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Psychosocial Interventions for Families Caring for Mental Health Care Users: A Nominal Group Technique

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ABSTRACT

Introduction: In light of the rising global prevalence of mental illness and the need for deinstitutionalised care, families are required to provide community-based care to mental healthcare users. Family members need to be prepared and supported to undertake this role.

Aim: The aim was to develop psychosocial interventions to ease the burden of family caregivers of mental healthcare users.

Method: Using convenience sampling, 21 stakeholders were selected. The participants had at least 2 years' experience and/or expertise in the care of family members of mental healthcare users. During a workshop, a nominal group technique was used to collect data. The six steps of Braun and Clarke guided the data analysis.

Results: Three themes were identified, namely, interventions to provide mental health education, interventions to promote social support for families and interventions to ensure effective psychological support for families and mental healthcare users.

Discussion: The nominal group technique allowed healthcare and community stakeholders to become aware of their role in supporting family caregivers of mental healthcare users. Healthcare providers need to be empowered to use basic family counselling skills.

Implications for Practice: Implementation of the developed interventions might lead to a reduction in relapse rates and relieve the caregiver burden.

1 | Background

The World Health Organization [WHO] (2022) reports that the prevalence of mental illness is still rising despite evidence-based mental healthcare interventions. The move to community-based mental healthcare requires families to take responsibility for mental healthcare users (MHCUs) in need of long-term care (Middleton 2019). In many cases, families are overwhelmed and not prepared to perform the caregiver role because of inadequate

knowledge, skills and unmet support needs (Aass et al. 2022; Mabunda et al. 2022). This study therefore aimed to develop psychosocial interventions to support family caregivers.

Both intrapersonal and interpersonal well-being are components of mental health. The term 'intrapersonal' describes a person's internal self-care process that is focused on self-awareness and self-regulation and involves balancing thoughts, feelings and behaviours (Coronel-Santos and Rodríguez-Macías 2022).

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Summary

- What is known on the subject?
 - Deinstitutionalisation and community-based mental health care shifted the burden of care to family caregivers.
 - Family caregivers of mental healthcare users are prone to physical and psychological health problems.
- What does the paper add to existing knowledge?
 - Family members and mental healthcare users are not receiving adequate psychological and social support from their extended family members, healthcare professionals and the community at large.
 - Healthcare providers and community leaders developed psychological, educational and social interventions to address the psychosocial burden experienced by family caregivers in under-resourced areas.
- What are the implications for mental health nursing practice?
 - Family caregivers' psychological, educational and social challenges should be considered when designing psychosocial interventions.
 - Individual and family psychotherapy is recommended to facilitate family caregivers coping with their caregiving role.
 - Community leaders to be at the forefront in raising awareness campaigns about mental illness, to increase mental health literacy and reduce stigma and discrimination.

Physical, social and cultural aspects of the environment in which an individual lives and works have an impact on interpersonal well-being (Barnett and Casper 2001). All diagnosable mental disorders, characterised by aberrant thinking, feeling, or behaviour are collectively referred to as mental illnesses (WHO 2022).

Like other nations, South Africa has seen substantial changes in mental healthcare provision since the move to deinstitutionalised care in the 1970s. Although primary healthcare and general health settings are required to provide mental healthcare (Mental Health Care Act No. 17 of 2002; National Mental Health Policy Framework and Strategic Plan 2013–2020), such integrated services are not readily available in under-resourced settings in South Africa (Anokye 2018; Docrat et al. 2019; Middleton 2019). Without access to psychosocial, psychoeducational and crisis support, families carry most of the burden of long-term caregiving (Chronister et al. 2021; Brooke-Sumner et al. 2015; Sin et al. 2017).

Mbedzi et al. (2018) conducted a study in South Africa wherein family members conveyed their dissatisfaction and inability to cope with the mental health problems and challenging behaviour of MHCUs. They attributed these problems to the premature discharge of MHCUs. According to Mabunda et al. (2022), the family may reject the MHCU as a result of these sentiments. Other problems include the inadequate participation of families in the treatment programme and discharge planning of MHCUs (Aass et al. 2022; Mabunda

et al. 2022), which leaves them psychologically unprepared to provide continuity of care.

The stress related to providing care negatively affects families' physical and emotional health (Matambele and Tshifhumulo 2021). Family caregivers in South Africa faced emotional, physical, financial and social pressure leading to feelings of helplessness, fear, shame and hopelessness (Ntsayagae et al. 2019). The aforementioned emotions are linked to a lack of appropriate healthcare support, such as psychoeducational interventions, resulting in burnout, caregiver burden and a reduced quality of life (Akbari et al. 2018). Stigmatisation in the community makes caring for MHCUs at home even more difficult (Mabunda et al. 2022).

The third Sustainable Development Goal which relates to individual health and well-being will be accomplished in part if families who are providing care for MHCUs are appropriately supported by mental healthcare professionals and the community. Family members must be equipped to give quality care to achieve positive health outcomes and the well-being of MHCUs. Existing evidence showed that psychosocial interventions yielded a significant improvement in the quality of life of relatives of patients with schizophrenia (Kumar et al. 2020). Psychosocial interventions can support families to provide quality care (WHO 2022) when such interventions meet the physical, emotional and social needs of the family (Iswanti and Rumambo Pandin 2022). The first author worked as a mental health care provider in Vhembe district, the research context. She observed that inadequate psychosocial support interventions were rendered to family caregivers of MHCUs. Family caregivers verbalised difficulties in caring for MHCUs. Feelings of inadequacy led to family conflict and struggles to ensure MHCUs adherence to their treatment plans. These experiences resulted in relapse and readmissions. It was deemed relevant to involve community stakeholders in developing psychosocial interventions. Stakeholder involvement strengthens community participation and the roles and responsibilities of healthcare providers and traditional leaders in family support (Matsea et al. 2019).

The study aimed to develop psychosocial interventions to improve support for family caregivers of MHCUs.

2 | Method

2.1 | Study Design and Sample

The interventions for supporting family caregivers of MHCUs were informed by the results of the first phase of this research. In the first phase, the healthcare challenges of family members were qualitatively explored. In phase two, on which this manuscript is based, a consensus design was employed. Stakeholders participated in a workshop where a nominal group technique (NGT) was used to develop psychosocial interventions to address the needs of family caregivers.

The population of phase two consisted of community stakeholders: healthcare providers, policy developers and representatives of community structures involved in the support of family

caregivers of MHCUs. Purposive sampling was used to recruit 21 stakeholders, based on the following criteria:

2.1.1 | Inclusion Criteria

- Healthcare providers practising for a minimum period of 2 years: nursing and medical practitioners based in primary healthcare, managers responsible for mental healthcare co-ordination, members of the mental health review board, occupational therapists and community healthcare workers.
- Traditional healers, community and religious leaders involved in community care.
- Policy developers and primary healthcare managers involved in policy development and implementation.
- Willingness to participate.

2.1.2 | Exclusion Criteria

- Stakeholders who could not express themselves either in English or Tshivenda.
- Stakeholders without sufficient experience of the research phenomenon.

2.2 | Participants and Setting

After the researchers obtained permission from the director of the primary healthcare facilities, managers assisted with the identification of potential stakeholders for the NGT workshop. The participants were invited telephonically and via emails by the first author. Inclusion criteria were: community leaders involved for a minimum of 2 years in assisting family caregivers of MHCUs; mental health care providers, managers involved in policy development and implementation and primary healthcare managers. In addition, the stakeholders should have been able to speak either English or Tshivenda as the languages spoken by the majority of the population.

2.3 | Data Collection

The second author, experienced in qualitative research, facilitated the NGT. A NGT is a consensus method used to facilitate group meetings and develop interventions to address a specific problem (Mullen et al. 2021). The following phases of the NGT (Søndergaard et al. 2018) were used:

2.3.1 | Phase 1: Introduction and Explanation

The first author presented the aim of the research and the results of the first study phase one, which indicated the psycho-educational and social needs of family caregivers of MHCUs. The facilitator presented the main research question on a whiteboard: ‘What interventions do you think should be considered to address the healthcare needs of family members caring for MHCUs?’

2.3.2 | Phase 2: Silent Generation of Suggested Interventions

Based on their expertise, participants were requested to answer the main research question in writing. No group discussions were allowed at this stage.

2.3.3 | Phase 3: ‘Round Robin’

Participants were provided the opportunity to share the responses they recorded in phase 1. The facilitator wrote the responses on a flip chart until no new suggestions emerged. The participants were not allowed to discuss or debate the ideas and suggestions.

2.3.4 | Phase 4: Discussion and Clarification

Opportunities were provided to ask for explanations and clarify ideas that were not clearly described or understood. The participants categorised the suggested interventions into themes and categories. No suggestions were ignored. The facilitator recorded the themes and categories on a flip chart and clustered similar interventions together with the help of the participants. The stakeholders reached consensus on the three themes and categories. This phase allowed the stakeholders to be involved in the data analysis process.

2.4 | Data Analysis

Apart from the analysis in Phase 4 of the NGT, the authors applied six steps of thematic analysis to refine the findings and ensure rigour. The data consisted of individually written narratives (NGT Phase 1) and audio-recorded transcripts of the NGT proceedings as the groups reached consensus on the different interventions. The translation of the transcripts from Tshivenda to English were done by a person skilled in both languages.

2.5 | Scientific Rigour

Trustworthiness was ensured by applying dependability and confirmability when all three authors independently reviewed the data and reached consensus on the findings. Credibility was obtained through the triangulation of participants from diverse disciplines and the supplementation of data with field notes. A thick description of the context and the results were supported by participants’ direct quotations to ensure authenticity (Polit and Beck 2021).

2.6 | Ethical Considerations

The Ethics committee of the academic institution approved the study protocol. The participants signed informed consent and permission to record the NGT proceedings. The researchers requested participants not to discuss NGT proceedings outside the workshop. Data was anonymised using numbers to identify participants and all data were saved in a password-protected institutional data repository. Participants may indirectly benefit

from the study recommendations to improve support to family caregivers of MHCUs.

3 | Results

The five variables describing the features of the sample are gender, age, position, educational level and employment. Of the 21 participants, three were male. The youngest participant was 30 years old, and the oldest 67, representing a mean age of 48.5. The majority of the participants ($n = 17:81\%$) were employed as public healthcare workers by the health department, whereas a few ($n = 4:19\%$) represented community organisations, as indicated in Table 1.

The analysis of data revealed three themes that should be included as interventions for supporting family caregivers of MHCUs: interventions to provide mental health education, to promote social support for families and to ensure effective psychological support for families and MHCUs. The verbatim quotations that provided evidence for the themes and categories were obtained from the stakeholders' individual written narratives and transcribed audio-recordings. The ranked interventions (themes) and their actions (categories) are depicted in Table 2.

3.1 | Interventions to Provide Mental Health Education for Families

Three categories were derived from this theme: education about mental illness; education about indications and side effects of psychiatric medication; and guidance on management of challenging behaviours.

3.1.1 | Education About Mental Illness

Participants expressed the view that education should be given about the causes, signs and symptoms, prognosis and treatment of mental disorders. One participant gave a list of topics to be discussed with family caregivers of MHCUs. The information should be made available in the form of pamphlets that caregivers can refer to as needed.

Causes, signs and symptoms, courses, prognosis, treatment option, early warning signs of relapse, its management, management of day-to-day challenging behaviours, substance abuse, medication adherence side-effects and management thereof should be included.

(P2 audio-recorded)

There should be pamphlets given to relatives regarding mental health conditions which the family should keep at home...verbal information is easily forgotten.

(P10 written narrative)

The stakeholders indicated that the family caregivers should be given information on the warning signs and management of

symptoms of relapse. If families are well informed, they will be in a better position to reduce the relapse rate among MHCUs, which often leads to frequent admissions and negatively affects the level of functioning of the MHCU.

...information about how to see the signs and symptoms of relapse...the causes of mental illness before it started... how to manage the person during relapse...causes of mental illness so that we can prevent it before relapsing.
(P8 written narrative)

3.1.2 | Education About Indications and Side-Effects of Psychiatric Medication

As narrated by participants, family caregivers of MHCUs need information about psychiatric medication and the management of different side-effects that may be experienced by the MHCUs. They also need information regarding the management of side-effects. If side-effects are not treated, it can lead to non-adherence to medications.

TABLE 1 | Socio-demographic characteristics of participants.

Current position Occupational categories	Social workers	4
	Occupational therapist	1
	Psychiatric nurses	2
	Advanced psychiatric nurses	5
	Nurse educator	1
	Mental health review board member	1
	Local area clinic manager	1
	Community health workers	2
	SANCO (Civic) member	1
	Church leader	1
Educational level	Traditional health practitioners	2
	Primary	1
	Secondary level	0
	Certificate	6
	Diploma	5
	Degree	3
Years of experience in the above work position	Honours	4
	Master's degree	2
	All categories of stakeholders	1-28

TABLE 2 | Themes and categories derived from the NGT workshop.

Themes	Categories
Interventions to provide mental health education for families	<ul style="list-style-type: none"> • Education about mental illness • Education about indications and side effects of psychiatric medication • Guidance on management of challenging behaviours
Interventions to promote social support for families and MHCUs	<ul style="list-style-type: none"> • Alleviation of stigma and discrimination against family caregivers and MHCUs • Police assistance during crises • Engagement of MHCUs in community activities
Interventions to ensure effective psychological support for families and MHCUs	<ul style="list-style-type: none"> • Individual and family psychotherapy • Home visits by healthcare providers • Availability of psychiatric medication • Rehabilitation of MHCUs • Community mental health awareness campaigns

So, I think there is a need to educate families more about medication, what are they supposed to do when things are not going on well with medication.

(P19 audio-recorded)

To have positive outcomes, MHCUs must regularly be assessed for side effects. Family members must be informed about the management of side effects so that family caregivers can differentiate between physical and psychological symptoms and side effects caused by neuroleptic medication.

Treatment of side effects must be addressed. Our patients, when they are given treatments, they become weak, experience that they cannot sleep.

(P1 written narrative)

...started to use the medication for treating mental illness, things have not been going well. I am not sure whether it is due to medication or depression.

(P19 written narrative)

3.1.3 | Guidance on Management of Challenging Behaviours

Participants voiced the challenge of family caregivers being unable to control the difficult behaviours sometimes displayed by MHCUs. Some participants identified with the challenges experienced by family caregivers who are confronted with aggressive, dangerous and inappropriate behaviour displayed by MHCUs. Guidance will help family caregivers to manage the MHCUs when they relapse. Some participants verbalised that they themselves do not know how to guide the families and also require training.

...[families] live in fear due to threats made by the patient—assaults done or pain inflicted...fear of staying with him because sometimes he or she is aggressive.

(P19 written narrative)

Stakeholders were concerned regarding family caregivers who struggle with MHCUs who display oppositional behaviour and refuse treatment, follow-up visits and efforts to help them. They gave examples of families who live through constant struggles and rely on community members to offer support.

...the patient leaves home early hours of the morning without eating food and taking medications...family need help as he does not want to drink his medication, he refuses to eat food and at times he refuses to go for check up at the hospital or clinic...Thanks to community members because they intervene when they find him fighting people.

(P5 written narrative)

3.2 | Interventions to Promote Social Support for Families and MHCUs

This theme yielded three categories, namely, alleviation of stigma and discrimination against family caregivers and MHCUs, police assistance during crises and engagement of MHCUs in community activities.

3.2.1 | Alleviation of Stigma and Discrimination Against Family Caregivers and Mental Healthcare Users

Participants indicated their concerns related to stigma and discrimination from healthcare workers and community members. The family caregivers and MHCUs are isolated from the community because they are stigmatised. Stigmatisation can have serious effects when mental illnesses are associated with witchcraft and lead to violence. Participants maintained that mental health campaigns could help to mitigate the stigma and discrimination through the empowerment of community members.

Community campaigns on mental health to spread awareness to reduce stigmatization and

discrimination by healthcare workers and relevant stakeholders.

(P13 written narrative)

It is to engage community leaders in a sense that sometimes you find issues in the community where for example schizophrenic patients are being killed because people are accusing them of practising witchcraft and what not.

(P16 audio-recorded)

Participants identified strategies to reduce the stigma and discrimination of MHCUs and their families. A call was made for traditional, spiritual and civic association structures to take the lead in raising awareness. Church ministers and traditional health practitioners are prominent community members who are influential in the villages. The community leaders should be capacitated on how the community can live with MHCUs and accept them as members of the community.

Stigmatization and discrimination can be reduced through the empowerment of the community members through chiefs and civic members who should be taught how to live with the patient.

(P3 written narrative)

3.2.2 | Police Assistance During Crises

Data analysis revealed the need for intervention by police officers when families are faced with a crisis, for example when a MHCU has relapsed and is aggressive. Participants were concerned about the lack of support from the police who refer families to emergency ambulance services and may not restrain a person that is physically aggressive. This situation increases the family members' psychological stress as some fear for their life.

SAPS [South African Police Service] can help by restraining the patient if he or she is aggressive and posing potential danger to him/herself or others.

(P13 written narrative)

Families are not assisted by police officers and are referred to emergency personnel who are not able to offer any help. This situation leaves the family caregivers of MHCUs devastated and frustrated, not knowing what to do.

SAPS [South African Police Service] are disappointing us together with the emergency services here in [name of municipality] if there is a crisis situation ... they will refer us to the emergency officers, who will refer us to SAPS.

(P16 written narrative)

The participants suggested that a dedicated community representative and police officer be assigned to assist MHCUs and

their families to ease their burden during crises. The community representative should liaise with caregivers and police officers to ensure clear communication and appropriate support. Family caregivers also need help to take an MHCU who relapsed to the hospital for admission.

...should be contacted by community representative... to assist in term of crisis situation. There should be an office which should deal with relationship between family members of the mental health care users and SAPS [South African Police Service]. There should be a person to assist family members at the office when they have a crisis...A dedicated SAPS...who must deal with the concerns raised by the family members.

(P3 written narrative)

But the moment, when the illness start he [MHCU] ran away. In that case we need people to assist in helping him to go the hospital.

(P5 written narrative)

3.2.3 | Engagement of Mental Healthcare Users in Community Activities

Participants recommended involvement of family caregivers in social support groups and religious activities in the community to reduce stress. They need to be engaged in different community activities such as cultural, religious and sport activities.

Establishment of social group so that they can come together with other families so this can lessen the stress. They must be involved in home and church activities.

(P1 audio-recorded)

Most of the stakeholders highlighted the importance of the involvement of the MHCUs in different community activities to mitigate discrimination by community members. In rural settings like Vhembe district, there are no mental health rehabilitation centres and employment opportunities for the MHCUs. Engaging the MHCUs in community activities might prevent discrimination while instilling a sense of belonging as the MHCUs would feel accepted.

So, patients must be involved in community activities. It will help to prevent discrimination in order for them to feel accepted in the community.

(P16 written narrative)

3.3 | Interventions to Ensure Effective Psychological Support for Families and MHCUs

The categories to be discussed under this theme include individual and family psychotherapy, home visits by healthcare

providers, availability of psychiatric medication, rehabilitation of MHCUs and community mental health awareness campaigns.

3.3.1 | Individual and Family Psychotherapy

Participants recommended more effective family support through the use of individual and family psychotherapy. These therapeutic interventions could assist family caregivers in learning how to live with the MHCUs, identify and deal with their emotions and relieve their stress.

They need to be given assistance by being given counselling so that they can be able to understand well that they are not the first one to stay with a mental health care user. Counselling will lessen the stress....

(P2 written narrative)

The family members...after identifying their emotions...they should be provided with individual or family therapy.

(P3 written narrative)

Individual and family therapy for family caregivers was determined to be an essential intervention to reduce stress and prevent family caregivers from also developing mental illness.

...psychological counselling so that the mind can function well so that they [families] do not get mentally affected too. Counselling and family therapy to reduce the level of stress.

(P17 written narrative)

3.3.2 | Home Visits by Healthcare Providers

Home visits may help to reinforce MHCUs' adherence to prescribed medication, to evaluate compliance to treatment and assess the care rendered by the family caregivers and to do counselling. In addition, participants mention that home visits also provide an opportunity to assess the home environment and appreciate the efforts of family caregivers.

I think psychologically it is important for the staff members to visit and also do a family counselling... not at a hospital set-up, but family set-up...may be once a month that can make the client to realise that there is monitoring. As client respect staff members better than their family members, so the presence of staff members providing family visit can assist in the change of behaviour of our patient...to check how the patient is coping with medication and how the family members are coping with the patient...

(P1 audio-recorded)

As family members there is always a great feeling when healthcare professionals appreciate the efforts, we do care for our mental health care users.

(P11 written narrative)

Home visits may help to assess the home environment if it is conducive. Visits by social workers may assist the MHCUs in being recommended for a disability grant.

Provide supportive home visit by social workers to assess home living conditions and provide the necessary support by motivating *mudende* [disability grant].

(P13 written narrative)

3.3.3 | Availability of Psychiatric Medication

The participants stated that psychiatric medication should always be available at the local clinics to ensure families do not have to travel long distances to obtain medication from other facilities. A specific person should be responsible to ensure the availability of psychiatric medication at the healthcare facilities.

Ensure that they do not have to travel long distance to get medication. What to do if they don't get medications...what to do if they don't find the medication at a nearby clinic...

(P7 audio-recorded)

There should be facilitator who should be checking if medication at the clinic or hospital is available.

(P3 written narrative)

Delivering medication at MHCUs' homes can assist because family caregivers sometimes experience challenges to access the primary healthcare clinics.

Medication should be delivered at the homes because at certain time it is difficult to get the medication at the clinics and hospitals.

(P6 written narrative)

3.3.4 | Rehabilitation of Mental Healthcare Users

Rehabilitation was recommended, such as employment opportunities and support for MHCUs and their families. Rehabilitation should include the use of disability grants and sponsors to facilitate the vocational training of MHCUs so that they can generate an income and relieve the financial burden on the family. Supported accommodation was also mentioned as a possibility to support MHCUs during rehabilitation programmes.

With the disability grant patients can be empowered to start some projects in order to generate extra

income, such as gardening, car wash and pig farming.

(P12 written narrative)

So financially there should be development of projects through engagement of the business people so that the mental health care users should have an income.

(P10, audio-recorded)

The supported accommodation is the best where qualified staff will be able to supervise patients.

(P17 audio-recorded)

The stakeholders recommended involvement of MHCUs in different community activities to help to prevent stigma and discrimination of MHCUs by community members. The MHCUs can be involved in church activities, sports activities and work-related activities to make them feel accepted by other people.

So, the last issue is that patients must be involved in the community activities. It will help to prevent discrimination in order for them to feel accepted in the community.

(P16 audio-recorded)

3.3.5 | Community Mental Health Awareness Campaigns

Community mental health awareness campaigns are suggested to address the stigmatisation and discrimination towards family caregivers and MHCUs. The participants believed that interventions such as a mental health month will raise community awareness and increase the chance of MHCUs being accepted in the community.

Community education programme on acceptance of ill patients can help. Community campaigns on mental health to spread awareness, reduce stigmatisation and discrimination.

(P13 written narrative)

It will involve the community where in our health calendar we are having...mental health month...that will help us during the campaigns where we are supposed to involve them.

(P15 audio-recorded)

Different options were suggested such as reaching out to the community to enhance mental health awareness regarding treatment methods and causes of mental disorders. Information on prevention of mental illness can be disseminated through radio talks, pamphlets written in English and Tshivenda (the local language), awareness talks during

church gatherings and involving the community leaders to disseminate information.

The programme can facilitate knowledge sharing of information on mental illness by giving health pamphlets, education at the church to community gatherings, students to be taught through community radio stations and involvement of traditional healers.

(P1 written narrative)

4 | Discussion

Participants regarded mental health education as an essential intervention to support family caregivers. According to a study done in Beijing, health education and community support groups provided opportunities to enhance the knowledge and skills of family caregivers and helped to reduce psychological stress (Chen et al. 2019). Families in the study were not well-informed, similar to caregivers in another South African study who doubted their caregiving abilities and knowledge about mental illness (Ntsayagae et al. 2019). On the contrary, most participants (67.3%) in a quantitative study done by Madlala et al. (2022) on community mental health literacy in an urban area in South Africa recognised the clinical symptoms of schizophrenia as indicative of a mental disorder. This may indicate that urban participants were better informed than families in poorly resourced rural areas. More family members should contribute to the care process, including the younger ones (Dalky et al. 2017).

Family caregivers were stigmatised by their own families and community members, which contributed to their physical and psychological health problems. Mental health stigma takes different forms, such as discrimination against families. Families may become socially isolated, and stigma may inhibit the use of mental healthcare services (Lund et al. 2012). Even in the clinical environment, psychiatry wards are marginalised, and psychiatric patients are treated less efficiently once their diagnosis is known (Bravo-Mehmedbašić and Kučukalić 2017).

The reduction of stigma to facilitate acceptance of MHCUs requires consistent interventions targeting specific communities (Mehrotra et al. 2018). Mental health support services are not readily available in the primary healthcare facilities of South Africa where resources are limited (Mothwa et al. 2020). Kemp et al. (2019) observed that stigma reduction interventions for mental illness are given lower priority than HIV/AIDS in low- and middle-income countries and recommended awareness campaigns for mental illness and other interventions to enhance social support for family caregivers. Anti-stigma programmes have to involve primary prevention of stigma through media such as television and radio which can help to spread information to the general population (Bravo-Mehmedbašić and Kučukalić 2017). Traditional and social media can be employed for anti-stigma awareness initiatives to reach the general population. The use of community events such as competitions and carnivals is recommended to target different age groups

and create mental health awareness among the general public (Shahwan et al. 2022). In this study, participants suggested school outreach programmes to raise awareness among learners so that they grow up having basic information about mental illness (Shahwan et al. 2022). Monnapula-Mazabane and Petersen (2023) underscored positive coping mechanisms for families such as disclosure of the diagnosis to close family members and reaching out to supportive family or friends.

As recommended in the study, family caregivers who struggle with a MHCU with aggressive behaviour or symptoms of relapse may require support from police officers, especially when families struggle to apprehend the MHCU (Kneisl and Trigoboff 2004). Police officers might benefit from in-person or telephone support from nurses to help them understand and manage complicated medical situations such as a mental health crisis (Wood et al. 2021).

Healthcare workers should share responsibilities with family caregivers of MHCUs through initiating support groups and home visits. Social support increases psychological resilience, which mitigates distress. Support groups are therapeutic, affordable, facilitate the exchange of knowledge and help family members control the stress brought on by the demands of providing care (Baumann 2021). Peer support reduces feelings of loneliness and isolation, which can trigger depression. Support for families should be tailored to meet their healthcare needs while considering their personality, unique set of circumstances, cultural background and personal beliefs (Phillips et al. 2023). Vukeya et al. (2022) indicated that apart from home visits, an emergency line for support and a place of safety can be beneficial. In a study done in Israel (Yeshua-Katz 2021) participants appreciated emotional support through the use of digital platforms such as WhatsApp and Facebook as they are convenient and affordable for the rural communities. The foreseen challenge is access to data for these platforms by the family caregivers.

Psychological support such as family psychotherapy provides opportunities for family caregivers to establish working relationships with healthcare providers (Monyaluoe et al. 2014; Lavhelani et al. 2020). Psychoeducational assistance from health professionals helps families to cope better with the demands of home care and reduce relapse (Tlhowe et al. 2017). Family caregivers who are not supported may reject the MHCU, which poses a challenge in mental health institutions. Family rejection has a negative outcome on the MHCUs in the sense that it often results in frequent relapse episodes detrimental to their level of functioning.

Healthcare professionals should ensure the availability of psychotropic medication at the clinics at all times (Modise et al. 2021). Defaulting medication leads to disruptive and unpredictable behaviour, stigma and discrimination by community members. In support, van Rooyen et al. (2019) stated that inconsistency in the supply of medication results in high rates of non-adherence to medication.

Participants in other studies also recommended home visits to provide healthcare providers the opportunity to assess the coping skills of family caregivers (Vukeya et al. 2022). In Tanzania, healthcare providers were encouraged to do home visits to

assess the progress of MHCUs (Ambikile and Iseselo 2023). Interventions aimed at rehabilitating MHCUs demonstrated positive results (Killaspy et al. 2022). The participants indicated that the establishment of community rehabilitation centres could be beneficial to both family caregivers and MHCUs.

5 | Limitations of the Study

The research was done in eight primary healthcare centres in Vhembe district, Limpopo province, and hence the findings cannot be generalised to other settings. The fact that not all mental healthcare disciplines were represented in the NGT could have affected the interprofessional applicability and holistic nature of the interventions. The researchers wished to include clinical psychologists to ensure all mental healthcare practitioners form part of the NGT; however, due to work commitments, a clinical psychologist could not participate.

6 | Conclusion

The authors concluded that the NGT was a useful tool that sensitised the healthcare providers and community stakeholders towards their role in supporting families through psychosocial interventions. The interventions include family mental health education, community awareness campaigns and additional efforts by healthcare workers such as family counselling and home visits. Advanced mental healthcare practitioners can play a role in training and supervising primary healthcare nurses to support family members in turn. The interventions are ideal for under-resourced areas as community stakeholders (police officers, community and spiritual leaders and healthcare providers) can take responsibility for the implementation of the interventions, provided they receive training to facilitate community empowerment and involvement. These interventions could reduce the burden of care experienced by family caregivers while achieving the third Sustainable Development Goal by 2030, which talks about maintaining health and well-being.

7 | Implications for Practice

The study findings may assist policymakers and managers in facilitating the implementation of programmes for the psychosocial support of family caregivers of MHCUs. Primary healthcare nurses should be capacitated to provide family therapy, mental health education, crisis intervention and counselling. These nurses can also become involved in awareness campaigns and lobby with community and traditional leaders to take the lead in community interventions and reduce stigma towards mental illness. Community stakeholders such as police officers should be capacitated to support family caregivers in times of crisis.

Disclosure

The two authors A.E. and M.M. supervised T.M. in the completion of the Doctoral thesis which has formed the basis of this article. A.E

participated in the NGT workshop, acting as moderator. All contributed to the drafting of the manuscript and made corrections to the article.

Ethics Statement

The study received ethical approval from the Research Ethics Committee of the Faculty of Health Sciences, University of Pretoria (Ref: 624/2020).

Conflicts of Interest

The authors declare no conflicts of interest.

Data Availability Statement

The data that support the findings of this study are available on request from the corresponding author. The data are not publicly available due to privacy or ethical restrictions.

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