadequate understanding of and appreciation for the complexity of MHC which resulted in misdiagnosis or ill-suited treatment plans (Burgess, 2016; Janse van Rensburg et al., 2018[a]). Poor knowledge of mental illness amongst traditional healers resulted in healers failing to detect common mental disorders in patients and to accordingly refer them to relevant biomedical services to obtain necessary psychiatric medication (Campbell-Hall et al., 2010; Sorsdahl et al., 2010). While some traditional healers indicated that they would like to receive training on Western perspectives towards the treatment of mental illnesses, others did not see the use in such knowledge as they believed "stress" and "bewitchment" can only be treated with traditional medicine and rituals (Campbell-Hall et al., 2010; Sorsdahl et al., 2010).

4.4.2.5 Low prioritisation and stigmatisation of mental illness

Health workers' stigmatising attitudes towards mental health contributed to non-participation in collaborative efforts and deferral of responsibilities when dealing with the mentally ill. In addition to stigma, viewing mental health separately from general health, added to the low priority status of mental health and negatively impacted attitudes amongst health workers towards collaboration.

Several studies documented the presence of stigmatising attitudes amongst PHC nurses, general doctors and NGO workers towards mental illness. This translated into a general unwillingness to deal with MHSUs and deferral of responsibilities on PHC level (Burgess, 2016, 2016; Gerber, 2018; Janse van Rensburg et al., 2018[b]; Mendenhall et al., 2014; Petersen et al., 2016), abuse towards MHCUs (Hanlon et al., 2014), and doctors being absent at meetings scheduled to address collaboration (Burgess, 2016). Collaborative policy guidelines stipulate that PHC nurses should follow-up on patients discharged from hospital to monitor treatment adherence, but studies showed that PHC nurses overlooked the care of mental health patients and preferred to wait for mental health specialists to see MHCUs due to fear of aggression and violence amongst the mentally ill (Burgess, 2016; Petersen et al., 2009). The purpose of mental health specialist visits was to identify new patients and support problematic cases, but instead time was spent on basic care (Burgess, 2016). In a similar line, when mental health patients were referred from hospitals to NGOs, Mendenhall et al. (2014) observed how NGO workers refused to see mental health patients based on stigmatised beliefs that they were "insane" and aggressive. Stigma was

seemingly linked to a lack of training and a poor understanding of the complexity of mental illness (Janse van Rensburg et al., 2018[a]).

A general tendency amongst health workers to view mental health separately from general health contributed to stigmatising attitudes and added to the already low priority status of mental health (Mendenhall et al., 2014; Skeen et al., 2010). For example, general doctors displayed a lack of respect for the mental health discipline (Burgess, 2016; Petersen et al., 2016), care for HIV and TB were deemed more important than mental health (Marais & Petersen, 2015) and physical disability was considered more acute than mental disability (Janse van Rensburg et al., 2018[a]). Subsequently, nurses and medical doctors (Gerber, 2018; Marais & Petersen, 2015) and CHWs (Mendenhall et al., 2014) expressed a reluctance towards collaboration on primary care level and voiced their preference to keep MHC separate from PHC.

4.4.2.6 Power dynamics

NGO members, nurses, CHWs, and traditional healers felt like they had limited power in comparison to psychiatric services and medical doctors to shape MHC. The hierarchical structure of MHC, and lower tiered members feeling frustrated with and disrespected by members working in higher levels of care, impeded collaborative efforts.

SNA showed considerable inequality in a network of mental health service provision in the Mangaung Metropolitan District, Free State which indicated a hierarchical structure (Janse van Rensburg et al., 2018[b]). The apparent strong hospital centric nature of collaboration can be explained by the power afforded to psychiatric expertise. Representatives from well-established NGO facilities expressed their frustration towards the reluctance of PHC workers to refer MHCUs to their facilities (Janse van Rensburg et al., 2018[b]). Yet, NGO participants felt like they had no voice in state and non-state collaborative initiatives, especially given their dependence on state funding and a fear of losing funding (Janse van Rensburg et al., 2018[a]). Additionally, NGOs were in competition with one another for state funding which was also not conducive to collaborative efforts (Janse van Rensburg et al., 2018[a]). In a similar line, conflicting priorities of the DOH, DOSD, and NGOs, a focus on personal objectives and recognition, and a seeming need to compete for resources led to individuals not attending meetings aimed towards intersectoral collaboration. Instead, people from different sectors continued to work in “silos” (Brooke-Sumner et al., 2016).

District-level staff, such as psychiatric nurses, absorbed responsibilities from higher and lower tiered actors who failed to fulfil their roles in the PHC system (Burgess, 2016). Despite this substantial responsibility afforded to psychiatric nurses, they have limited power to shape patient care in terms of reassessing and reducing medication. The power resided with higher-ranked professionals, like medical doctors, who were either reluctant to participate due to stigmatised attitudes or were unavailable due to other responsibilities. For example, doctors are needed to sign off treatment plans, but according to psychiatric nurses some doctors lacked an adequate mental health knowledge base which resulted in misdiagnosis or ill-suited treatment plans. In turn, psychiatric nurses felt like they have no power to question doctors' authority (Burgess, 2016).

Traditional healers felt like their services were unacknowledged and they were treated with disrespect by western practitioners who supposedly believed that they did not have adequate skills and knowledge (Campbell-Hall et al., 2010). Similarly, CHWs complained that their efforts to assist MHSUs were hampered as community members and government departments did not respect them as if they were afforded too little power to assert change (Petersen et al., 2012). Moreover, comprising mostly economically marginalised women, situated in a patriarchal society, further limited CHWs capacity to address mental health concerns (Petersen et al., 2012).

4.4.2.7 Problems delineating roles

An unsystematic approach to intersectoral collaboration resulted in a difficulty to delineate the roles and responsibilities of different sectors in the provision of MHC (Brooke-Sumner et al., 2016; Marais & Petersen, 2015; Skeen et al., 2010). Participants from the DOH, DOSD, NGOs, and MHSUs described varying understandings of the roles to be played by sectors other than their own in the provision of psychosocial rehabilitation services (Brooke-Sumner et al., 2016; Marais & Petersen, 2015). The relationship between sectors was further complicated by the inter-dependency of inputs from different sectors for comprehensive community-based residential care. For example, the role of the DOH to provide community-based services, rehabilitation and social grants was complicated by an apparent failure in DOSD to establish community residential facilities. In their defence, DOSD participants complained of a lack of clear strategy that outlines their role. Furthermore, there was confusion around whose responsibility it is to manage residential services and whether it is considered a health 'competency' (Brooke-Sumner et al., 2016). On a PHC level, poor role clarification of existing lay counsellors and CHWs resulted in a lack of confidence and hesitancy to take on additional counselling duties (Petersen et al., 2016)

4.4.3 Theme 3: Detrimental outcomes of Collaborative Care

Failing to address the barriers to CC had detrimental consequences for the quality of MHC. First, an absence of formal collaborative relationships and established referral pathways contributed to poor treatment adherence amongst patients. Where western practitioners were required to collaborate with traditional healers, confusion and mixed opinions regarding taking psychotropic and traditional medicine at the same time, resulted in problems with treatment adherence and relapse (Campbell-Hall et al., 2010). Poor follow-up of patients admitted to hospital and down-referred to clinics also led to poor adherence to treatment and high relapse rates (Marais & Petersen, 2015; Petersen et al., 2016) which was further complicated by problems with a consistent supply of psychotropic medication at district level (Marais & Petersen, 2015).

Second, an insufficient number of mental health specialists available for referral and supervision combined with time, space, and workload constraints on PHC level, caused PHC workers to pay less attention to common mental health problems. As a result, common mental illnesses were often not detected or patients were discharged before receiving adequate care (Janse van Rensburg et al., 2018[b]; Petersen et al., 2009).

4.4.4 Theme 4: Facilitative factors in the implementation of Collaborative Care models

Compared to the discussion of barriers to the implementation of CC models, less focus was given to facilitative factors in the implementation process. Existent mental health policy documents, specifically The National Mental Health Policy Framework and Strategic plan (2013-2020), and the state recognising the contribution of traditional healers through the Traditional Health Practitioners Act (RSA, 2007b), were considered important mechanisms to support participation in CC models in South Africa (Hanlon et al., 2014; Marais & Petersen, 2015; Schierenbeck et al., 2018; Skeen et al., 2010). Additional facilitative factors included the extensive network of available CHWs (Hanlon et al., 2014) and the presence of NGOs(Janse van Rensburg et al., 2018[b]; Marais & Petersen, 2015) that can assist with service delivery if utilised effectively. Given their position in the community, PHC and psychiatric nurses considered CHWs to be ideally placed to provide psychosocial interventions for people with common mental disorders in the community (Petersen et al., 2011). CHWs have the potential to promote social inclusion and reduce stigma as they can provide insight on local issues and develop appropriate mental health responses (Skeen et al., 2010). The double competence of some nurses and psychiatrists (i.e. who were also traditional healers) proved helpful in bridging the gap between western and traditional healing paradigms by acting as translators between CAPs and WPs (Schierenbeck et al., 2018).

A willingness amongst different stakeholders to participate in CC models and holding the belief that CC will improve the quality of MHC smoothed the implementation process. Studies reported on the presence of such positive attitudes amongst psychiatrists and nurses to interact with traditional healers (Schierenbeck et al., 2018) and vice versa (Sorsdahl et al., 2010) and amongst different government and non-governmental sectors for greater intersectoral initiatives(Skeen et al., 2010).

4.4.5 Theme 5: Proposed strategies to improve the implementation of Collaborative Care models

Studies proposed different strategies to address the aforementioned barriers and to improve CC models. I identified four main strategies in the data namely (1) formalise relationships and improve leadership, (2) redirect resources and improve infrastructure, (3) improve training and education, and (4) improve communication and supervisory structures.

4.4.5.1 Formalise relationships and improve leadership

Clarifying the roles of different health service providers, governmental and non-governmental sectors and formalising relationships on all levels (i.e. ward, district, provincial, intersectoral) will allow for more efficient referral practices and ultimately improved quality of care (Skeen et al., 2010). Improvements in leadership are further required to monitor and sustain collaborative relationships.

Researchers identified a need for especially greater role clarification for CHWs and lay counsellors and providing them with symbols, such as badges or uniforms, to help distinguish them from other community members and to work towards enforcing respect and trust in MHSUs (Petersen et al., 2016; Petersen, et al., 2012). Some studies suggested that CHWs, or PHC nurses, should take on a case management role which would involve following up on patients in the community, liaising with families and caregivers to provide continues care, and to refer such patients to specialist care or other services when necessary (Brooke-Sumner et al., 2016; Petersen, et al., 2012). To further ensure that CHWs stay in the health system, remuneration should be improved (Mendenhall et al., 2014; Petersen, et al., 2012).

Several researchers argued for the professionalisation of traditional and faith practitioners and more structured and organised collaboration between CAPs and WPs, which could improve their recognition in the health care system as legitimate partners in health care provision (Campbell-

Hall et al., 2010; Petersen, et al., 2012; Schierenbeck et al., 2018). For example, traditional healers argued for the creation of spaces in hospital settings for them to collaborate with western practitioners to provide MHC (Campbell-Hall et al., 2010) while the establishment of a community collaborative forum, involving service providers on all levels, service users, and community representatives, could facilitate meetings between western and traditional practitioners to discuss collaboration (Petersen et al., 2012).

Studies concurred that leadership regarding CC efforts should come from the DOH. They argued that it is the state's responsibility to initiate and foster collaboration with non-state providers, coordinate intersectoral provision of services, identify gaps in collaboration and set up plans to manage this (Brooke-Sumner et al., 2016; Janse van Rensburg et al., 2018[a]; Skeen et al., 2010). More specifically, this responsibility also entailed illustrating the benefits and importance of collaboration, building trust amongst different stakeholders, and ensuring that resources spent on specialist facilities filter through to community care. For example, Brooke-Sumner et al. (2016) illustrated how a DOH mental health coordinator strengthened relationships between the DOH and NGOs and made frequent visits to community residential facilities which fostered open communication. Likewise, participants in Brooke-Sumner et al.'s (2016) study also identified specific roles for the DOSD. For example, the DOSD should provide disability grants, ongoing funding of NGOs, and informal services to empower families and community members to better address community needs.

4.4.5.2 Re-direct resources and improve infrastructure

Studies suggested that more efficient use of finances and resources and improvements in infrastructure will simplify the implementation of CC policies. More specifically, strategies included a reorganisation of the mental health budget, more efficient use of resources that will follow MHCUs into the community, creating more posts for CHWs and specialist MHC workers, the provision of community residential facilities where psychosocial care could be provided, and developing a more efficient mental health information system

Studies acknowledged the poor likelihood of more resources being allocated to MHC and, therefore, identified a need for an analysis of services provided and a reorganisation of budgets to enable more efficient use of resources (Brooke-Sumner et al., 2016; Janse van Rensburg et al., 2018[b]). Given that NGOs carry the burden of community psychosocial care, researchers once again argued that it is the state's responsibility to direct resources to NGOs to provide adequate

quality care and in this way investment will follow MHCUs from the hospital into the community (Brooke-Sumner et al., 2016; Marais & Petersen, 2015).

A reorganisation of the mental health budget should also allow for the creation of more posts for human resources at PHC level, especially specialist mental health workers (Hanlon et al., 2014) and CHWs (Gerber, 2018), and equip them with the necessary resources to provide psychosocial interventions (Marais & Petersen, 2015). Developing a more efficient health information system will facilitate referral practices between all stakeholders, PHC workers, mental health specialists, and traditional healers (Mendenhall et al., 2014; Petersen et al., 2016; Petersen, et al., 2012; Petersen, et al., 2011).

Regarding the creation of community residential facilities as a necessity for the provision of psychosocial support services, researchers proposed the use of converted cargo containers (Brooke-Sumner et al., 2016) or park homes (Marais & Petersen, 2015) for support groups in overcrowded clinics. Alternatively, liaising with community members could assist in the mobilisation of community resources, such as making a community hall available for psychosocial services (Petersen, et al., 2012). Given that CC strategies involve the provision of care outside of hospital facilities, reliable and appropriate transportation of MHSUs is a requirement (Mendenhall et al., 2014).

4.4.5.3 Training and education

A poor understanding and awareness of existing mental health policies and low confidence levels amongst PHC workers and CHWs to provide MHC calls for improvements in training and education. Training programmes also offer a platform to tackle stigmatised attitudes regarding mental health.

First, better communication between national, provincial, and district levels regarding the South African Mental Health Framework Policy of South Africa is essential to promote consensual understanding on the application of policy (Gerber, 2018; Marais & Petersen, 2015). Considering the resistance from some PHC workers to participate in CC strategies, their training should involve a focus on raising awareness of the benefits of integration for overall health (Marais & Petersen, 2015).

Pre-service training for CHWs and PHC workers to provide MHC should be more comprehensive and consistent (Mendenhall et al., 2014). Particularly, CHWs should be trained to not only

provide general health care, and the focus should shift towards the identification, management and referral of individuals with mental disorders(Gerber, 2018; Hanlon et al., 2014; Petersen et al., 2009; Petersen, et al., 2011). In addition to more effective pre-service training, ongoing training, supervision, and support from specialist district mental health teams to guide and oversee mental health service delivery are necessary to promote the sustainability of integration (Gerber, 2018). The application of mHealth, mobile technologies, might assist lowered tiered staff with the screening of mental disorders and treatment management (Burgess, 2016).

Biomedical training of mental health workers should include an orientation towards the "meaning centred" approach to care that incorporates diverse cultural explanations of mental illness while traditional healers could be trained to provide basic psychosocial care and to identify common mental disorders (Hanlon et al., 2014). Training should focus on fostering mutual respect and learning from both sides rather than enforcing power dynamics. In other words, if traditional healers are expected to learn from western practitioners and westernised treatment modalities, western practitioners ought to learn from traditional healers as well for arrangements to be truly collaborative (Campbell-Hall et al., 2010; Petersen et al., 2009).

Training programmes should further focus on stigma-reducing exercises on levels of PHC workers and general doctors (Burgess, 2016). Researchers stressed the importance of targeting mental health stigma on all levels, including employers, service providers, the community and MHCUs themselves through advocacy and awareness-raising campaigns (Marais & Petersen, 2015). For example, Petersen et al. (2016) recommended the use of waiting room education talks and information leaflets for patients to improve patient mental health literacy.

4.4.5.4 Improve communication and supervisory structures

Studies noted the importance of creating a culture of communication and support between sectors and different staff members on PHC level to facilitate collaboration (Burgess, 2016; Hanlon et al., 2014; Petersen et al., 2016; Skeen et al., 2010). Especially given the increased burden of emotional labour on mental health workers, proposed strategies to minimise burnout included strengthening employee assistance programmes, introducing stress management workshops, instilling more containing leadership, and the use of telemedicine to provide remote supervision (Hanlon et al., 2014; Petersen, et al., 2012). On an intersectoral level, strategies to ease communication included regular intersectoral meetings to address and strategize around gaps in collaboration and to inform authorities (Brooke-Sumner et al., 2016; Skeen et al., 2010).

4.4.6 Theme 6: Beneficial outcomes of Collaborative Care

Some researchers reported on the positive outcomes they observed following more effective implementation of CC models. These included reduced stigma and improved socialisation, CHWs feeling empowered and engaging in health-promoting initiatives, MHCUs perceptions of receiving more culturally-appropriate MHC, and PHC nurses feeling more equipped to deal with mentally ill patients.

Although stigma was identified as a barrier to collaboration at some sites, other researchers reported that when MHCUs were integrated into PHC with patients with other chronic conditions like hypertension and diabetes, such MHCUs experienced less stigmatisation and improved socialisation over time (Gerber, 2018; Marais & Petersen, 2015; Mendenhall et al., 2014). The establishment of a community collaborative multi-sectoral forum contributed to a heightened awareness of the importance of treating mental illness amongst community representatives and therefore also a reduction in stigmatising attitudes (Petersen, et al., 2012; Petersen, et al., 2011).

Other positive outcomes of CC were the empowerment of CHWs to take initiatives to provide psychosocial support in their communities, and MHCUs experiences of receiving more culturally-appropriate care. For example, the involvement of community members in the development of specific psychosocial interventions for common mental disorders resulted in a manualised group-based interpersonal therapy for depression which was reported to be responsive to the cultural and social realities of users (Petersen, et al., 2012). CHWs also established self-help groups, which promoted mental health through the creation of supportive networks that group members could access in the future to cope with stress and addressing poverty-related social determinants of mental ill health by creating income-generating projects in the community. Users felt better understood when fellow community members, rather than nurses or doctors, delivered psychosocial interventions (Petersen, et al., 2012) and outcomes measured amongst participants included improved interpersonal skills, cognitions, and problem-solving capacities, empowerment, and health-promoting actions. Likewise, collaboration between WPs and traditional healers provided culturally appropriate understanding and more successful treatment (Schierenbeck et al., 2018).

Receiving training in MHC and having access to a reliable support system from MHC specialists, made PHC nurses feel more confident and equipped to deal with psychiatric patients (Gerber, 2018; Petersen, et al., 2012; Petersen, et al., 2011). Nurses who received supportive counselling and problem management training reported that it helped strengthen their capacity to identify,

provide counselling, or refer people with emotional problems (Petersen, et al., 2012; Petersen, et al., 2011). Given the high work load of PHC nurses, having a referral pathway in place for people with common mental disorders in the form of a mental health counsellor and trained CHWs under their supervision was greatly valued by PHC nurses (Petersen, et al., 2011).

4.5 Conclusion

In this chapter I presented the results obtained from the systematic review of CC for mental health in South Africa. I first discussed the results of the review process, which included a flow diagram to illustrate how I identified included studies and a summary of the quality assessment of included studies. Thereafter, I provided an overview of the sample characteristics using tables to summarise the general description of each included study, methods used by studies, and the main findings and recommendations of each study. In the final section I presented the themes and subthemes that I identified in the data.

In the present review, I identified six dominant themes which included: (1) The context of CC in South Africa, (2) barriers to the implementation of CC models, (3) detrimental outcomes of CC, (4) facilitative factors in the implementation of CC models, (5) proposed strategies to improve the implementation of CC models, and (6) beneficial outcomes of CC.

In the next section, I discuss the findings of this review by drawing on existing literature in the field to go beyond the original content (descriptive themes) to generate additional understanding and hypothesis (analytic themes) and to finally make recommendations for future CC efforts.

Chapter 5: Discussion

5.1 Introduction

The aim of this study was to systematically review the available literature to produce a summary of CC in the context of mental health care (MHC) in South Africa. Furthermore, this study aimed to identify strategies to facilitate the use of CC models on an inter-professional, community, intersectoral, and paradigm level, and to make recommendations for future efforts to use CC in South Africa. In this chapter, I discuss the findings of this review by drawing on current literature in the field and placing my findings within the existing body of evidence. I first provide an overview of the available research on collaborative care (CC) in South Africa before I use the findings of this review, alongside other relevant local and international research, to make recommendations for future CC efforts. Thereafter, I discuss possible strengths and limitations of this study and conclude this chapter with some recommendations for future research.

5.2 The Current Context of Collaborative Care in South Africa

Altogether, the included studies in this review show that CC models hold promise for closing the mental health treatment gap and providing culturally appropriate MHC, however, despite progress made, several challenges remain to implement collaborative policies in South Africa. Although this review highlighted some facilitative factors in the process of implementing CC models and beneficial outcomes of CC, more predominant were articles discussing barriers to the implementation of CC. Named barriers included: a shortage of resources, poor infrastructure, perceptions of a lack of support and trust, poor information and referral systems, inadequate education and training on how to collaborate to provide MHC, and the low prioritisation, and stigmatisation, of mental health. Failing to address these barriers was linked to detrimental consequences for the quality of MHC, including poor treatment adherence, poor identification of common mental illnesses, and discharging patients before they had received adequate care. As such, the risk is that the failed implementation of CC initiatives could contribute to the revolving-door phenomena of patients entering, exiting, and re-entering mental health treatment multiple times (see also Breen et al., 2007). This finding aligns with Kleinman's explanatory model theory which states that when there is poor communication between the popular, professional, and folk sectors, health care for the individual patient is significantly impeded (Kleinman, 1978).

Apart from the barriers identified in this review, other research suggests that support for the implementation of CC models on a larger scale seems to be complicated by a lack of evidence on successful implementation. Although some studies documented evidence of successful individual efforts (Brooke-Sumner et al., 2016; Janse van Rensburg et al., 2018[a]), dependence on individual efforts is not sustainable for long-term provision of country-wide services. The included studies in this review were predominantly qualitative in nature and all had an exploratory or descriptive research design, revealing a gap in the literature related to explanatory and correlational studies investigating specifically the efficacy of CC models. Indeed, various other researchers have commented on the lack of implementation and post-intervention studies of CC, echoing the findings in this review (Ameermia, 2009; El Ansari et al., 2001; Gureje et al., 2017; Lund et al., 2015; Mutsago et al., 2017). The lack of evidence for CC as a strategy to improve MHC, alongside studies mostly reporting challenges and associated negative outcomes, could contribute to the perception that collaboration is not working which further strengthens practitioners' lack of support or resistance to implementation (see also (Gerber, 2018; Janse van Rensburg, 2009; Lund et al., 2015).

Other reasons for the lack of research includes the low prioritisation of mental health compared to physical health. I excluded several articles due to their limited discussion of CC for mental health, or mental health not being a primary component of the study. Van der Watt et al. (2017) also noted that South African research regarding collaborative efforts focused mostly on the prevention and treatment of HIV/AIDS and Tuberculosis, and MHC received little focus. Therefore, research has documented more progress in the field of CC for general health and there have been discussions about whether these models can be transferred to CC for mental health. A comprehensive discussion of such possibilities is beyond the scope of this study.

Although research efforts are lacking on all levels of CC, compared to research on inter-professional collaboration, I found less studies considering CC efforts on a community, intersectoral, and healing paradigm levels. Relating this to Kleinman's (1978) explanatory model theory, the explanatory models operating on the professional level appear to be prioritised in South Africa's approach to MHC while less emphasis is placed on explanatory models in the popular and folk sectors. Research on inter-professional collaboration has seemingly been prioritised as this approach is believed to be the most feasible in making MHC more accessible to all South Africans (Jack et al., 2014; Mutiso, 2016; Ngo et al., 2013; Petersen & Lund, 2011) while offering MHC in primary care settings have shown to complement general health care, by, for example improving the outcomes of HIV care via improved medication adherence (Joska &

Sorsdahl, 2012). In a similar vein, this review was predominated by research representing the voices of PHC nurses and community representatives, identifying a need to interview more traditional healers and mental health specialists, psychiatrists and psychologists, regarding collaboration. The poorly defined role and lack of training programmes available for CHWs in South Africa can possibly account for the paucity of research on community-level CC initiatives (Hanlon et al., 2016). Compared to South Africa, other African countries seem to be at the forefront with regards to research on CC on a healing paradigm (eg. Nkrumah, 2017) while peer reviewed evidence on the real world application of intersectoral collaboration is lacking even in high income countries (Brooke-Sumner et al., 2016; Petersen et al., 2016).

In sum, CC for mental health seems to be a relatively novel term and a topic that has more recently moved into the spotlight, as indicated by the majority of studies being published in the last five years. Recent poorly planned and failed attempts towards CC, like the Life Esidimeni tragedy, created an urgent need to generate more research on intersectoral collaboration (Janse van Rensburg et al., 2018[ab]). In support of this, I found several research protocols in my initial literature search representing efforts to study existing collaborative efforts - showing that this research field is developing both locally and internationally (eg. Fairall et al., 2018; Gureje et al., 2017; Lund et al., 2015; Petersen et al., 2018).

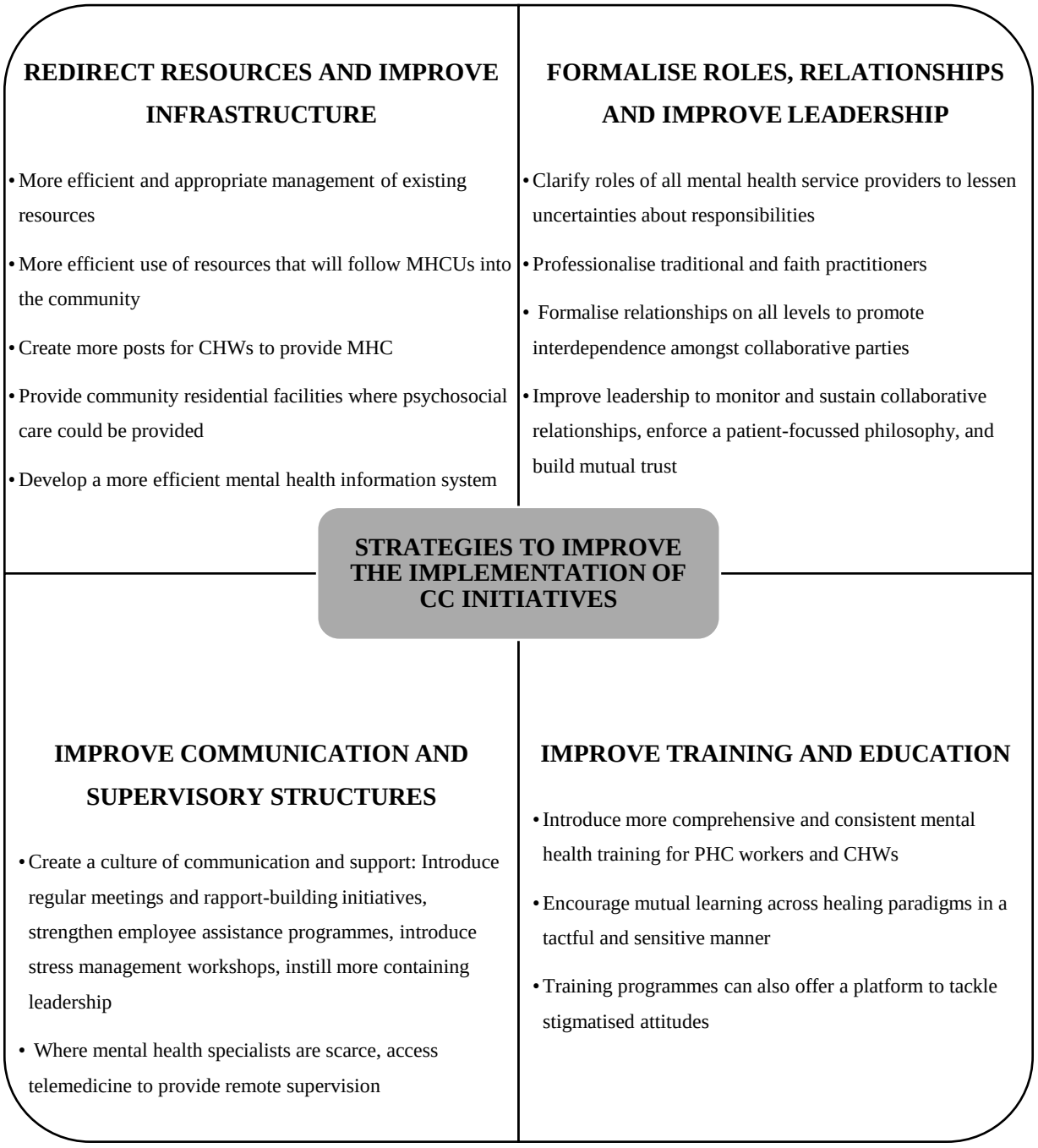
Given the abovementioned lack of implementation and post-intervention studies, it was not possible to provide an in-depth discussion of the outcomes, in terms of costs and benefits, of CC models in South Africa. Instead, synthesis of the available data allowed several broader conclusions regarding the requirements for CC. In the next section, I integrate the themes from my results with other available literature in the field in the hopes of providing useful insights into the experiences of stakeholders' collaborative efforts and how barriers and challenges have been addressed.

5.3 The Way Forward for Collaborative Care in South Africa

I identified four dominant strategies from the findings of this review to prepare the ground for successful implementation of CC models in South Africa. Additional themes discussed in the Results chapter of this review included barriers and facilitators to the implementation of CC initiatives as well as the detrimental and beneficial outcomes post implementation. The strategies discussed below aim to draw on these facilitating factors to address specific barriers, decrease the detrimental outcomes and maximise the beneficial outcomes of CC initiatives. Figure 5-1 provides a schematic overview of the four main strategies, including (1) redirect resources and

improve infrastructure, (2) formalise roles and relationships and improve leadership, (3) improve training and education, and (4) improve communication and supervisory structures. Next, I discuss these strategies in greater depth, mention and explore the specific barriers they aim to address, and provide real-life examples of how these strategies can be implemented.

Figure 5.1. Strategies to Improve the Implementation of CC Initiatives



5.3.1 Redirect resources and improve infrastructure

Arguments in favour of CC is that it is a cost-effective strategy to improve access to MHC. CC models reportedly require less resources to implement as integration is expected to piggy-back on existing health system structures (Abas et al., 2016; Mutiso, 2016). Even so, the results of this study indicate that the inefficient use of finances and resources and poor infrastructure are all salient barriers to the implementation of CC policies. In support of this, various other researchers posit insufficient resourcing in South Africa and other LMICs as the main blockage to the delivery of mental health services (Coovadia et al., 2009; Padmanathan & De Silva, 2013; Schneider, et al., 2016; Stanton, 2017; Tomlinson et al., 2016). Globally, insufficient resources and investment were also documented barriers to CC initiatives in high-income countries like Australia (Lawn, Lloyd, King, Sweet, & Gum, 2014).

The major reasons for CC efforts being under-resourced appears to be poor governance and contradictory legislative frameworks to support MHC activities (Docrat et al., 2019; Lawn et al., 2014; Stanton, 2017). In light of the aforementioned competing health care priorities, especially HIV/AIDS and TB pandemics, Stanton (2017) demonstrated how the budget for mental health is shrinking as the government apparently lacks commitment to improve MHC. Stanton (2017) cited examples of the government freezing the positions of psychologists as soon as someone leaves as they cannot afford to hire more psychologists. In support of this, the White Paper on the NHI (2015) has excluded Psychiatry and/or Mental Health from services to be provided at district level (Docrat et al., 2019). These decisions are in contradiction with other legislations, including the Mental Healthcare Act and The National Mental Health Policy Framework and Strategic plan (2013-2020) which prioritises access to MHC by promoting more collaborative and community-based care (Department of Health, 2013).

CC strategies, specifically the integration of MHC at PHC level, require existing mental health treatment to shift from a few, relatively well-resourced psychiatric hospitals, to largely underfunded and under-resourced primary health clinics across South Africa (Cooper, 2016; Department of Health, 2013). Cooper (2016) cautions that if the infrastructure and resources to integrate MHC on the primary and community levels are not available, efforts towards CC and downsizing hospital care will do more harm than good. Examples of such harm was evident in the Life Esidimeni Tragedy while a lack of financial resources to create and sustain posts, according to the findings of this review, increased the burden on existing psychiatrists and psychologists which, subsequently, contributed to specialists leaving state services. The findings

of this review are aligned with those of several past commentators, in noting that this shift necessitates a reorganisation of the mental health budget, more efficient use of resources that will follow MHC users (MHCUs) into the community, creating more posts for CHWs to provide MHC, providing community residential facilities where psychosocial care could be provided, and developing a more efficient mental health information system (Cooper, 2016; Docrat et al., 2019). These strategies will be discussed in more detail below.

This review highlighted that funding for mental health is inadequate and poorly budgeted. Docrat et al. (2019) agree with the finding of this study in that government's focus should shift from allocating more "non-existent" resources to MHC towards more efficient and appropriate management of existing resources. This includes directing resources to NGOs to provide adequate quality care and in this way, investment will follow MHCUs from the hospital into the community (Jenkins et al., 2011). A first step in this process could be to systematically capture available assets through resource mapping. Resource mapping is a method often used in social action research and is considered as a useful tool to strategise about mental health interventions in settings with limited resources (Schneider, et al., 2016; Selamu et al., 2015). Other suggested strategies to improve efficiency of existing resources include reducing budgets for new facilities, with a focus on dedicating budgets to ensure existing facilities that are only partially operationalized become fully operational (Docrat et al., 2019). Similarly, rather than creating more posts for CHWs as suggested in the findings of this review, other researchers proposed that the provision of adequate training to existing CHWs on how to effectively manage mental health conditions might be a cheaper and more feasible strategy to increase the number of competent CHWs (Docrat et al., 2019; Mutiso, 2016). A facilitative factor highlighted in this review is the available network of CHWs that could receive training.

With regards to the available infrastructure at facilities, the findings noted in this review cited the absence of a mental health information system and community residential facilities as two major constraints. Other local (Van Rooyen et al., 2015) and international researchers (Horvitz-Lennon, Kilbourne, & Pincus, 2006; Suter, Oelke, Adair, & Armitage, 2009) have also called for a more efficient health information system which will facilitate referral practices between all stakeholders, PHC workers, mental health specialists, and traditional healers. Indeed, sharing patient information is important to ensure continuity of care across primary, secondary and tertiary care, and to ensure access to medication and psychosocial care (Schneider, et al., 2016) For example, Lawn et al. (2014) developed a shared client information management system software which enabled health professionals working in a medical centre to share client

information across services. Some of the mental health professionals in Lawn et al.'s (2014) study, however, felt that such an information sharing system conflicted with their desire to protect their client's privacy. Smart (2005), therefore, emphasised the need amongst medical practitioners to first clarify confidentiality issues before they will feel free to share patient information with traditional healers in South Africa. Agbiji and Landman (2014) similarly stressed the need to consider ethical issues in the creation of such an information sharing software, including asking patients' written consent before information could be shared with the CHW and/or traditional healer.

Regarding the creation of community residential facilities as a necessity for the provision of psychosocial support services, included studies in this review proposed the use of converted cargo containers or park homes while Van Rooyen et al. (2015) proposed that collaboration also entails the sharing of resources including health facilities and other community spaces.

Consistent with the findings in this review, Kleinman (1978,1980) also emphasised how larger political and economic determinants can influence explanatory models in the different social sectors and, in turn, impact health care provision. Even so, Lawn et al. (2014) caution against the prioritising of practical issues, such as redirecting resources and improving infrastructure, and neglecting the issue of collaboration amongst participants. Stanton (2017) agrees and is of the opinion that the successful implementation of CC models is more dependent on effective management and leadership to promote a culture change in favour of collaboration rather than regulatory change.

5.3.2 Formalise roles, relationships and improve leadership

The findings of this review indicated that poor role clarification amongst different sectors, as well as amongst existing lay counsellors and CHWs, resulted in confusion around responsibilities, a lack of confidence, and hesitancy to take on duties to provide MHC. NGO members, nurses, CHWs, and traditional healers felt like they had limited power in comparison to psychiatric services and medical doctors to shape MHC that often led to CHWs leaving the workforce. Referring to Kleinman's theory, the professional sector, rather than the popular and folk sectors, seemingly is at the top of the hierarchy when it comes to MHC provision in South Africa. Consequently, lower tiered staff's sense of powerlessness combined with a lack of formal agreements for partnerships and referrals altogether impeded collaborative efforts.

Other researchers also drew attention to how these identified barriers hampered CC efforts. According to a systematic review investigating the feasibility of CC in low and middle income countries, failure to consider stakeholders' self-perceived levels of competence to perform their specific responsibilities threatened the feasibility of CC efforts (Padmanathan & De Silva, 2013). Lawn et al. (2014) reports on an Australian experience of co-locating a range of different primary health services into one building, with the aim of providing CC services, and similarly demonstrated how the absence of shared values and understanding of responsibilities were major challenges and hampered CC efforts. Consequently, an insecurity about their new work structure and a hesitancy to trust other service providers, resulted in an unwillingness to participate in CC efforts. For example, agencies maintained their boundaries by establishing separate signs for mental health services on the building soon after moving in (Lawn et al., 2014). Another way of establishing boundaries in other studies was a reluctance amongst mental health professionals to refer patients to alternate psychological services (Schneider, et al., 2016; Vergunst, 2018). Thus, although having a mental health information system in place seems to be a necessity for CC, it is not a guarantee for collaboration when mechanisms that foster mutual trust are not in place (Vergunst, 2018).

This review identified strategies to address these issues. First, the roles of different health service providers (in both governmental and non-governmental sectors) should be clarified and relationships all levels (i.e. ward, district, provincial, intersectoral) should be formalised. In turn, implementing these strategies will help lessen uncertainties around roles and responsibilities. Billups (1987) identified a solid professional identity as an important component of successful teamwork while Bronstein (2003) situated the formalisation of relationships as important to promote interdependence amongst collaborative parties. Mattessich and Monsey (1992) considers interdependence to be a key requirement for interdisciplinary collaboration. Interdependence can be strengthened when stakeholders take collective ownership of a goal, for example to commit to high quality patient-centred MHC, and share the responsibility to obtain this goal (Bronstein, 2003; Suter et al., 2009). To function interdependently, professionals must have a clear understanding of their own roles and what they can offer, and, in turn, what they can rely on others to provide. In other words, formalising relationships promotes the understanding that parties have more to gain than lose by collaborating and would, therefore, allow for more efficient referral practices. Conversely, as seen in the findings of this review, when role clarification is poor, interdependency prevented the Department of Health and Department of Social Development from collaborating to provide comprehensive community-based residential

care. The focus in this review was on clarifying the roles and addressing the marginalised status of lower tiered staff, particularly CHWs and CAPs.

To address the marginalised status of CHWs and lay counsellors in Kleinman's popular sector, Petersen et al. (2014) indicated a need to clearly define their role and scope of practice and formal responsibilities at PHC level in writing. They could also be provided with symbols, such as badges or uniforms, to help distinguish them from other community members and to work towards enforcing respect. Remuneration could further help to ensure that CHWs stay motivated in the system (Mutiso, 2016; Padmanathan & De Silva, 2013; Petersen et al., 2014).

Various African studies have called for the professionalisation of traditional and faith practitioners in Kleinman's folk sector, and formalising collaborative relationships between CAPs and WPs (Akol, Moland, Babirye, & Engebretsen, 2018; Mokgobi, 2013; Mutiso, 2016). In Kenya, Mutiso (2016) advocated for the operationalising of the traditional health practitioner's bill and to pass it as a law in the country. According to Mutiso (2016) this will not only regulate the informal health sector in ensuring that that ethical standards are adhered to, but it would also improve their recognition in the health care system as legitimate partners in health care provision. As is the case in South Africa, traditional healers in Uganda were also reluctant to collaborate with WPs as they viewed WPs to harbour feelings of disrespect and feared that their methods and indigenous knowledge would be exploited (Akol et al., 2018). Mokgobi (2013) takes an optimistic stance in relation to this issue by citing examples of health care authorities making deliberate efforts to protect the intellectual properties of traditional medicine and mentioning existing collaborative efforts between the Research Council of Zimbabwe and the Zimbabwe Medical Practitioners Council. Another example mentioned in this review to professionalise and delineate the roles of CAPs was the creation of spaces in hospital settings where CAPs can meet with and collaborate with WPs to provide MHC. This would strengthen collaboration between the professional and folk sector in Kleinman's model. However, traditional practitioners appearing to only assist the biomedical health sector have caused researchers to question the true collaborative nature of such arrangements (Hopa et al., 1998; Wreford, 2005).

From the findings of this review, improvements in leadership are further required to monitor and sustain collaborative relationships. Leadership initiatives should specifically focus on continuously enforcing a patient-focussed philosophy and the unique roles of different stakeholders to promote interdependence and to build mutual trust and support for participation. Preliminary results from a Brazilian study stressed the importance of promoting such a team

climate, where there is support for participation, to successful interprofessional collaboration in a primary health care setting (Agreli, Peduzzi, & Bailey, 2017). Effective leadership can also help to instil a strong, cohesive culture to address power imbalances in collaborative relationships (Suter et al., 2009). Included studies in this review argued that it is the state's responsibility to initiate and foster collaboration with non-state providers, coordinate intersectoral provision of services, identify gaps in collaboration and set up plans to manage this.

5.3.3 Improve communication and supervisory structures

According to the findings of this review, perceptions of a lack of support for stakeholders to work collaboratively towards a mutual goal and a sense of mistrust in other stakeholders' competencies to do their part hampered efforts aimed towards collaboration**.** Lower tiered staff did not feel adequately supported by higher tiered staff and PHC workers complained about a lack of support and supervision from mental health specialists. Other researchers also commented on this barrier (Abas et al., 2016; Agbiji & Landman, 2014; Shidhaye, Lund, & Chisholm, 2015). Additionally, poor communication across health care platforms was positioned as the main contributing factor to perceptions of a lack of support and a sense of mistrust amongst stakeholders (Athié et al., 2016; Struwig & Pretorius, 2009; Tenea, 2016).

This review noted the importance of creating a culture of communication and support between sectors and different staff members on PHC level to facilitate collaboration. Especially, given the increased burden of emotional labour on mental health workers (Padmanathan & De Silva, 2013), various researchers agree that supportive supervision is vital for the sustainable integration of MHC into PHC (Hanlon et al., 2010; Patel et al., 2013). Even so, Shidhaye et al. (2015) underscored the scarcity of mental health specialists available to supervise lower tiered staff. Alternative strategies suggested to minimise burnout included strengthening employee assistance programmes, introducing stress management workshops, instilling more containing leadership, and the use of telemedicine to provide remote supervision Adding to this, Mutiso (2016) showed how supportive supervision improved the quality of CHWs work, maintained productivity, and increased their efficiency and effectiveness.

This review further proposed strategies to ease communication amongst stakeholders. First, regular meetings could facilitate communication on all levels to address and strategize around gaps in collaboration. Other researchers support this view and illustrated how dialogue formation between practitioners from different healing paradigms was crucial in establishing mutual trust and respect in India (Balaji et al., 2012; Shields et al., 2016) and Kenya (Musyimi, Mutiso,

Nandoya, & Ndetei, 2016) and improved referral interactions in Ghana (Ae-Ngibise et al., 2010; Gyasi et al., 2017). For example, in a collaborative intervention in India, psychiatrists' questioned CHWs competency to provide care for people with schizophrenia, but regular meetings between CHWs and psychiatrists addressed their initial hesitancy to collaborate with CHWs (Balaji et al., 2012). Moreover, several researchers argue for a co-location strategy based on the assumption that being close to one another will increase opportunities for communication, promote understanding of each other's roles and responsibilities, and facilitate information sharing (Bentley, Freeman, Baum, & Javanparast, 2018; Sloper, 2004). Bentley et al. (2018), however, stressed that co-location is not only about placing individuals together in a physical sense and also requires additional strategies to facilitate communication (see also Lawn et al., 2014). Shields et al. (2016) documented such rapport-building strategies which included emphasising that different MHC platforms are not in competition with each other and to rather encourage stakeholders to hold onto their unified goal and common values – i.e. to provide quality MHC to the patient (Mokgobi, 2013). Having a unified goal and committing to improve the lives of patients may in itself spark dialogue formation which was crucial for the establishment of mutual trust and respect in MHC settings in Kenya (Musyimi et al., 2016). Indeed, Kleinman (1978) noted that quality of care improves when health care sectors work together to match the patient's explanatory model of his or her mental illness.

5.3.4 Improve training and education

Other researchers confirm the findings of this review that a poor understanding and awareness of existing mental health policies(Athié et al., 2016), sporadic training for PHC workers in how to care for mental health (Dube & Uys, 2016; Van Deventer et al., 2008), and a general lack of knowledge regarding mental illness and different healing platforms hinder the effective implementation CC models on all levels (Saraceno et al., 2007). Inadequate knowledge on mental health can further fuel distrust in other stakeholders (Gyasi et al., 2017) and has been shown to contribute to the mental health treatment gap (Stanton, 2017). For example, Petersen (2000) studied primary health care settings in KwaZulu Natal and found that although PHC nurses understood the need for holistic care, they provided largely bio-medical care and avoided discussions on psychological/psychosocial problems when such problems were overtly raised by patients. Lovero et al. (2019) attributes these nurses apparent unwillingness to provide MHC at PHC level to a substantial lack of training and clarity of roles for PHC workers in South Africa.

These identified barriers call for improvements in training and education. This review demonstrated how training programmes can also offer a platform to tackle stigmatising attitudes regarding mental health, to communicate policy demands and raise awareness of the benefits of CC (see also Li et al., 2019). A focus was on offering more comprehensive and consistent mental health training for PHCs and CHWs and to encourage mutual learning across healing paradigms. Improved knowledge in these cases would improve collaboration between PHC and specialist health workers and CAPs and WPs.

Strengthening mental health training for primary care staff has proved a worthwhile strategy to strengthen CC initiatives. PHC workers in India (Balaji et al., 2012), Kenya (Jenkins et al., 2013), Lebanon (Hijazi, Weissbecker, & Chammay, 2011) and South Africa (Petersen, et al., 2011), reported that training, alongside supervision, had helped them overcome difficulties, prevent workforce distress, and strengthened their capacity and tolerance to deal with mental health patients in primary settings. Two of these studies were randomised control trials which demonstrated that health workers receiving training in the intervention group noticed improvements in their communication, diagnostic, and counselling skills while health workers in the control group reported a lack of such skills (Hijazi et al., 2011; Jenkins et al., 2013).

Despite evidence of training programmes indicating promising effects, studies commenting on the specifics of such programmes were scarce (for an example refer to Hijazi et al., 2011). In support of this view, a recent systematic review on CHWs identified reports on effective approaches to train and supervise for CHWs as a gap in the research evidence (Scott et al., 2018) while there is a need for researchers to use more robust scientific methods to evaluate the effect of their training approaches (Patel, 2015). Particularly, in South Africa, the role of CHWs are poorly articulated in National and Provincial health policy and thus limits the guidance on the qualification requirements, training, and basic role of CHWs within the health system (Hanlon et al., 2016). For this reason, Petersen et al. (2014) argues for a clear definition of the role and scope of practice of CHWs which could, in turn, help with remuneration challenges and the development of standardised training programmes in South Africa. South Africa can learn from India about evidence-based training programmes for CHWs. More specifically, Sangath is a leading mental health institution and research initiative committed to improve access to MHC in India through training and supervising CHWs to deliver psychosocial treatments (Patel, 2015; ‘Sangath’, n.d.). Sangath has completed research involving the systematic development of such interventions and subsequent randomised controlled trials of interventions which showed significant benefit in terms of social and clinical outcomes (Chatterjee et al., 2014; Patel, 2015).

Some researchers made useful suggestions to keep in mind when designing such training programmes. First, given the finding in this review that CHWs often feel overburdened with the demand of caring for illnesses such as HIV/AIDS and TB, Rahman (2007) demonstrated the importance of pre-intervention focus groups with CHWs in Pakistan during which they advised researchers to integrate psychological interventions into their existing training to prevent it being perceived an additional burden. In a similar line, Bhugra, Kar, and Lawton-Smith (2014) notes the importance of educative programmes to help ensure that staff members have a positive attitude towards a CC approach. Second, Furthermore, training avenues to disseminate information regarding MHC in primary settings, such as websites and telehealth, can be useful initiatives to facilitate ongoing training of CHWs and PHC workers (Athié et al., 2016).

Various researchers concur with the findings of this review in that mutual understanding and respect are crucial to effective collaboration between the western/biomedical and traditional health systems. Training involving bi-directional conversations has been suggested as a way to promote greater understanding between different healing paradigms, which in turn, will help foster mutual respect, acceptance and trust (Incayawar et al., 2009; Mokgobi, 2013; Torri, 2012). Conversely, researchers have demonstrated how a lack of knowledge of each other's practices have hampered referral practices between WPs and CAPs in the Eastern Cape, South Africa (Van Rooyen, Pretorius, Tembani, & Ham-Baloyi, 2017) and Ghana (Ae-Ngibise et al., 2010)

The focus of training on this level should be on cultivating an openness to mutual learning between CAPs and WPs. Indeed, effective collaboration on a healing paradigm level is only feasible in a climate where the integrity and distinctiveness of each body of knowledge is recognised and respected (Incayawar et al., 2009; Mulaudzi, 2001). Training should further be done in a sensitive way as to not reinforce power dynamics that was identified in this review. In other words, CAPs can learn from WPs and vice versa (Mutiso, 2016; Salan & Maretzki, 1983; Shields et al., 2016). For example, In India, allopathic mental health practitioners (AMHPs) provided training to faith-based healers (FBHs) on basic detection of mental illness and when and how to refer clients. In turn, this helped to improve the mental health literacy amongst FBHs and they could detect more CMDs (Shields et al., 2016). This review identified poor detection of CMDs as one of the detrimental outcomes of unsuccessful CC models in South Africa. In Kenya, training of traditional healers further resulted in a reduction of stigmatised attitudes and expressed interest to further train in MHC (Mutiso, 2016).

In addition to the post-training changes documented amongst faith-based healers (FBHs) in Shields et al.'s (2016) study, they found that exposure to other practices outside of the allopathic system also motivated allopathic mental health practitioners (AMHPs) to consider referral that might benefit their patients. Other researchers add to this finding in arguing for the inclusion of basic training in the traditional healing systems as part of the nursing and medical curricula in South Africa which could further facilitate cross-referrals (Mulaudzi, 2001; Osafo, 2016; Janse van Rensburg, 2014; Van Rooyen et al., 2015). For example, in one of the leading medical schools in Ghana, a postgraduate diploma in traditional medicine was introduced to expose doctors to traditional healing practices(Tsey, 1997). Indeed, a case study in Chile found that allopathic health practitioners who had more knowledge and respect for different cultures were more willing to collaborate with traditional healers (Torri, 2012).

Some researchers made useful suggestions to keep in mind when designing such training programmes to facilitate collaboration on a healing paradigm level. First, considering that the relationship between CAPs and WPs was historically characterised by mistrust and suspicion, Mutiso (2016) recommends initially training these groups separately and tactfully demystifying their perceptions about the other group. Once a willingness to collaborate was cultivated, Mutiso (2016) thereafter organised structured dialogue to build collaborative relationships between these groups. Second, given that most traditional healers in South Africa are illiterate or poorly educated, Steyn and Muller (2000) propose the use of pictures, illustrated pamphlets, and other material that was easy to understand and which would match the level of education of a traditional healer.

These findings are useful for understanding CC in South Africa. However, this study is not without limitations.

5.4 Limitations of the Review

The first limitation of this study was that I was the sole reviewer. Given time and resource constraints, it was not possible to appoint a secondary reviewer to independently screen titles, abstracts, and articles. It is therefore possible that my investigator biases influenced the study selection and that a different reviewer might have yielded slightly different results. Even so, other steps were taken to ensure high quality research and methodological rigour. I hope that through discussing my research process and reflections with my supervisor, including a section on reviewer reflexivity, consulting an expert librarian who has experience in conducting systematic reviews, and using a quality screening tool, I have contained some of my biases.

A second limitation regarding the search strategy employed was the likelihood of publication bias and language bias. This review only included studies published in the public domain and excluded, for example, grey literature. In addition, this review only included studies published in English. Readily available literature published in English are likely not an accurate representation of the larger body of research that has been conducted. Conclusions drawn in this review might, therefore, not be an accurate reflection of available research. In hindsight, it might have been useful to contact public hospitals or experts in the field of CC for informal publications (eg. hospital newsletters) and to include grey literature such as university research projects and conference papers. However, due to time constraints such an exhaustive data-gathering search was not possible.

A further limitation is that the concept of CC for mental health seems to be a relatively novel term for the South African context. Given that this concept is still poorly defined in the South African literature, including search words such as “cooperation”, “alliance”, and “partnership” would have widened the literature search and could have possibly allowed me to access more relevant studies. Related to the field of CC being in the developing research phase, this review included a wide heterogeneity of study designs that only allowed broad generalisations to be made. Even so, I also consider the heterogeneity of study methods included in this review to be a strength of this study.

5.5 Strengths of the Review

Despite the abovementioned limitations, this study also had some strengths. Based on all my searches of the databases, a first major strength of this review was that it seemingly is the first study to review CC for MHC in South Africa. This systematic review provided a quick and thorough mapping of available research on CC for mental health in South African, described the current status of this research field, and offers a metacommentary that can inform policy. More specifically, this review provided insight into the barriers to CC and highlighted some strategies to facilitate the implementation of CC models in South Africa. Importantly, this review emphasised the use of pre-intervention research to assess whether requirements for CC are present before CC models can be implemented in a specific context.

A second strength is that findings of this review can also prove useful for other resource constrained countries. A common critique of systematic reviews is that it decontextualizes individual studies. In an attempt to preserve context, I provided structured summaries of the sample, setting, methods, and findings of each of the study included in this review. In this way,

readers are able to decide for themselves whether the contexts of the included studies in this review are similar or different to theirs. This review, therefore, contributes to the growing body of literature on CC both locally and internationally.

Third, this review accessed a wide range of participant voices and documented diverse perspectives on the same issue. Participants included policy makers, key informants from various governmental departments and non-governmental organisations, health professionals (including medical doctors, psychiatrists, psychologists, social workers, primary health care nurses, and psychiatric nurses), CHWs, traditional healers and herbalists, and mental health service users. Additionally, this review included a wide variety of study designs, which yielded a variety of insights regarding CC efforts. For example, while an observational study illuminated issues of power and stigma in CC mental health services (Burgess, 2016), a social network analysis mapped interactions between state and non-state stakeholders and demonstrated how a hospital centric network can hamper CC efforts (Janse van Rensburg et al., 2018[b]).

A last strength of this study was that I assessed all included studies to be of a high quality and classified them as low risk. Although using a more sensitive quality assessment instrument might have yielded slightly different or more specific results, based on the quality assessments conducted in this review, it can be concluded that the findings of this review are robust.

5.6 Recommendations for Future Research

Based on questions that emerged from this study and the gaps I identified in the literature, I will make some recommendations for future research. First, the lack of clarity around an agreed upon definition for CC for mental health is considered an obstacle to supporting and improving collaboration. This review summarised the available literature on how CC is defined in the context of MHC in South Africa. Future research should, therefore, work towards a defining CC more comprehensively and designing instruments that could measure levels of effective collaboration. Such an instrument could be used to monitor and evaluate the outcome of collaborative efforts between teams of health care professions.

Second, given the inconsistencies in the research regarding the cost-effectiveness of CC strategies, there is a need for cost-benefit studies to show cost savings and the impact of CC models for mental health on improved health outcomes. Moreover, the included studies in this review were predominantly qualitative in nature and all had an exploratory or descriptive

research design, elucidating the gap in explanatory and correlational studies investigating specifically the efficacy of CC models.

Lastly, there is a need for research to investigate the effectiveness of indigenous therapies for mental health. A major barrier towards CC identified in this review was perceptions of mistrust, especially between western practitioners and traditional healers. Research could determine whether such negative attitudes are only misconceptions and, in turn, make collaboration between stakeholders more acceptable. Incayawar et al. (2009), however, underscore the issue of philosophy of science and questions whether we can impose western scientific models to make sense of indigenous treating models.

5.7 Conclusion

From this review, it is evident that CC models hold promise for closing the mental health treatment gap and providing culturally appropriate MHC. However, despite progress made, several challenges remain to implement collaborative strategies. These barriers included a shortage of resources, poor infrastructure, perceptions of a lack of support and trust, poor information and referral systems, inadequate education and training on how to collaborate to provide MHC, and the low prioritisation, and stigmatisation, of mental health. Failing to address these barriers had immediate detrimental consequences for the quality of MHC including poor treatment adherence, poor identification of common mental illnesses, and discharging patients before receiving adequate care. In other words, the risk is that the failed implementation of CC initiatives could contribute to the revolving-door phenomena or a second Life Esidimeni tragedy. These findings align with Kleinman's theory and support the notion that when explanatory models in the professional, folk, and popular sector conflict, MHC for the individual is typically impeded.

Considering the specific barriers highlighted in this review, four main strategies to improve the implementation of CC models in South Africa can be identified. These include (1) redirecting resources and improving infrastructure, (2) formalising roles and relationships and improving leadership, (3) improving communication and supervisory structures, and (4) improving training and education. This review offers valuable recommendations for South African MHC policy that might also be useful for other resource-constrained countries.

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APPENDIX A: PRISMA Checklist

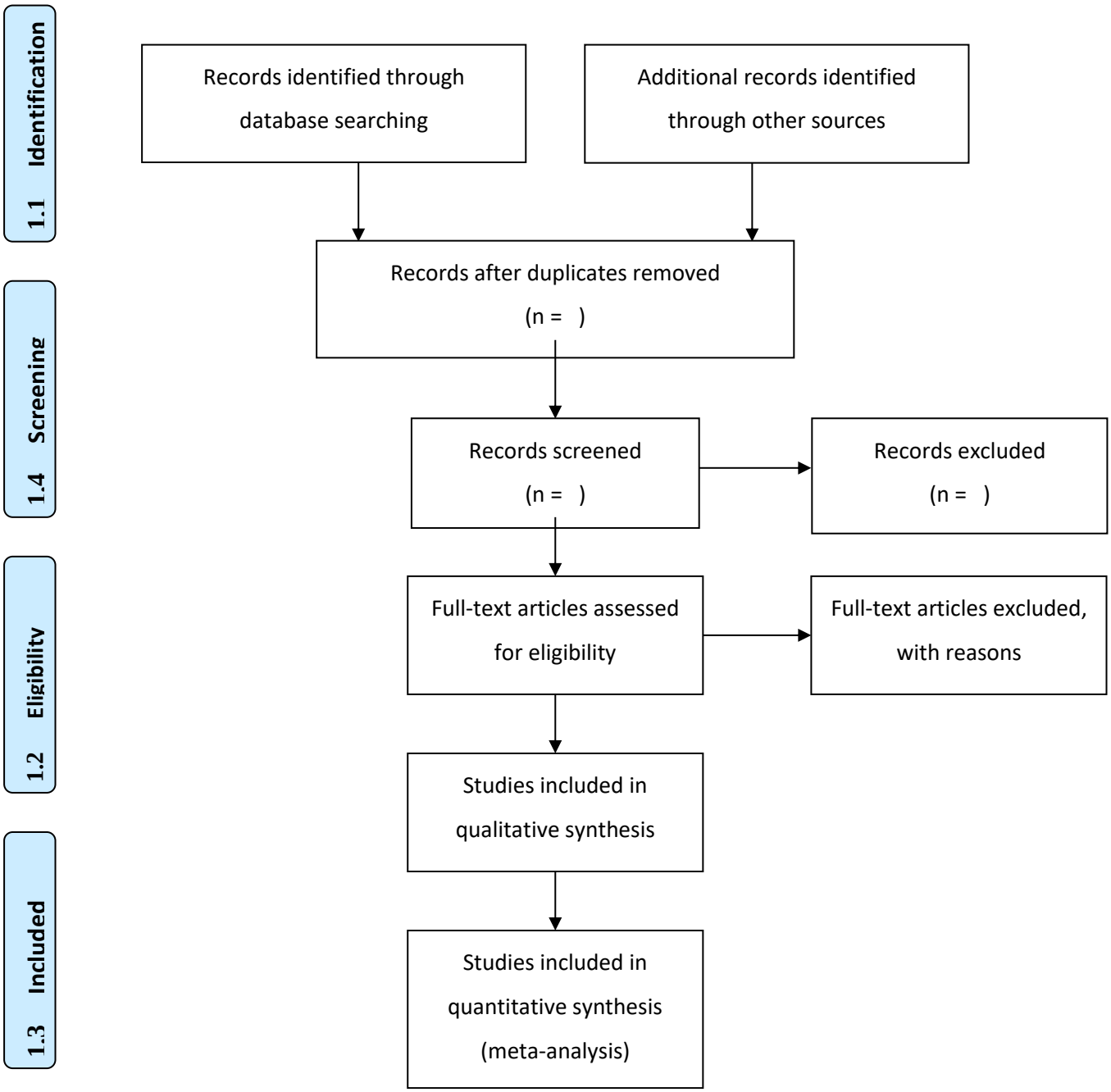
Section/topic	#	Checklist item	Reported on page #
TITLE			
Title	1	Identify the report as a systematic review, meta-analysis, or both.	
ABSTRACT			
Structured summary	2	Provide a structured summary including, as applicable: background; objectives; data sources; study eligibility criteria, participants, and interventions; study appraisal and synthesis methods; results; limitations; conclusions and implications of key findings; systematic review registration number.	
INTRODUCTION			
Rationale	3	Describe the rationale for the review in the context of what is already known.	
Objectives	4	Provide an explicit statement of questions being addressed with reference to participants, interventions, comparisons, outcomes, and study design (PICOS).	
METHODS			
Protocol and registration	5	Indicate if a review protocol exists, if and where it can be accessed (e.g., Web address), and, if available, provide registration information including registration number.	
Eligibility criteria	6	Specify study characteristics (e.g., PICOS, length of follow-up) and report characteristics (e.g., years considered, language, publication status) used as criteria for eligibility, giving rationale.	
Information sources	7	Describe all information sources (e.g., databases with dates of coverage, contact with study authors to identify additional studies) in the search and date last searched.	
Search	8	Present full electronic search strategy for at least one database, including any limits used, such that it could be repeated.	
Study selection	9	State the process for selecting studies (i.e., screening, eligibility, included in systematic review, and, if applicable, included in the meta-analysis).	
Data collection process	10	Describe method of data extraction from reports (e.g., piloted forms, independently, in duplicate) and any processes for obtaining and confirming data from investigators.	
Data items	11	List and define all variables for which data were sought (e.g., PICOS, funding sources) and any assumptions and simplifications made.	
Risk of bias in individual studies	12	Describe methods used for assessing risk of bias of individual studies (including specification of whether this was done at the study or outcome level), and how this information is to be used in any data synthesis.	
Summary measures	13	State the principal summary measures (e.g., risk ratio, difference in means).	
Synthesis of results	14	Describe the methods of handling data and combining results of studies, if done, including measures of consistency (e.g., I^2) for each meta-analysis.	

Section/topic	#	Checklist item	Reported on page #
Risk of bias across studies	15	Specify any assessment of risk of bias that may affect the cumulative evidence (e.g., publication bias, selective reporting within studies).	
Additional analyses	16	Describe methods of additional analyses (e.g., sensitivity or subgroup analyses, meta-regression), if done, indicating which were pre-specified.	
RESULTS			
Study selection	17	Give numbers of studies screened, assessed for eligibility, and included in the review, with reasons for exclusions at each stage, ideally with a flow diagram.	
Study characteristics	18	For each study, present characteristics for which data were extracted (e.g., study size, PICOS, follow-up period) and provide the citations.	
Risk of bias within studies	19	Present data on risk of bias of each study and, if available, any outcome level assessment (see item 12).	
Results of individual studies	20	For all outcomes considered (benefits or harms), present, for each study: (a) simple summary data for each intervention group (b) effect estimates and confidence intervals, ideally with a forest plot.	
Synthesis of results	21	Present results of each meta-analysis done, including confidence intervals and measures of consistency.	
Risk of bias across studies	22	Present results of any assessment of risk of bias across studies (see Item 15).	
Additional analysis	23	Give results of additional analyses, if done (e.g., sensitivity or subgroup analyses, meta-regression [see Item 16]).	
DISCUSSION			
Summary of evidence	24	Summarize the main findings including the strength of evidence for each main outcome; consider their relevance to key groups (e.g., healthcare providers, users, and policy makers).	
Limitations	25	Discuss limitations at study and outcome level (e.g., risk of bias), and at review-level (e.g., incomplete retrieval of identified research, reporting bias).	
Conclusions	26	Provide a general interpretation of the results in the context of other evidence, and implications for future research.	
FUNDING			
Funding	27	Describe sources of funding for the systematic review and other support (e.g., supply of data); role of funders for the systematic review.	

From: Moher D, Liberati A, Tetzlaff J, Altman DG, The PRISMA Group (2009). Preferred Reporting Items for Systematic Reviews and Meta-Analyses: The PRISMA Statement. PLoS Med 6(7): e1000097. doi:10.1371/journal.pmed1000097

For more information, visit: **www.prisma-statement.org**.

APPENDIX B: PRISMA Flow-diagram



From: Moher D, Liberati A, Tetzlaff J, Altman DG, The PRISMA Group (2009). *P*referred *R*eporting *I*tems for *S*ystematic Reviews and *M*eta-*A*nalyses: The PRISMA Statement. PLoS Med 6(7): e1000097. doi:10.1371/journal.pmed1000097

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APPENDIX C: CASP Qualitative Checklist

Screening Questions:

1. Was there a clear statement of the aims of the research? **□Yes □Can't tell □No**

HINT: Consider

- What was the goal of the research?
- Why it was thought important?
- Its relevance

2. Is a qualitative methodology appropriate? **□Yes □Can't tell □No**

HINT: Consider

- If the research seeks to interpret or illuminate the actions and/or subjective experiences of research participants
- Is qualitative research the right methodology for addressing the research goal?

Is it worth continuing?

Detailed questions:

3. Was the research design appropriate to address the aims of the research? **□Yes □Can't tell □No**

HINT: Consider

- If the researcher has justified the research design (E.g. have they discussed how they decided which method to use)?

4. Was the recruitment strategy appropriate to the aims of the research? **□Yes □Can't tell □No**

HINT: Consider

- If the researcher has explained how the participants were selected

 If they explained why the participants they selected were the most appropriate to provide access to the type of knowledge sought by the study

 If there are any discussions around recruitment (e.g. why some people chose not to take part)

5. Was the data collected in a way that addressed the research issue? **Yes Can't tell No**

HINT: Consider

 If the setting for data collection was justified

 If it is clear how data were collected (e.g. focus group, semi-structured interview etc.)

 If the researcher has justified the methods chosen

 If the researcher has made the methods explicit (e.g. for interview method, is there an indication of how interviews were conducted, or did they use a topic guide)?

 If methods were modified during the study. If so, has the researcher explained how and why?

 If the form of data is clear (e.g. tape recordings, video material, notes etc)

 If the researcher has discussed saturation of data

6. Has the relationship between researcher and participants been adequately considered? **Yes Can't tell No**

HINT: Consider

 If the researcher critically examined their own role, potential bias and influence during

(a) Formulation of the research questions

(b) Data collection, including sample recruitment and choice of location

 How the researcher responded to events during the study

and whether they considered the implications of any changes in the research design

7. Have ethical issues been taken into consideration? **□Yes □Can't tell □No**

HINT: Consider

□ If there are sufficient details of how the research was explained to participants for the reader to assess whether ethical standards were maintained

□ If the researcher has discussed issues raised by the study (e.g. issues around informed consent or confidentiality or how they have handled the effects of the study on the participants during and after the study)

□ If approval has been sought from the ethics committee

8. Was the data analysis sufficiently rigorous? **□Yes □Can't tell □No**

HINT: Consider

□ If there is an in-depth description of the analysis process

□ If thematic analysis is used. If so, is it clear how the categories/themes were derived from the data?

□ Whether the researcher explains how the data presented were selected from the original sample to demonstrate the analysis process

□ If sufficient data are presented to support the findings

□ To what extent contradictory data are taken into account

□ Whether the researcher critically examined their own role, potential bias and influence during analysis and selection of data for presentation

9. Is there a clear statement of findings? **□Yes □Can't tell □No**

HINT: Consider

□ If the findings are explicit

□ If there is adequate discussion of the evidence both for

and against the researchers arguments

 If the researcher has discussed the credibility of their

findings (e.g. triangulation, respondent validation,

more than one analyst)

 If the findings are discussed in relation to the original

research question

10. How valuable is the research?

HINT: Consider

 If the researcher discusses the contribution the study makes to existing knowledge or understanding e.g. do they consider the findings in relation to current practice or policy?, or relevant research-based literature?

 If they identify new areas where research is necessary

 If the researchers have discussed whether or how the findings can be transferred to other populations or considered other ways the research may be used

APPENDIX D: CASP Quantitative Checklist (Adapted)

Screening Questions:

1. Was there a clear statement of the aims of the research? **□Yes □Can't tell □No**

HINT: Consider

- What was the goal of the research?
- Why it was thought important?
- Its relevance

2. Is a quantitative methodology appropriate? **□Yes □Can't tell □No**

HINT: Consider

- If the research seeks to examine a relationship between variables with the aim of making predictions
- Is quantitative research the right methodology for addressing the research goal?

Is it worth continuing?

Detailed questions:

3. Was the research design appropriate to address the aims of the research? **□Yes □Can't tell □No**

HINT: Consider

- If the researcher has justified the research design (E.g. have they discussed how they decided which method to use)?

4. Was the recruitment strategy appropriate to the aims of the research? (Assess selection bias) **□Yes □Can't tell □No**

HINT: Consider

- If the researcher has explained how the participants were selected
- Are the individuals selected to participate in this study likely to

be representative of the target population?

 If there are any discussions around recruitment (e.g. why some people chose not to take part)

5. Was the data collected in a way that addressed the research issue? **Yes Can't tell No**

HINT: Consider

 If the setting for data collection was justified

 If it is clear how data were collected

 If the researcher has justified the methods chosen

 If the researcher has made the methods explicit

 Were data collection tools shown to be valid?

 Were data collection tools shown to be reliable?

 If methods were modified during the study. If so, has the researcher explained how and why?

6. Have ethical issues been taken into consideration? **Yes Can't tell No**

HINT: Consider

 If there are sufficient details of how the research was explained to participants for the reader to assess whether ethical standards were maintained

 If the researcher has discussed issues raised by the study (e.g. issues around informed consent, anonymity, and confidentiality or how they have handled the effects of the study on the participants during and after the study)

 If approval has been sought from the ethics committee

7. Was the data analysis sufficiently rigorous? **Yes Can't tell No**

HINT: Consider

 If there is an in-depth description of the analysis process

 Were the statistical methods appropriate for the study design?

 If sufficient data are presented to support the findings

 To what extent contradictory data are taken into account

 Were potential sources of bias discussed?

8. Is there a clear statement of findings? **Yes Can't tell No**

HINT: Consider

 If the findings are explicit

 If there is adequate discussion of the evidence both for

and against the researchers arguments

 If the findings are discussed in relation to the original

research question

9. How valuable is the research?

HINT: Consider

 If the researcher discusses the contribution the study makes to existing knowledge or understanding e.g do they consider the findings in relation to current practice or policy, or relevant research-based literature?

 If they identify new areas where research is necessary

 If the researchers have discussed whether or how the findings can be transferred to other populations or considered other ways the research may be used