

The Relationship between Public Mental Health Policy and the Practice of Community Psychology through Family Support Groups

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Abstract

This article will examine the relationship between public mental health policy and the practice of community psychology through the lens of family support groups (FSGs). Government policy promotes community psychology, but the implementation thereof is lacking and gives way to approaches that deny the involvement of communities and families as equal owners in the psychotherapeutic process. However, the psychiatric system expects families to act as the ‘primary carers’ or ‘case managers.’ Family involvement is cited as invaluable to the overall success of recovery and, therefore, represents an opportunity for self-critique within the psychiatric system in its orientation towards partnering with families. In this context, FSGs were initiated within the adult male and adolescent inpatient units in the Western Cape at Lentegeur Hospital (LGH). This article promotes FSGs as central to psychotherapeutic interventions and offers an empirical grounding for an inclusive approach to family support. This practice of inclusivity is underpinned by a community psychology ethos and is based on the analysis of 24 FSG sessions involving 446 family members between July 2013 and November 2015.

Keywords: Advocacy; community psychology; family support groups; mental health; policy

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New Voices in Psychology

<https://unisapressjournals.co.za/index.php/NV>

Volume 13 | 2023 | #14816 | 17 pages

<https://doi.org/10.25159/2958-3918/14816>

ISSN 2958-3918 (Online), ISSN 1812-6371 (Print)

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Introduction and Background

In seeking to promote FSGs as central to psychotherapeutic interventions within the public mental health arena, this article will propose an organising framework for FSGs based on the relevant literature regarding the efficacy of family psychoeducation and the author's experience in coordinating 24 FSG sessions. In addition, the client experience will also be considered in the delineation of the organising framework. In this article, the author defines client community as a collective construct inclusive of the patient, the family of the patient, as well as affected communities and stakeholders. It is important to point this out here, as this article posits that community psychology looks systemically at providing mental health services to the patient, constituting an inclusive view of the client community.

Furthermore, in considering the FSGs as a community psychology practice, the article will also reflect on the traditional psychology practices within a public mental health setting. In juxtaposing these paradigms with one another, the impact of the policy terrain on the provision of mental health will also be explored. Here, specific reference will be made to the National Mental Health Policy Framework and Strategic Plan 2023-2030, the National Development Plan 2030, Healthcare 2030, and the Comprehensive Mental Health Action Plan 2013-2030.

The article concludes by offering recommendations regarding the organising framework for FSGs introduced and the policy platform on which FSGs should be built. Given the overall discussion framed here, it is important to reflect on broader studies regarding the efficacy of FSGs, as introduced below.

Does Family Psychoeducation Support Patient Care?

Traditionally, as Leggatt (2002) states, the psychiatric system has generally not recognised the role of families in facilitating the recovery of their sick relatives. However, the expectation exists by the very same psychiatric system that these families should take responsibility for their sick relative and should act as the "primary carers" or "case managers" in the absence of adequate education or skills training (Aass et al., 2020; Dirik et al., 2017; Leggatt, 2000; Vukeya et al., 2022). This recognition implies that the psychiatric system has a role to play in adequately equipping family members to take responsibility for their relatives. With this understanding, the FSGs were initiated within the adult male and adolescent inpatient units at LGH in July 2013 and February 2015, respectively.

McFarlane et al. (2003, p. 223), in their review of the literature on family psychoeducation, stipulated that "[f]amily psychoeducation has emerged as a treatment of choice for schizophrenia, bipolar disorder, major depression and other disorders." The effectiveness of family psychoeducation has been demonstrated by more than 30 randomised clinical trials that have shown reduced relapse rates, improved patient recovery, and family well-being (McFarlane et al., 2003). Studies of family education

programmes have also shown benefits to families to include an increased understanding and acceptance of mental illness, shaping of more realistic expectations, and improved coping strategies (Allchin et al., 2022; Foster et al., 2015; Kartalova-O’Doherty et al., 2006; Worrall et al., 2018).

Several models of family psychoeducation programmes have evolved to address the needs of families of individuals with psychiatric disorders. These include but are not limited to individual family consultation; professionally-led family psychoeducation in single-family and multi-family group formats; various forms of more traditional family therapies; and a range of professionally-led models of short-term family education (therapeutic education) (Allchin et al., 2022; Baker et al., 2019; Kartalova-O’Doherty et al., 2006; McFarlane et al., 2003; Worrall et al., 2018). It is important to note that, as per McFarlane et al. (2003), “[o]f these models, family psychoeducation has a deep enough research and dissemination base to be considered an evidence based-practice.”

Methodology

Study Design

To propose an organising framework for FSGs, a qualitative design was used to explore and understand the client experience of the FSGs at LGH and the author’s experience coordinating these 24 FSG sessions. Based on the relevant literature regarding the efficacy of family psychoeducation and relevant policy documents, themes were drawn and analysed from the collected data.

Setting

The FSGs were conducted at LGH, situated in Mitchell’s Plain, Cape Town, and the largest of the four regional hospitals providing mental health services for the Western Cape. The FSGs were conducted within the adult male and adolescent inpatient units at LGH between July 2013 and November 2015. During this period, 24 FSG sessions were conducted involving 446 family members.

Population and Sampling

This study’s population was comprised of two cohorts of family members of individuals with a mental illness. The one cohort was family members of individuals who were admitted to the adult male inpatient unit between September 2013 and September 2014. The second cohort was family members of individuals who were admitted to the adolescent inpatient unit between February and November 2015.

Family members were invited to attend the FSGs, and attendance was voluntary; as such, convenience sampling was employed, as the data was collected from individuals who were readily available and convenient to access via the attendance of the FSGs.

Data Collection Process and Analysis

The data collected during this period provides the evidence base for the organising framework of FSGs (proposed in this article) and draws on the following:

- Seventeen needs assessment questionnaires were completed anonymously in June 2013 by family members who had a relative admitted to the adult male inpatient unit.
- One hundred thirty feedback questionnaires were completed anonymously by family members who attended the FSGs in the adult male inpatient unit between September 2013 and September 2014.
- Twelve needs assessment questionnaires were completed anonymously between November 2014 and January 2015 by family members who had a relative admitted to the adolescent inpatient unit and
- One hundred fifty-five feedback questionnaires were completed anonymously by family members who attended the FSGs in the adolescent inpatient unit between February and November 2015.

Family members completed the needs assessment questionnaires voluntarily and anonymously when visiting their ill relative in the inpatient unit. The feedback questionnaires were completed voluntarily and anonymously on attendance at each FSG session. Both questionnaires were made available in English, Afrikaans, and isiXhosa, the three official provincial languages in the Western Cape.

Once the data had been collected, the content was translated into English by the author and a translator in the employ of LGH. Thematic analysis was applied to the data, and common themes were grouped together to gain a broad picture of the FSGs. A literature review was then conducted to support the meaning of the themes identified.

Ethical Considerations

The data was collected anonymously, and no individually identifiable elements were recorded on the questionnaires. As such, confidentiality was secured.

Ethics approval was received for the publication of this article by the Health Research Ethics Committee of Stellenbosch University (Reference: C16/01/001)¹ and by the Lentegeur Hospital Research Committee (dated 6 October 2016).

¹ Ethics authorisation obtained during the author's tenure as a joint appointee of Stellenbosch University.

Results

Demographic Data

The participants were comprised of 446 family members who had a family member admitted to either the adult male inpatient unit or the adolescent inpatient unit at LGH. Most of these participants were the parents, siblings, or extended relatives of the individual admitted to either of these inpatient units. Many participants had a low-income status, were unemployed, and depended on social grants.

The Client Community's Experiences of the FSGs

Whilst a comprehensive evaluation is required to assess the efficacy of the FSGs, from data elicited from families, the FSGs do appear to offer support and education, which appears to be of value to families. This article recognises that the client community's experiences of the FSGs may impact its efficacy. In this regard, the following prominent themes emerged from and were explored in the data collected.

Family-Based Selection of FSG Topics.

The families' choice of topics for the FSGs is a key indicator under the organising framework proposed in this article as to the FSG's responsiveness to the educational needs of families. Information on substance abuse appeared to be a priority for families. This points to the importance of developing partnerships with organisations that offer substance abuse treatment and prevention programmes and have a grassroots presence. Families also indicated that they require information regarding mental illness and medication compliance. This suggests that psychoeducation must be emphasised throughout the admission and post-discharge process. Lastly, many families require information regarding the emotional well-being of the caregiver. Across the adult male and adolescent inpatient units, regardless of the age of one's ill relative or the number of admissions that they may have had, families require support throughout the admission process and after that.

Repeat Attendance of Families.

In 2015, the author could track repeat attendance of the FSGs at the adolescent inpatient unit. For the author, repeat attendance illustrates the value the FSGs hold for these families, as they would not return if they did not 'gain' anything from it. Furthermore, this ongoing attendance is deemed important in that it creates the opportunity for peer support, may instil hope for newly admitted families, and allow for informal follow-up of patients and opportunities for relapse prevention.

Levels of Satisfaction with the FSGs.

Here, a series of questions tested how satisfied families were with the information provided and the methods used during the FSG sessions. It is important to note the

overwhelming levels of ‘satisfaction’ with the group. Factors contributing to this satisfaction include the following:

- The use of multimedia.
- The encouragement of mother tongue engagement.
- The use of expert presenters.
- Ensuring relevant topics.
- The use of materials in the most representative languages spoken.
- A dedicated question and answer session at the end of each group.
- Post-group family engagement and follow-up on urgent issues raised in the group.

The client experience highlighted here, which will be echoed in the organising framework for FSGs discussed later in the article, is located within the theoretical tradition of community psychology and resonates with contemporary public health policy, as introduced below.

The Policy Environment

In the author’s opinion, there is a fundamental disconnect between policy and practice in the public mental health arena in South Africa. Government policy promotes community psychology, but the implementation thereof is lacking and gives way to stale approaches that deny the involvement of communities and families as equal owners in the psychotherapeutic process. These policies are briefly discussed below, particularly in encouraging family and/or community participation.

Individuals/Community as Active Collaborators

The Western Cape Government (WCG): Health (2014, p. 15), in its healthcare vision for 2030, is cognisant of the need for a paradigm shift amongst healthcare workers from health ‘providers’ to health ‘facilitators/enablers’ to promote co-responsibility for wellness. As employees, we are called upon to view people as ‘purposeful beings’ (Kagan & Burton, 2001, p.7) with the agency to effect change in their lives. We are encouraged to promote the active participation and collaboration of individuals and communities, strengthening individual and community capacity in what the WCG: Health (2014 p.15) refers to as a ‘whole of society approach.’ The value of participation is also emphasised in the National Mental Health Policy Framework and Strategic Plan 2023-2030 (National Department of Health, 2023) and stipulates the importance of the involvement of mental health care users in the planning, delivery, and evaluation of mental health services.

Similarly, the National Development Plan (NDP) – 2030 (National Planning Commission, The Presidency, 2013) also recognises the importance of citizen participation in bringing about transformation and encourages citizens to use the avenues in the legislation to help shape the country’s development process. Here, it is clear that the government is aware of the benefits of active civic participation and encourages this to strengthen our democracy further, ensure responsive service delivery, and advance social justice.

Objective 1 of the Comprehensive Mental Health Action Plan 2013 – 2030 (WHO, 2021) is to strengthen effective leadership and governance for mental health. This Plan points out that “[g]overnance is not just about government, but extends to its relationship with nongovernmental organizations and civil society” (p. 6). Here, like the NDP, the Mental Health Action Plan reinforces the value of civil society and its role in contributing to the promulgation of more effective and accountable policies, laws, and services for mental health.

Objective 2 of the Comprehensive Mental Health Action Plan 2013 – 2030 (WHO, 2021) is to provide comprehensive, integrated, and responsive mental health and social care services in community-based settings. To ensure that services are responsive, WHO (2021) encourages service users' active involvement and support in reorganising, delivering, evaluating, and monitoring these services. Furthermore, providing such services requires greater collaboration with "informal" mental health care providers, such as families (WHO, 2021).

Moreover, Healthcare 2030 (WCG: Health, 2014) recognises that communities can represent their interests by engaging with health management. To this end, the WCG: Health (2014, p.34), “[...] as part of a developmental state, and through its intention to give a stronger voice to the community, endeavours to build capacity and deepen this relationship and the mechanisms of communication and accountability through the relevant legislative provisions [...].”

Here, the WCG: Health (2014) realises that it needs to improve its advocacy role and work with other role players, including the community itself, to ensure the design of local and relevant interventions. This is echoed by the National Mental Health Policy Framework and Strategic Plan 2023-2030 (National Department of Health, 2023) in its value of community care, which stipulates that local community-based resources should be mobilised to provide mental health care.

Adopting Ecological Perspectives

With a focus on person-centeredness, Healthcare 2030 (WCG: Health, 2014) stipulates that patients and their relatives should be treated with dignity and respect and should be actively involved in managing their health. In this context, it is hoped that staff will “[...] manage their patients holistically, by locating the illness within a broader personhood, family and community context, understanding the socio-economic and

other contextual factors, and refraining from adopting a technocratic clinical approach to the management of the patient” (WCG: Health, 2014, p.29).

Healthcare 2030 further stipulates that the involvement of family and friends is a key contributory factor to a patient-centred experience. Here, attention is drawn to the understanding that illness can be anxiety-provoking and that the patient’s perspectives are dependent on his/her socio-cultural context, which is informed by his/her family, friends, and community. These factors influence health beliefs, such as adherence to interventions. In recognition, the WCG: Health encourages collaboration between communities, patients, families, and healthcare providers to ensure that the patient is provided with appropriate support for better health outcomes. Similarly, the National Mental Health Policy Framework and Strategic Plan 2023-2030 recommends maximum support to families and carers to broaden the patient’s support network.

Building Partnerships

Building strategic partnerships is one of the principles encapsulated in HealthCare 2030 (WCG: Health, 2014). Here, the WCG: Health points out the provincial government’s need to build partnerships with role players across multiple sectors. Inter-sectoral collaboration is also a value espoused in the National Mental Health Policy Framework and Strategic Plan 2023-2030. This Plan stipulates that the social determinants of mental health can only be comprehensively addressed via collaboration between the Health sector and several other sectors, including Education, Social Development, Labour, Criminal Justice, Human Settlements and civil society.

The WCG: Health recognises the importance of non-governmental organisations (NGOs) and community-based organisations (CBOs) and that they are well embedded within communities. As per the vision of Healthcare 2030 (WCG: Health, 2014), WCG: Health plans to partner with these organisations in providing community-based services, as such partnerships will improve access to basic health services, especially at a community level. Furthermore, in recognition of the value of NGOs and CBOs in providing support to patients and caregivers, Healthcare 2030 stipulates that it is our role to assist the patient and his/her family to make these linkages and access the services offered by these networks.

The FSGs can firmly be located within the policy environment discussed above. As discussed below, it is critical to point out how the FSGs are implementing these policy imperatives.

FSGs as a Praxis of Policy and Community Psychology

The point of departure to connect policy to practice is located within the organising framework of the FSGs proposed in this article. This connection is built through access, relevance, and participation. The underpinning principle here is that the individual and his/her community are viewed as capable collaborators. Within the FSGs, patients (and

families) possess the agency to effect change in their lives. The FSGs, by viewing people as ‘purposeful beings’ (Kagan & Burton, 2001, p.7), represent yet another major epistemological break with mainstream forms of psychology, further cementing itself within the practice of community psychology.

The elements of relevance and participation within the organising framework emphasise the importance of the active participation of individuals and communities in the planning, delivery, and evaluation of mental health services to ensure comprehensive and responsive service delivery. The fifth element, community networks, recognises the value of community-based resources and emphasises building strategic partnerships with these organisations. Such partnerships allow for broadening the support network to which our client community may have access.

Lastly, the sixth element of the organising framework, institutionalisation and resource management, finds synergy within the strategic objectives of Healthcare 2030 (WCG: Health, 2014) and its focus on person-centeredness. Here, the focus is the adoption of an ecological perspective regarding the delivery of health services and the cultivation of a leadership corps that ensures that this perspective is inculcated into the fabric of the organisational culture.

As such, the policy environment is the basis for operationalising a community psychology approach. This requires policy-level education and an institutional will to link this to practice, accompanied by a firm commitment to the values of participation, advocacy, and social justice.

Here, in concluding the above section, several pertinent policy responses are required, as highlighted below:

- Ongoing self-critique of the psychiatric system through engagement with families (and policy) is essential to re-thinking and transforming our orientation towards partnering with families. The gap between policy and practice can be bridged within this critique process.
- Education on approaches to community practice should be inculcated in the training of emerging healthcare managers. The importance of education for health care managers cannot be underestimated, particularly as the Lancet Global Mental Health Group (2007) has identified the lack of effective public mental health leadership as a barrier to mental health service delivery and
- Advocacy around the significance of community psychology and community-oriented practices is vital. This advocacy must be firmly located within a social justice framework and, as such, will require campaign-level work with community structures, particularly as “[l]obbying by interest groups and NGOs has been found to have enormous potential for influencing the direction and

implementation of social and health policy” (Kleintjes et al., & The MHaPP Research Programme Consortium, 2010, p.574).

Discussion of Findings

The Limitations of Current (Traditional) Practices

To fully appreciate the community psychology practice paradigm, it is important to explore the limitations of hegemonic or traditional practices within a public mental health setting. These considerations are as follows.

Decision-Making is Largely Located with the Clinician.

The clinician is deemed the expert regarding the patient’s distress, and decisions as to the treatment required are often autocratically decided upon by the clinician. Frequently, these decisions are made with limited engagement with the patient and/or family.

Peripheral Family Participation in the Therapeutic Process.

With limited active or sustained engagement between families and the psychiatric system, families generally are on the periphery regarding the treatment and recovery process of their ill relative. A collaborative relationship between families and clinicians still appears largely absent, and the families’ knowledge and expertise often go unacknowledged. In this context, it is very difficult for families to be actively involved in the care of their ill relatives. As such, the potential of families to facilitate recovery is lost.

Limited Post-Discharge Support.

Given the realities of high clinical load and resource constraints within public mental health settings, the focus is often on the clinical needs of the patient, to the exclusion of their social, educational, or occupational needs (Dirik et al., 2017). As such, we often fail to generate a comprehensive management plan, which results in limited support post-discharge.

The Absence of Collaborative Community Engagement in Supporting Recovery.

The assumption appears to exist within the psychiatric system that the community plays no role in supporting rehabilitative or therapeutic efforts. To this end, interventions are often individually focused, with limited active engagement sought from familial and/or external support networks. Furthermore, these support networks are often misrepresented as unwilling or unable to support the recovery process of their ill relative. This Eurocentric frame is contrary to the needs of our client community and devoid of an appreciation of the social settings within which our client community is located. Here, the author agrees with Naidoo (2000, p.5), who states that “[t]he proclivity for individual curative therapy may not be culturally appropriate or

comfortable for all sectors of the South African society, especially for those cultures that are more group (collectivistic) oriented.”

The Concept of a Family Support Group in the Traditional Sense.

Whilst the concept of family support is not new to the discipline of psychology, particularly in the context of child psychotherapies where parent involvement is standard practice (Hoagwood et al., 2010), it has, however, been relegated to the periphery in that it has received far less research attention, as compared to other components of healthcare (Foster et al., 2015; Hoagwood et al., 2010). In the author’s experience, family support is frequently seen as an adjunct to more traditional psychotherapeutic interventions and is engaged by clinicians on an ad hoc basis.

Community psychology promotes greater decision-making by the family, a more central role by the family in the therapeutic process, greater collaboration with communities in supporting recovery, and, lastly, active reliance on families in sustaining therapeutic interventions. This is a fundamental departure from traditional models of psychology.

FSGs as a Community Psychology Practice

Based on the above discussion, it is the author’s opinion that the FSGs constitute the practice of community psychology, if considered through Prilleltensky’s (2001) definition, as they encourage active family involvement and, therefore, engage the family system as a whole, as opposed to defining mental health problems as the sole domain of the ill relative (Joubert, 2007). In addition, the FSGs foster self-reliance via the inclusion of community networks. Within the FSGs, the author, the founder and coordinator of these groups, does not see herself as the expert but as a collaborator in promoting the strengths and wellness of both the family members and their ill relatives throughout the recovery process. The importance of viewing the families as active collaborators in, and equal owners of, the psychotherapeutic process allows clinicians to benefit from the intelligence and insights that families bring to bear on the therapeutic process (Dirik et al., 2017; Foster et al., 2015; Hayes et al., 2023)

This collaborative approach firmly locates the FSGs within the context of community psychology, as this constitutes what Kagan and Burton (2001) refer to as an ‘epistemological break’ with mainstream forms of psychology in that the FSGs advocate for participatory approaches, “in which the psychologist’s ‘expert knowledge’ is combined with the people’s ‘popular knowledge’ in every aspect of their work” (Kagan & Burton, 2001).

Lastly, within this collaborative approach, one of the aims of the FSGs is to educate families about psychiatric disorders and mental health and to provide them with information and practical help. This educational component is a key community psychological praxis task (Kagan & Burton, 2001). However, this educational task requires what one of the nursing staff at LGH referred to as a “bi-directional

communication channel” – that is, an interaction, or dialogue, between two people. This dialogue allows for the encouragement of pluralistic interpretations, as “[i]t is through the sharing of information and perspectives on the world that we all become more aware of our place in it and the possibilities for constraint and change” (Kagan & Burton, 2001). Traditional practices in psychology will remain pervasive if the policy environment for public mental health provision does not translate the ethos of community psychology into practice.

Conclusions and Recommendations

Based on the analysis provided here, two important findings emerge:

An organising framework is required to improve the efficacy of FSGs within a community psychology paradigm, and the need for adequate orientation towards and leaning on relevant policy is essential.

The Organising Framework for FSGs

Based on the author’s experience in coordinating 24 FSG sessions, an organising framework comprising of the following six elements is proposed: format and frequency, relevance, access, participation, community networks, and institutional and resource management.

A brief description of these elements is provided below.

Format and Frequency

A multiple-family format characterises the FSGs. The patient is excluded from the group to ensure that families have the space to discuss challenges in caring for their ill relative. The FSGs constitute a psychoeducational programme held once a month on a Sunday afternoon during visiting hours. Given the nature of the inpatient units and the continual admission of new patients, the FSGs are open-ended and remain open to families of discharged patients.

Relevance

For FSGs to be effective, they need to respond to what families want to know and what families and patients are experiencing. The FSGs have established, and continue to establish, relevance via a needs assessment and feedback questionnaires completed by the families at the end of each group.

Access

The group needs to occur at the right time (at a time that is convenient for most families and a time that does not infringe too much on their daily obligations) to ensure accessibility. At LGH, FSGs are, therefore, conducted once a month on a Sunday afternoon, with the time of the groups coinciding with visiting hours. Given that the FSGs are conducted within inpatient units, this time is operationally opportune, as many families visit their ill relative on a Sunday afternoon and/or return them to the hospital following weekend leave.

Participation

It is important to create a space for meaningful participation. This is achieved by building a dedicated question-and-answer session at the end of each group and by allowing for engagement between families, staff, and the speaker. Furthermore, to maximise participation, suitable language use (minimal use of jargon) is crucial, and psychoeducation materials provided should be easily understandable and available in the most representative languages spoken.

The FSGs aim to make all group-related content available in English, Afrikaans, and isiXhosa, the three official provincial languages in the Western Cape. Moreover, as the groups encourage mother tongue engagement, translation is available in each group. This practice encapsulates what Kagan and Burton (2001) refer to as ‘giving psychology away.’ As such, within the FSGs, “community psychologists have opportunities to use psychological knowledge and expertise in liberatory ways: to make concepts and practices accessible and to develop participatory working relationships” (Kagan & Burton, 2001).

Community Networks

The fifth element is community networks, in the form of local non-governmental organisations, non-profit organisations, community-based organisations, and review and advocacy bodies. Here, subject matter experts bring richness to the conversation regarding content areas related to the needs of families. The inclusion of such experts and the mobilisation of these external resources builds important linkages for the families to these resources, which could help to reduce the burden of care on the hospital (Foster et al., 2015). A secondary benefit of such engagement is that it may further the potential for collaborative partnerships between the hospital and other relevant stakeholders and, in this manner, allow for the delivery of a more comprehensive service.

Institutionalisation and Resource Management

The allocation and provision of resources are central to the operational viability of the FSGs. Families must feel that they are adequately catered for and that the FSGs are a

space that is sufficiently resourced so that they may engage effectively. The resourcing elements central to the viability of the FSGs are as follows:

- Provision of adequate catering.
- Printing/photocopying.
- Suitable ‘workshop’ materials.
- SMS bundles for communication and marketing purposes with families and
- Honorarium payments to speakers or respective organisations.

Given the constraints within which public health facilities operate, these resources are not always available. However, it is critical that management find an appropriate long-range funding solution for the provision of this service as it cannot remain a self-funded endeavour, as has been the case with the FSGs at LGH.

Policy Orientation

At the level of policy, the analysis has unearthed two considerations:

1. The policy provides sufficient space for an empirical model to emerge, as much of the policy provision, advocating for the central participation of the client community, is based on actual research. This provides an important entry into the notion that praxis (the relation between policy and practice) is fundamental to building FSGs within a community psychology model and
2. Policy, especially within the public mental health arena, legitimates quality assurance and standards. Here, clinicians must adhere to the policy and the legislation that may buttress this policy. In this way, the policy acts as a quality assurance tool for clinicians and urges us to adopt a community psychology approach to the services we deliver.

At the level of the organising framework, this article has illustrated that consideration must be given to issues related to format and frequency, relevance, access, participation, community networks, and institutional and resource management. As delineated in this article, the fundamental problem within public mental health settings appears to be the lack of integration and coordination between the role of the clinician and the role of the family. The organising framework proposed here goes a long way in mitigating this tension.

Perhaps a final point to make is that in the absence of a community psychology model being integrated and institutionalised within the public mental health arena in South

Africa, hegemony (which, in the main, does not view the individual or the community as active collaborators) will prevail. A compounded alienation between the end user and the provider will ensue. This alienation contradicts Healthcare 2030 and the National Mental Health Policy Framework and Strategic Plan 2023-2030, both of which stipulate the importance of the active participation of individuals and communities in ensuring comprehensive and responsive service delivery. From a rights perspective, as understood within a social justice framework, the constitutional imperatives, as enshrined within the Bill of Rights, will be severely compromised should individuals and communities continue to be excluded from participating in the planning, delivery, and evaluation of mental health services.

References

- Aass, L. K., Skundberg-Kletthagen, H., Schröder, A., & Moen, Ø. L. (2020). Young adults and their families living with mental illness: evaluation of the usefulness of family-centered support conversations in community mental health care settings. *Journal of Family Nursing*, 26 (4), 287–363. <https://doi.org/10.1177/1074840720964397>
- Allchin, B., Weimand, B. M., O’Hanlon, B., & Goodyear, M. (2022). A sustainability model for family-focused practice in adult mental health services. *Frontiers in Psychiatry*, 12, 1–8. <https://doi.org/10.3389/fpsy.2021.761889>
- Baker, D., Burgat, L., & Stavely, H. (2019). We’re in this together: Family inclusive practice in mental health services for young people. Melbourne: Orygen. Retrieved 10 November 2023 from https://www.orygen.org.au/Orygen-Institute/Policy-Areas/Government-policy-service-delivery-and-workforce/Service-delivery/We-re-in-this-together/Orygen_We-re-all-in-this-together_2019
- Dirik, A., Sandhu, S., Giacco, D., Barrett, K., Bennison, G., Collinson, S., & Priebe, S. (2017). Why involve families in acute mental healthcare? A collaborative conceptual review. *BMJ Open*, 7, 1–10. <https://doi.org/10.1136/bmjopen-2017-017680>
- Foster, K., Maybery, D., Reupert, A., Gladstone, B., Grant, A., Ruud, T., Falkov, A., & Kowalenko, N. (2016). Family focused practice in mental health care: An integrative review. *Child and Youth Services*, 37 (2), 129–155. <https://doi.org/10.1080/0145935X.2016.1104048>
- Hayes, D., Edbrooke-Childs, J., Town, R., Wolpert, M., & Midgley, N. (2023). A systematic review of shared decision making interventions in child and youth mental health: Synthesising the use of theory, intervention functions, and behaviour change techniques. *European Child & Adolescent Psychiatry*, 32, 209–222. <https://doi.org/10.1007/s00787-021-01782-x>

- Hoagwood, K. E., Cavaleri, M. A., Serene Olin, S., Burns, B.J., Slaton, E., Gruttadaro, D., & Hughes, R. (2010). Family support in children's mental health: A review and synthesis. *Clinical Child and Family Psychology Review*, 13 (1), 1–45. <https://doi.org/10.1007/s10567-009-0060-5>
- Joubert, S. (2007). *Mainstreaming community psychology: The road to relevance* [Unpublished master's thesis]. University of Cape Town.
- Kagan, C., & Burton, M. (2001, March). Critical Community Psychology Praxis for the 21st Century. Paper presented to British Psychological Society Conference, Glasgow (pp. 1–30). Retrieved 5 April 2016 from <http://www.compsy.org.uk/GLASGOX5.pdf>
- Kartalova-O'Doherty, Y., Doherty, D. T., & Walsh, D. (2006). Family support study: A study of experiences, needs, and support requirements of families with enduring mental illness in Ireland. Dublin: The Health Research Board. Retrieved 5 April 2016 from http://www.hrb.ie/uploads/tx_hrbpublications/FamilySupportRep.pdf
- Kleintjes, S., Lund, C., Swartz, L., Flisher, A., & the MHaPP Research Programme Consortium. (2010). Mental health care user participation in mental health policy development and implementation in South Africa. *International Review of Psychiatry*, 22(6), 568–577. <https://doi.org/10.3109/09540261.2010.536153>
- Lancet Global Mental Health Group (2007). Scale up services for mental disorders: A call for action. *Lancet*, 370, 1241–1252. [https://doi.org/10.1016/S0140-6736\(07\)61242-2](https://doi.org/10.1016/S0140-6736(07)61242-2)
- Leggatt, M. (2000). Families in limbo. Paper presented at WFSAD One-Day Conference, Dublin, 27 September 1993.
- Leggatt, M. (2002). Families and mental health workers: The need for partnership. *World Psychiatry*, 1 (1), 52–54.
- McFarlane, W. R., Dixon, L., Luckens, E., & Luckstead, A. (2003). Family psychoeducation and Schizophrenia: A review of the literature. *Journal of Marital and Family Therapy*, 29 (2), 223–245. <https://doi.org/10.1111/j.1752-0606.2003.tb01202.x>
- Naidoo, A. V. (2000). Community psychology: Constructing community, reconstructing psychology in South Africa [Inaugural Lecture]. University of Stellenbosch. Retrieved 11 March 2016 from <http://academic.sun.ac.za/psychology/tvnaidoo/Art-1-Inaugural-Lecture.pdf>

- National Department of Health (2023). *National Mental Health Policy Framework and Strategic Plan 2023-2030*. Pretoria: National Department of Health. Retrieved 10 November 2023 from <https://www.health.gov.za/wp-content/uploads/2023/08/National-Mental-Health-Policy-framework-and-strategic-Plan-for-Web-15%EF%80%A208%EF%80%A223-2.pdf>
- National Planning Commission, The Presidency (2013). *National Development Plan 2030: Our future - make it work*. Pretoria: National Planning Commission. Retrieved 12 April 2016 from <http://www.poa.gov.za/news/Documents/NPC%20National%20Development%20Plan%20Vision%202030%20-lo-res.pdf>
- Prilleltensky, I. (2001). Value-based praxis in community psychology: Moving toward social justice and social action. *American Journal of Community Psychology*, 29 (5), 747–778. <https://doi.org/10.1023/A:1010417201918>
- Vukeya, T., Temane, A. & Poggenpoel, M. (2022). Experiences of family members caring for a sibling with mental illness in Giyani, Limpopo. *Curationis*, 45 (1), 1–10. <https://doi.org/10.4102/curationis.v45i1.234>
- Western Cape Government, Health (2014). *Healthcare 2030: The Road to Wellness*. Cape Town: Western Cape Government, Health.
- World Health Organization (2021). *Mental Health Action Plan 2013-2030*. Geneva: World Health Organization. Retrieved 10 November 2023 from <https://www.who.int/publications/i/item/9789240031029>
- Worrall, H., Schweizer, R., Marks, E., Yuan, L., Lloyd, C., & Ramjan, R. (2018). The effectiveness of support groups: a literature review. *Faculty of Science, Medicine and Health - Papers: part A*. 5441. Retrieved 10 November 2023 from <https://ro.uow.edu.au/smhpapers/5441>