Mutual help groups: an important gateway to wellbeing and mental health

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Abstract

Objective: This study investigated the impact of GROW, an Australia-wide community mental health organisation, on psychological wellbeing and mental health.

Design: Triangulation of quantitative and qualitative research methods was employed. The study included a cross-sectional and a longitudinal survey of GROW members together with ethnographic and phenomenological work.

Research outcomes: The results pointed to length of membership/extent of involvement in GROW activities as being associated with improved wellbeing in the areas of autonomy, environmental mastery, personal growth, and self-acceptance/purpose in life, together with a reduction in medication and hospitalisation. In a longitudinal study surveying the wellbeing of 28 new GROW members with 6-month follow-up, there were statistically significant improvements on all wellbeing factors. A major theme emerging from ethnographic and phenomenological research was that GROW offers a "real life" mini-community where people learn social and life management skills. However, beyond skills acquisition, GROW offers the potential for identity transformation by assisting the realisation of core human needs — a sense of feeling useful, valuable and belonging.

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What is known about the topic?
Mutual help groups have been widely studied in the United States and Europe, however little research has been undertaken in Australia, with concomitant lack of professional knowledge about their potential benefits.

What does this paper add?
This research, employing a wellbeing scale with factors tapping into the wellbeing areas of life management skills, self-esteem and sense of meaning/purpose in life, emphasises the importance of community on the journey back to mental health and wellbeing, an area which is increasingly recognised now in mainstream mental health policies in Australia.

What are the implications for practitioners?
This study acknowledges the potential benefits of mutual help groups and suggests that it is important to view these groups as complementary to mainstream health services and as an important ingredient on the platter of therapies which can be offered to clients.

MUTUAL HELP GROUPS (MHGs) provide an important gateway to wellbeing and mental health.[1] The finding comes in an Australian context where the potential of MHGs for improving wellbeing and mental health is largely unrecognised professionally. This omission can be explained by the scarcity of research into MHGs in this country, and alongside this, a lack of teaching in mainstream health curricula about their potential benefits.

In America and Europe, however, mutual help research flourishes, and the benefits of MHGs are increasingly recognised. The literature points to enhancement of quality of life and health maintenance as being more appropriate than a cure approach for psychiatric populations, particularly for people with chronic mental health problems.[2,3] Where mental illness is associated with loss of social support and disintegration of lifestyle, MHGs are seen as being involved with the

maintenance of wellbeing and as affecting the social consequences of psychiatric problems rather than primary symptomatology.[4]

In order to add to our understanding of MHGs this study employed triangulation of quantitative and qualitative research methods to answer questions about the Australian mutual help group GROW program. The study investigated how GROW impacts on psychological wellbeing, how GROW members are helped and how people change in GROW.

This investigation builds on and extends research spanning 17 years into GROW in the United States by Rappaport and colleagues,[5-10] and the one other existing Australian doctoral study of mutual help conducted more than a decade ago by Young,[11,12] which also focused on GROW. These studies indicated that increased length of membership in GROW was associated with lower levels of symptomatology,[5] a reduction in duration of hospitalisation[13] and a reduction in the use of medication and professional help.[11] GROW membership has also been associated with fostering independence,[6] development of coping strategies,[7] increased sense of personal value and purpose,[12] and development of interpersonal skills.[6,7] Research into GROW employing qualitative methodology also captured a sense of change in social identity associated with involvement in GROW.[8]

Background to GROW

GROW was founded in Australia in 1957 by former psychiatric patients. The organisation's *modus operandi* falls within a well-utilised definition of a mutual help group, as being "peers who have a common predicament or illness, who come together to provide emotional and other support through sharing their personal lived experiences . . . citizens with the problem organise and control many such self help groups as voluntary associations".[14] (p. 644) Important concepts here are notions of a common problem, mutual support, and exchange of experiential knowledge or knowledge based on lived experience, and self-governance or control of

proceedings by members of the mutual help group.

In its early history, GROW sought to help its members recover from serious mental breakdowns, but later its goals broadened to the wider aims of prevention and mental health promotion.[11,12] It is estimated that some 6000 people Australia-wide have direct contact with GROW, with a total of 302 groups operating over all Australian states. Overseas, some 200 GROW groups have been established in countries including America, Canada, Ireland and New Zealand.[15]

Over time, GROW members wrote down what helped them manage or overcome their problems, and these aids or experiential knowledge are included in GROW literature.[5,11] For instance, the GROW program is encapsulated in what is called the "Blue Book",[16] a small booklet which is tapped into by group members at every GROW meeting to find solutions, aids or encouragement for others sharing problems or progress. Interestingly, the program most often used from this book could be described as layman's cognitive-behavioural therapy, employing layman's language to frame what are essentially behavioural or cognitive therapeutic strategies.[1]

Group meetings follow a highly structured "group method"[17] delineating how group time is to be spent. Importantly, this structured group procedure takes the place of a group facilitator, keeping the group on task, and preventing the meeting from becoming a free-for-all advice session. The meeting begins with a personal testimony by a group member sharing how GROW has helped them. Substantial time is then given to airing and discussion of problems or progress made.

A unique aspect of the GROW organisation is its leadership structure for running the groups. This includes roles such as leading, chairing or organising a meeting. These roles are specifically designed to extend the social and life management skills of GROW members in areas such as encouragement, welcome and support of group members and assertiveness and challenge. GROW's emphasis on networking with other members by phone and participation in residen-

tial training weekends and social activities are a deliberate ploy to enhance social and communication skills. Given that isolation and deterioration of social skills are major problems for some of the GROW population, particularly those who have been hospitalised, it is evident that GROW's operations and structure are designed not only to counter these tendencies but to actively promote the development of new skills.[5,11]

GROW operates with two-thirds government funding (although government interference is minimal).[16] A small team of paid staff, usually veteran GROW members, are employed as fieldworkers. The fieldworkers visit groups every 6 to 8 weeks to monitor and advise on group proceedings. They also run training activities where leaders enter a wider community beyond their own GROW group, to share leadership problems and progress with other group leaders.[11]

Methods

A complex research challenge

Mutual help groups are viewed as complex entities with multiple factors operating at different levels impacting on group effectiveness. This complexity presents a challenge to researchers attempting to understand how they work and their impact.[18-20] One paradigm proposed to aid conceptualisation of mutual help views an MHG as an "individual-group-community"-based phenomena, shaped by a complex and interrelated network of factors across multiple variable domains and analysis levels.[21]

In addition to multidimensional complexity, lack of researcher control has made research into MHGs difficult. Lack of control precluded scientific standards designed to enhance the validity of research, including random assignment of participants to groups, administration of equivalent treatments, or the use of placebo or delayed intervention controls.[22,23] Because controlled evaluations with MHGs are difficult, many evaluative studies employed cross-sectional designs using retrospective self-reports and convenience samples, both of which are vulnerable to validity threats.[24] Quasi-experimental studies with com-

parison groups and longitudinal research designs tracking individual functioning over time were considered a useful way of addressing the self-selection problem.[9,25] However, with regard to the former, without random assignment, the equivalence of quasi-experimental groups is unknown. Attempts to match comparison groups run into problems in defining or even operationalising a comparison group.[26-28]

Another view of mutual help group research warns against viewing MHGs as alternatives to treatment, seeking to conceptualise them rather as normative communities for living. Within this framework, a comparison between treatment programs and MHGs was described as being incongruous, in that they represent entirely different phenomena.[8,25] Participation in MHGs is not considered to be a discrete event like a treatment session, rather it is described as often including interaction before and after group meetings, as well as phone networking and social activities beyond the group.[29] Outcome goals for treatment programs and MHGs were also considered to differ,[22] the former looking to cure while the latter looked to maintenance.[30]

In the past decade, researchers have come to recognise that controlled studies of MHGs may be neither possible nor desirable for understanding mutual help groups. While experimental and quasi-experimental nomothetic research designs were considered useful, they were viewed as potentially failing to capture the complexity and richness of multiple MHG processes which required an idiographic approach.[25,29] Random assignment to comparison groups is viewed as jeopardising research validity in that the natural composition of MHGs would thereby be changed. MHGs are also viewed as not existing as an "intervention" apart from their members who are both the intervention itself and the objects of the intervention.[30] One solution suggested that a more readily answerable research question might be to ask whether a mutual help group assisted those who participated in it.[28]

The use of multiple research methods with MHGs has been recognised as the most effective way to map the phenomenon.[25] Quantitative

outcome research is still considered valuable, but as only one among a number of approaches. Qualitative research is viewed as providing important descriptive and theoretical material, as offering a cross-validation of quantitative knowing, and as being better suited to the description of change over time.[31,32] Qualitative approaches are considered to complement quantitative research, providing a rich source of information about local conditions which can assist the researcher's understanding.[23]

MHGs are described as cultural phenomena with special experiential knowledge, customs, rituals, meaning systems, ideologies or world views, and as culture-creating and culture-transmitting groups. The naturalistic paradigm including thick ethnographic descriptions and the researcher's immersion in the MHG culture over an extended period of time, as well as in-depth phenomenological interviews with MHG members to tap into their experience, is advocated to capture constructed and multiple realities.[25,33,34] Ethnography involves direct observation in the natural setting by the researcher of a behaviour, activity, process, organisation, relationships or network. Being part of the setting enables the observer to gain an experiential understanding of the setting.[23] The search for inner subjective meaning is seen as a central strength of phenomenological data. An individual's subjective impression of experiences can be examined to see how it relates to external behaviour and events, and to see how he/she makes sense of their actions.[35]

Congruence between quantitative and qualitative data is viewed as enhancing validity of findings.[36] Recognition of the value of inductive reasoning and triangulation of qualitative and quantitative research methods is widely advocated in the health literature.[37] Triangulation is defined as comparison of research evidence gathered from divergent sources to enhance accuracy of findings. The mutual help literature in particular recommends triangulation of research methods both as a means of enriching understanding and of enhancing validity of findings in an arena which cannot be controlled by the researcher.[10,23,36,38]

Research design

Triangulation of quantitative and qualitative research methods was employed to enhance confidence in the findings via cross-validation. For the quantitative study, an attempt was made to capture psychological wellbeing holistically in terms of multiple attributes such as the ability to make choices independently, coping/life management and social skills, self-esteem and a sense of purpose, and being open to new experiences.[39,40] These attributes can be seen to parallel and gather together the previous "separate" GROW study findings cited above in the literature review describing previous research into GROW. For instance, improved independence[6] and coping strategies,[7] social skills,[6,7] and a sense of personal value.[12]

Self-report measures including a demographic survey and a six-factor scale of psychological wellbeing (autonomy, environmental mastery, positive relations with others, self-acceptance, purpose in life and personal growth)[39,40] were employed in a large cross-sectional study conducted in the same time period at GROW branches around Australia. Use of medication and hospitalisation were also surveyed. A total of 2350 questionnaires were distributed to 267 GROW groups around Australia and 934 questionnaires completed by volunteer GROW members were returned from 209 groups. This represents response rates respectively of around 40% (GROW group members) and 78% (GROW groups). Returned questionnaires were screened. Where more than 25% of the data were missing on any one of the six factors included in the psychological wellbeing scales, the case was excluded from further analyses. Cases where there were critical omissions on the demographic survey were also excluded. After screening, 907 returned questionnaires were included in the study.[1]

The majority of the cross-sectional respondents came from an Australian ethnic background and two thirds were female. The mean age was 47 years with an age range of 19 to 87 years. Nearly three quarters of the respondents had been given a diagnosis: depression (49%) and anxiety (34%)

were the most frequent diagnoses, however panic attacks (23%) bipolar disorder (15%) and schizophrenia (12%) were among the diagnoses reported.[1]

Principle axes factor analysis with the cross-sectional data largely reflected the six factor psychological wellbeing scale employed. Autonomy, environmental mastery and personal growth came out as clear factors, while self-acceptance and purpose in life merged into one large factor. Positive relations with others loaded onto two factors reflecting respectively the 7 positively phrased items on the scale and 7 negatively phrased items on the scale.[1]

Zero order correlations were employed to examine the relationships between scores on these six "new" psychological wellbeing factors and demographic variables such as length of GROW membership and level of leadership role undertaken, as well as the use of medication and hospitalisation.[1]

A longitudinal survey employing a demographic questionnaire and the "new" six psychological wellbeing factors was conducted with GROW members with less than 2 months membership, with follow-up 6 months later. A volunteer sample of 54 GROW members undertook the first survey (Time 1). Time restraints prevented the collection of further data. At follow-up testing 6 months later (Time 2) only 28 of the original sample remained, representing a 52% retention rate. For this latter sample the mean age was 41 years, the age range 19–72 years and three-quarters of the sample were female. Again, nearly three quarters of the respondents had been given a diagnosis, the two dominant diagnoses being depression and anxiety. Differences between scores at Time 1 and Time 2 for the 28 subjects completing at Time 1 and Time 2 were assessed via repeated measures multivariate analysis of variance (MANOVA).[1]

Ethnographic research involving weekly observation of five GROW groups (three over a period of 6 months, and two over a period of 3 months) was employed to provide a thick description of what GROW members do within the MHGs. In total, 84 weekly GROW group meetings were observed. The researcher also attended GROW events including monthly training events for GROW group leaders, social activities and residential training weekends. Phenomenological work spanning a period of around 6 months included in-depth interviews with 24 GROW members who volunteered to describe their experiences before and after joining GROW, with a view to gaining insight into the meanings they attached to various events/experiences both within and without GROW.[1]

Thematic content analysis was employed with both the ethnographic and phenomenological data following computer-based coding of the material using a Microsoft Access program (Microsoft Corporation, Redmond, Wash, USA). Themes which emerged were refined into 8 major theme headings describing processes of change from 3 dimensions: group processes impacting on individual change; GROW group program or organisation procedures impacting on change; and individual change or outcomes.[1]

Results

Quantitative outcomes

In the cross-sectional study, bivariate correlations pointed to a moderate association between a reduction in the use of mainstream mental health services and the extent of involvement in GROW. Moderate positive correlations were found between a reduction in the use of medication and length of GROW membership, level of leadership role undertaken in GROW, and involvement in GROW leadership training events. Reported reduction in hospitalisation also correlated moderately with length of GROW membership and level of leadership role.[1]

Overall, the results for psychological wellbeing pointed to an association between improvements in autonomy, coping/life management skills, and sense of self-worth/purpose and extent of involvement in GROW activities. There were moderate positive correlations between length of GROW membership and autonomy, environmental mastery and the combined self-acceptance/purpose in

Overview of emerging themes: group observation[1]

	Group process	GROW program process	Individual process
Skills development and application			
Active-passive continuum	Encouragement by the group Challenge by the group	Practical tasks Pro-active *Blue book* content and group method	Becoming active Taking responsibility for change
Education	Group feedback/ suggestions Role models	Cognitive-behavioural therapy to develop life management skills Learning by "doing"	Learning to cope Behavioral change, cognitive restructuring
Interpersonal development	A group of people with whom to relate Universality and trust	Egalitarian organisational structure Emphasis on friendship as key to health	Development of trust Communication and social skills development
Helping	Affirmation Supportive "holding process"	Program keyed to a "mutual help ethos" while learning new skills	Maintenance of progress Inward to outward focus
Bridging skills out to the community	Practice in a "micro" GROW community	Hospital orientations Talks at GROW seminars	Using new skills in the wider community beyond GROW
Change in self-perception			
Sense of belonging	Group/community context to which to belong Universality	Regular attendance/active participation Part of a 12-step phone "network"	Member of a group Participant in a group
Feeling useful	Group provides context for being useful ("to others")	GROW program's "helping ethos" as medium for feeling useful	A purpose in helping others Role as a group member
Feeling valuable/ acceptance	Non-judgemental group approach Group acceptance	Focus on human potential Helping others as a medium for feeling valuable	Increased self-esteem/ confidence An "expert" helper

life factor. Similarly, level of leadership role undertaken showed a moderate association again with the factors autonomy, environmental mastery and the combined self-acceptance/purpose in life factor, and additionally to the factor personal growth suggesting a greater openness to new experiences or challenges as leadership skills develop.[1]

In the longitudinal study, the results indicated statistically significant improvements on the well-being factors autonomy, environmental mastery, personal growth and the merged self-acceptance/ purpose in life factor. These results combined with the Australia-wide cross sectional findings support a thesis that GROW does have an impact on psychological wellbeing.[1]

Qualitative outcomes

The qualitative work supplemented and extended findings of the quantitative study in describing process, a prime feature of group interaction. It also allowed documentation of the process of change at an individual level. The Box outlines an overview of the important themes of change which emerged from group observational data and interviews with GROW members. Two over-arching change processes, each with relevant sub-themes, were postulated, namely life skills development and application, and a change in self-perception.[1]

Movement along an "active–passive continuum" from a passive to an active stance appeared to be a fundamental change process fostered in GROW groups. Included in this sense of becoming active was improvement in members' ability to make choices/decisions and to take responsibility for change. Group and GROW program ingredients impacting on positive movement along the active–passive continuum included factors such as group challenge, support and

encouragement. "Education" in GROW also impacted positively via the *Blue book* tool kit with layman's cognitive-behavioural therapy, and a program endorsing "practical tasks" or homework tasks given out at meetings for GROW members to work on during the week. Notably, taking on a leadership role in GROW was described as a commitment which pushed GROW members forward into further action and the development of new skills. The idea of being challenged by leadership roles to undertake risks and extend skills beyond one's comfort zone was highlighted by a 40-year-old man who joined GROW with a diagnosis of depression.

> In the leadership roles I've had in GROW I have been more inclined to step forward because I was the sort of person if volunteers were called for who took two steps backward … I got into the way of doing the things which are necessary for those roles. Being a Group Organiser forces me to speak up, like when the new person comes into the group it's your job to say "Welcome". Everybody else can sit back but it's the Organiser's job to set up the meeting every week and to welcome and encourage new members. So it's just a bit of a challenge to take on that role.[1]

Interpersonal development in GROW was another important change process highlighted. Joining a group of people on a regular basis was viewed as providing a context which nurtured the development of communication and social skills. This was particularly the case for GROW members who had experienced the more severe psychiatric problems associated with isolation, loss of support network, and skills deterioration. The GROW community appeared to provide a safe environment to develop and practise interpersonal skills, together with group procedures which encouraged listening and turn-taking skills, and development of trust. This notion of change fostered within community was expressed by a man in his 40s who spent many years in isolation before he was finally hospitalised and given the diagnosis of schizophrenia. He talks about the way GROW residential training weekends put him in a safe context among a large

group of people where he started to build social and communication skills:

> … by the end of the first year I started to live-in at GROW weekends and spending time, like up until then I hadn't spent much time with people but I was at GROW weekends, sitting out until two in the morning, talking to people. And actually being with people, speaking with people, and then gradually the fear, because I had boosted my confidence, the fear collapsed for quite a long time. I began to socialise and do things outside of GROW.[1]

A pivotal mechanism in GROW group procedures, which was viewed as promoting motivation and maintenance for GROW members on a journey of change, was the practice of "helping" others. From the word go, the new GROW member appeared to be immersed in a group value system where it was clear that helping others to solve their problems was encouraged and highly valued. This could be done, for example, by offering a piece of *Blue book* program to address a problem shared, or offering practical tools based on lived experience of similar problems. Finn reported that in the act of helping, a GROW member became active, while at the same time developing a sense of being useful and valuable in the group.[1] With the adoption of a leadership role, a GROW member became involved in helping at a wider level, facilitating group proceedings by keeping the group on task and encouraging group members.[1] This helping process aligns with the well-known mutual help ethos of "helping yourself by helping others", where the helper is viewed as him/herself being assisted by helping others.[41]

The process of helping others appeared to be a central catalyst in GROW for a change in self-perception. One of the first changes in self-concept that a GROW member could experience was the development of a sense of belonging within a GROW group. A common problem (mental health) shared with other group members and the welcome, acceptance and understanding offered to help the new GROW member were described as assisting the development of a sense of belonging. In the very early stages of recovery, when commit-

ment to any strategy for change could be extremely fragile, the ability of a GROW group to foster a sense of belonging was seen to be crucial in motivating the newcomer to return to GROW meetings. A male GROW member in his 30s with a diagnosis of bipolar disorder articulated the development of a sense of belonging:

> When I joined GROW I was all by myself and so when you have got problems you bottle it up. With GROW there was a sense of connection with other people who had problems, but there was that connection that they were there to help you as well.[1]

The mutual help ethos of helping others to solve their problems was described as having the potential to bring about a further core change in self-perception from perhaps "feeling worthless and a failure" as a newcomer to GROW, to experiencing a real sense of usefulness and of personal value within community. For instance, the first time a new GROW member offered a piece of program to help another GROW member, he/she could be viewed as having moved to feeling a sense of usefulness and value in the group. This was articulated in an interview with a 30-year-old female GROW member who had been diagnosed with bipolar disorder:

> I think because you have helped somebody else and plus it's through your suffering so to speak . . . or watching other people suffering use the same GROW program that you have used and offered to them . . . it's that feeling, I've given some information here and it's been useful for that person. This makes me feel good, it makes me feel I have a purpose.[1]

Discussion

Research limitations

The findings need to be interpreted cautiously. The uncontrolled nature of this field study and the research design employed pose several threats to the validity of both quantitative and qualitative data. For both types of methodology sampling bias and self-selection could have impacted on the external validity of the findings. Generalisation of current findings across all types of MHGs is compromised because of the heterogeneity of MHGs.

The self-report data for both the quantitative and qualitative studies are subject to internal validity threats. Quantitative and qualitative information was gathered via volunteer groups and volunteer samples and is thus subject to potential bias. Outcomes on the quantitative psychological wellbeing scales employed could have been influenced by social desirability and acquiescence effects, as well as mood of the day, memory bias, and scaling effects. The qualitative research involving observation and interviews by the researcher would also be vulnerable to experimenter and social desirability effects.

Causality cannot be inferred from cross-sectional correlational research designs, and cross-sectional findings are also vulnerable to the internal validity threats of history/cohort differences and ageing/maturation. These threats are considered particularly pertinent with mental health research where, for example, level and type of medication may impact on outcomes and an individual with depression, even without treatment, is expected to return to normalcy within 6 months.

Countering these validity concerns are the reported convergent findings from triangulation of the ethnographic, phenomenological and quantitative studies. Self-selection would be of particular concern with outcomes pertaining to improvements in wellbeing associated with undertaking GROW leadership roles. However, on the basis of group observation and interview findings, while some self-selection would have occurred on the basis of innate leadership skills, this was by no means true in all cases. There were many examples in the study of leaders who had been through the revolving door of the mental health system, who had feared taking on leadership roles and yet on doing so reported that they benefited in a quantum leap. In summary, the coherent and plausible findings present a cogent picture of GROW's operations and potential impact which is worthy of consideration and further investigation.

An "in-vivo" training ground

Quantitative and qualitative findings pointed to a coherent and cross-validated picture of GROW's

impact on its membership and substantive synchronicity. The quantitative findings cross-validated the individual change level of analysis of the broad qualitative themes of proactive life skills acquisition and positive change in self-perception, and their positive association with length of time/extent of involvement in GROW. The quantitative results also suggested a positive association between personal growth, which includes an idea of being open to new experiences/challenges, and leadership-role level. This finding can tentatively be equated with the qualitative theme of being open to taking on the positive risks or challenges with GROW leadership roles. Quantitative demographic data indicated that the GROW population participating in the study was addressing significant mental health problems.[1]

The qualitative data supplemented quantitative findings and indicated that a more proactive coping stance was fostered in two important ways: firstly, within a framework of education including a pragmatic GROW program offering a layman's cognitive-behavioural therapy tool kit for addressing life challenges and problems. Secondly, within the framework of the helper-therapy principle[41] operating in GROW, positive change in self-concept was viewed as arising out of an increased sense of self-efficacy and the development of a sense of belonging, of feeling useful, and of feeling valuable, as a result of being involved in mutual helping.[1]

The study highlighted the benefits of GROW's standing as a "real life" miniature community and culture, complete with roles, social activities and phone networking. This miniature community, driven by a central ethos of mutual helping, appeared to provide the opportunity for re-entry into community for people who had become isolated and without support networks due to psychiatric problems. It also appeared to offer endless meaningful opportunities for action and thereby a change in sense of self-concept or identity. The community context was described as enabling one of GROW's primary benefits, namely achievement of goals within the framework of relationships, where the relationship opportunities or social technology provided by the community could be viewed as providing both the motivation and scope for skills development.

It is important for health professionals to realise the very real benefits which MHGs such as GROW can offer, to see them as being complementary to mainstream mental health services and as an important ingredient on the platter of therapies which can be offered to clients. For some people, particularly those with the more severe psychiatric problems, mutual help can be a vital ingredient for maintenance within community and reduction of the risk of relapse. To help raise this professional awareness, GROW members and staff around Australia were trained to present the research findings formally and directly to mental health and other health professionals. This enabled GROW to raise its therapeutic profile and increase referrals. GROW also has an active program of putting up contact posters in health sites, including general practices and mental health services. These strategies are assisting the development of important links between health providers and GROW, however ultimately a paradigm shift with concomitant systems change will be required. This would need to include changes in tertiary health professional education curricula to raise awareness of the potential benefits of mutual help groups such as GROW and other community mental health support organisations, as well as changes in health policy and funding at state and federal government level, some of which are being implemented.

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Competing interests

The authors declare that they have no competing interests.

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