Full Length Article

A student-facilitated community-based support group initiative for Mental Health Care users in a Primary Health Care setting

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ARTICLE INFO

ABSTRACT

Background: South African Mental Health Care (MHC) legislation advocates for supportive rehabilitative services in Primary Health Care (PHC) settings. PHC settings are often understaffed and MHC nurses in these settings overburdened with high patient loads. Alternative cost-effective psycho-social intervention strategies must be explored to supplement the overstrained MHC sector to meet the rehabilitative and supportive needs of service users in community settings. Using a social constructionist epistemology, this study aimed to highlight the value of a community-based support group for MHC users at a Tshwane District Community Health Centre. This was done by exploring the meaning group members attached to the group. The intervention was a collaborative partnership between a local University Psychology Department and the Department of Health, Tshwane District, utilising post-graduate psychology students as group facilitators.
Methods: Qualitative research methods were applied. Data were collected using semi-structured interviews and a collage-making and storytelling method. Thematic analysis highlighted the main themes representing the meaning the five participants ascribed to the group.
Results: The findings suggest that the group offered the participants a sense of belonging and a means of social and emotional support. The group also created opportunity for learning, encouraged mental and physical mobilisation and stimulation, and served as an additional link to professional services.
Conclusion: The findings suggest that student-facilitated support groups could offer a viable supplement for offering support to service users in PHC settings. The group assisted MHC users to cope with symptoms, social integration, and participating in meaningful activities as part of rehabilitation services.

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1.   Introduction

A central tenet of the Mental Health Care (MHC) Act No. 17 of 2002 and the National Mental Health Policy Framework and Strategic Plan 2013—2020 is psychosocial rehabilitation, services focussed on improving the lives and functional capacities of individuals with mental illness. This concept refers to an approach that combines pharmacological treatment, skills training, as well as psychological and social support focussed on improving the social functioning of service users (Kramers-Olen, 2014; South African Department of Health, 2012). As part of the psychosocial rehabilitation plan, MHC legislation thus promotes the provision of support groups for MHC users in Primary Health Care (PHC) settings (South African Department of Health, 2002).

Community-based social support encompasses services offered within community settings aimed at helping service users cope with their mental illness and improve their quality of life. Such services are supportive, educative, and empowering in nature and could be offered in the form of psycho-education or group initiatives (Becker, 2010; Sturgeon & Keet, 2010). Currently, there are limited community-based MHC resources available to meet the rehabilitative and support needs of service users (Kramers-Olen, 2014; Morgan & Sherry, 2016). MHC service providers in PHC settings are burdened with high patient loads and insufficient staff, which negatively impact services rendered. This calls for creative ways to supplement MHC resources in PHC settings (Parker, 2012).

The difficulties MHC users endure reach beyond their symptoms and may include a multitude of challenges depending on the severity and chronicity of their illness. These may include job loss, unemployment, stigmatisation, social isolation, inactivity, and difficulty with co-ordination, planning, and execution of social engagements (Drake & Whitley, 2014; Gard et al., 2014; Kramers-Olen, 2014; Malchow et al., 2013). Medication alone is not enough to treat mental illness and subsequent challenges. Psychosocial interventions are instrumental in the recovery process and are linked to more favourable health outcomes (Botha, Koen, Oosthuizen, Joska, & Hering, 2008; Kramers-Olen, 2014). Support groups could offer cost-effective psycho-social intervention to meet the social and emotional needs of service users in community-based settings (Becker & Duncan, 2010; Kramers-Olen, 2014). Group settings provide opportunities that could improve service users' quality of life, such as social support and integration, opportunities to regain autonomy, and participating in meaningful activities (Drake & Whitley, 2014; Kramers-Olen, 2014).

This paper explores the meaning MHC users in a PHC setting attached to a student-facilitated community-based social support group. The research highlights how the group members benefited from the initiative, to offer some support for the feasibility of such initiatives as a means to provide additional supportive services to MHC users.

1.1.   Support group intervention

This research was a collaborative effort between a local University Psychology Department and the Department of Health, Tshwane District. Fourth year psychology students were placed at PHC clinics and Community Health Centres (CHCs) around Tshwane to assist mental health nurses (professional nurses with specialised training in mental health or psychiatry) to establish support groups for MHC users as they lacked the capacity to develop and maintain the group services recommended by MHC legislation.

The project leader offered skills training to students prior to their placements. This entailed four weeks of 2-h sessions which focussed on establishing groups and group norms, basic counselling and group facilitation skills, needs assessments, and action research. As the students began to set up and facilitate the groups, weekly supervision sessions were held. The project leader purposefully adjusted his role over the course of the year to enable students to become a support network for one another. There was a focus on ethical behaviour, including the limitations of these interventions and when to refer group members for additional treatment. Ad hoc support was also provided by the clinical psychologist on site and the mental health nurse as required and when available. Referral routes to mental health and other services were elucidated for participants in need of further assistance. Students were expected to spend at least 1 h per week at the specific site and were required to attend all contact sessions with the project leader and arrange for on-site support as necessary.

Students established collaborative partnerships with the mental health nurses and psychologists at the various sites. Initial contact meetings with the service providers served to determine the unique needs of the sites. The type of group depended on the specific setting and the focus of the groups were either psycho-educational or supportive. The interventions were not manual-based but designed to address the specific needs identified at each site. Some groups were focussed on social support due to stigmatisation and social isolation of MHC service users, while others were more focused on offering psycho-education due to service users' need for information. However, the specific focus of the groups could change according to the particular needs of the attending service users.

The group discussed in this paper was a support group initiative at a CHC in the Tshwane District. The nurses identified service users attending the clinic who were socially isolated due to stigmatisation who could benefit from additional support and socialisation. The group was initiated in March 2010, for MHC outpatients who received on-going pharmacological treatment from the CHC, and continued onwards with weekly sessions for five consecutive years. Group facilitators were replaced each year with newly enrolled students.

The service providers were instrumental in promoting the initiative. They used their unique knowledge of the service users and the difficulties they experienced to refer MHC users that could benefit from the group. The invitation to join was open to any MHC users who showed interest. An open group was formed to encourage project continuity. This allowed new members to join at any time and existing members to exit when they desired. Group members, therefore, changed throughout the years. Each year there were approximately ten to twelve service users involved in the group and the group

size fluctuated between six to eight members at a time. Members were heterogeneous regarding age, gender, and diagnosis which included schizophrenia, panic disorder, major depression, and bipolar disorder.

A needs analysis with the group members conducted at the outset highlighted a desire for information on mental illness, medication, and side effects. A need for socialisation and physical activities was also highlighted. Group activities thus included psycho-educational discussions, playing games and singing songs, sharing experiences, offering advice for problems and difficulties, and a fundraising project that involved the selling of second-hand clothing. The money raised through the fundraising initiative allowed the group to go on annual outings.

Initially, the interaction amongst the members was reserved, but the researcher noticed considerable changes in the interaction patterns of regularly attending members after some time. These observations sparked the research initiative to explore what the members gained from attending the group.

1.2. Researcher's position in the study

The researcher was involved in the establishment of the group and kept contact with the core members for the following five years. The dual-role status of researcher and group facilitator warranted the insider researcher perspective (Blythe, Wilkes, Jackson, & Halcomb, 2013; Greene, 2014). This position bore unique strengths and challenges for the research process and required careful consideration. Advantages inherent in the long-standing relationship with the participants encompassed in-depth knowledge of the research context, which enabled the researcher to ask meaningful questions, probe meaningfully, and afforded the ability to project a unique and authentic understanding of the topic (Greene, 2014).

The greatest challenge requiring cognisance was guarding against over-subjectivity and personal bias, making assumptions based on pre-existing knowledge and experience with the participants, and reporting of favourable findings (Greene, 2014). It also required caution of the power differential between the researcher and the participants, considering that they might have been subjected to social desirability bias by over-reporting positive aspects and experiences. In an effort to mitigate these challenges, a social constructionist epistemology was adopted.

1.3. The guiding epistemology

Social constructionism is concerned with the co-creation of meaning between people in social relationships (Burr, 2003; Gergen, 1985). It holds that people come to know the world through their interpretations of it, allowing for multiple, equally valid accounts of truth (Burr, 2003). Adopting this epistemology allowed for the co-construction of meaning between the researcher and participants by drawing on their unique history.

Five social constructionist assumptions (Burr, 2003; Du Preez & Eskell-Blokland, 2012; Gergen, 1985) informed the research processes namely: 1) The co-construction of meaning between people in social contexts; 2) The role of language in the construction of lived experiences; 3) Social relations as a context for meaning making; 4) The fluidity of identity; and 5) Influences of power on people's construction of reality and meaning making processes. These assumptions guided the research and analytical processes and offered the backdrop for the researcher to make sense of the participants' stories.

1.4. Research aim

The research aimed to explore the meaning the participants attributed to the support group to highlight the value of the initiative. The primary research question was: What meaning did the group members attribute to the group?

2. Research methodology

A qualitative research approach was employed. Qualitative methods are characteristically open ended and flexible to enable the emergence of new and unanticipated participant-generated categories of meaning and experience (Creswell, 2014; Willig, 2008). In qualitative research the number of participants does not determine the quality of the research, but the value rather lies in the richness of the stories obtained from participant-led data collection methods (Willig, 2008). Qualitative data collection tools allowed for the elicitation of rich descriptions of the participants' group experiences to gain a deeper understanding of the meaning they attributed to the group (Willig, 2008). Their stories were used to determine what being part of the group meant to them and offered evidence for the potential value of community-based support groups in the rehabilitation process of MHC users.

2.1. Selection of participants

During the time of data collection the group consisted of eight consistent members. Due to the open nature of the group, members left and joined the group depending on their needs and availability. Eligible participants were selected through purposive sampling (Babbie, 2013) based on two inclusion criteria: (a) Participants should have had group membership for a minimum of one year to ensure sufficient experience with the group to create meaning regarding the group's value; and (b) Be asymptomatic at the time of data collection as affirmed by the mental health nurse with whom they had a long-standing relationship. This was to ensure that the participants were fully capable of providing informed consent and able to participate in the research activities. All active group members who met both inclusion criteria were invited to participate in the study. Previous members who had left the group could not be reached to extend the invitation for research participation. Some had moved to different communities, some were working and not available for interviewing, and others' contact numbers were no longer valid.

Five of the core group members voluntarily participated in the study: four males and one female, all of African origin. Their ages ranged from 23 to 60 years. All suffered from severe and chronic mental illness including schizophrenia and

bipolar mood disorder with psychotic features. They were of lower socio-economic status, unemployed, and received disability grants. The small sample size is in accordance with the characteristics of qualitative research (Stein & Mankowski, 2004; Willig, 2008), which focuses on richness and uniqueness of experiences, rather than numbers. Unique experiences were unveiled through qualitative approaches which offer a deeper understanding of the participants' lived experiences and what being part of the group meant to them (Willig, 2008).

2.2.   Data collection methods

Data collection took place in two consecutive phases at two separate occasions. Phase one entailed individual semi-structured interviews that elicited information on the participants' biographical profiles, their mental illness history and diagnosis, treatments received, reasons for joining the group, their experiences with the group, and what the group meant to them.

Phase two encompassed the Collage Life-story Elicitation Technique (CLET), a narrative story-telling technique that utilises collage making to gain a deeper understanding of how individuals experience relationships, and how societal customs, attitudes, and interactions influence individual's perceptions and experiences (Van Schalkwyk, 2013). The participants were asked to make individual collages using pictures, taken from local magazines, to represent what the group meant to them. The participants were asked to share their story of their collages and explain the significance of the pictures in relation to the meaning it represented of the group. Probing techniques were used when necessary. The CLET was used as an additional data collection tool as it assisted the participants with the recollection of memories of their group experiences and to structure their experiences in a unique way while creating their collages. The participant-led story telling that followed the collage making also limited the researcher's biases to influence the interviews. It could be considered to generate more authentic information (Lijadi & Van Schalkwyk, 2014).

Both interviews were conducted with the assistance of an interpreter, allowing the participants to express themselves in their vernacular. All interviews were audio recorded with the participants' consent.

2.3.   Data analysis

The interviews were transcribed and translated into English by two research assistants from the local community. The transcripts were cross-checked for accuracy against the audio recordings. Discrepancies were highlighted and addressed. Conflicting discrepancies were resolved by the on-site interpreter.

The datasets from the two data collection phases were not treated as separate entities. The collages served as a reference during the phase two interview processes in assisting the participants with the recollection of memories and the construction of their stories. All the transcripts were thematically analysed according to the six phases suggested by Braun and Clarke (2006) which entailed the following: 1) Reading the interview transcripts several times with the research question in mind to become familiar with the data, noting initial ideas; 2) Coding pieces of text; 3) Searching for themes by reviewing codes and quotations and grouping relevant codes; 4) Reviewing the themes to ensure the data accurately reflected the overarching theme; 5) Naming themes; and 6) Reporting the findings by providing extracts to demonstrate what constitute the themes and sub-themes.

2.4.   Measures of trustworthiness

Strategies employed to ensure the trustworthiness and authenticity of the findings included Guba's constructs of credibility, transferability, dependability, and confirmability (Shenton, 2004; Tobin & Begley, 2004). Credibility was enhanced by means of the researcher's insider position, prolonged engagement, and well-established relationship with the participants. The phase one interview schedule was pilot tested to ensure it elicited relevant information. Data analysis by an independent co-coder assured the credibility of the findings. Member checks were conducted during individual debriefing sessions with the participants to establish whether they agreed with the findings and to offer them an opportunity to reflect on their research participation and provide final contributions (Creswell, 2014; Denzin & Lincoln, 2011; Van Schalkwyk, 2013).

Transferability was met by means of offering detailed background on the research context to allow audiences to draw comparisons to other similar settings. Measures of dependability included detailed documentation of the research methodology and processes, allowing for replication of the study. Triangulation of findings from the two phases of data collection using different data collection tools also contributed to dependability. Strategies of confirmability entailed continuous reflexive commentary and documenting an audit trail of the analysis to illuminate personal influence on the research processes and findings.

2.5.   Ethical considerations

The research received ethical approval from the Department of Psychology's Research Ethics Committee at the University of South Africa (Reference number: PERC-12009). Permission to conduct the research was obtained from the Tshwane Research Committee at the Department of Health and Social Development, Gauteng Province (Project number: 11/2013), the head of the CHC, and the mental health nurses.

All participants provided written informed consent after receiving a detailed explanation of the research purpose, aim, and processes with the help of an interpreter. Participation was voluntary, and they could withdraw from the study at any time with no negative consequences (APA, 2002; Fisher et al., 2002). The mental health nurse confirmed that all participants were asymptomatic at the time of data collection. Participants were treated with respect and dignity, and confidentiality was maintained. Although it was not foreseen that their participation would cause psychological distress, the local psychologist was available to offer the required support if necessary (APA, 2002; Fisher et al., 2002).

3.   Findings

The major themes and sub-themes highlighting the meaning the participants ascribed to the group are presented.

3.1.   Theme 1: a sense of belonging

In their community, the participants felt stigmatised and socially alienated because of their mental illness. The group offered an opportunity for social interaction, which gave them a sense of belonging and opportunities to experience a sense of normality. Participant 1 said: …*[in the group] we did many things, we had fun. We were sharing things… we eat, we drink tea, and we go to the movies…*

Participant 2 recalled a time when the group celebrated his birthday: …*I was excited when you did [a] birthday [party] for me… we were celebrating, all of us, eating cakes and drinking cold drinks…*

Participant 5 shared how the group offered him a sense of belonging opposed to the social rejection he experienced in the community:

> …*it [the group] helps me… because I'm mentally disturbed nobody wants me and I'm always alone. But when I'm in the group, when we are together I feel alright, because when you are alone all the time you will not live freely and it's like you are not alright, but when in the group, I am alright.*

3.2.   Theme 2: a source of support

The participants highlighted the group as an important source of support. They described receiving support from the facilitators and their peers.

3.2.1.   Support from group facilitators
The participants expressed appreciation for the support they received from the group facilitators. Participant 3 explained how being with the facilitators consoled him: …*it's these (facilitators) that help us… they make us play games, it's them who teach us games, they console us.*

Participant 1 described his appreciation for the group facilitators' support:

> *You group leaders… you don't get angry with us, but you always accept the way we are… We forget things, we've got side effects, we've got many things on our plates that we cannot manage… You, the group leaders, you help us with that…*

3.2.2.   Peer support
The group setting also afforded an opportunity for peer support. Because all the members lived with mental illness, they could relate to each other's difficulties and offer consolation and advice. Participant 5 said:

> …*when we are in the group we can give each other strength and advice… and when someone has a problem we can talk about our problems… the hospital helps us with medication and the group members with advice…*

Participant 5 alluded to the value of medication in treating psychotic symptoms, but he also highlighted the importance of social and emotional support. Participant 1 described how sharing his academic stresses in the group benefitted him. He said: *I'm still fighting to get my—to go to university… Being with them, sharing, helps me…*

3.3.   Theme 3: the learning experience

This theme illuminates the various forms of learning that took place in the group. Psycho-educational discussions allowed for structural learning and interpersonal learning took place between the members through sharing stories and experiences.

3.3.1.   Psycho-education
Group members suggested various topics to discuss during group sessions which offered them information on mental and other physical illnesses, side effects, and how to live healthy lives. They felt the information empowered them. Participant 2 said:

> *[The] group [facilitators] was showing us everything, they were telling us about side effects, depression, and TB… and HIV… It was good being in the group because I now know about illnesses and how to prevent them.*

Participant 3 shared the value he attributed to the psycho-education:

> …*they taught us and we were exercising and getting taught about mental—the brain, and that you have to drink the pills… and if you don't drink your pills what sort of person you are going to be… You will end up going back to the hospital again… they gave us knowledge to save ourselves…*

3.3.2.   Interpersonal learning
Interpersonal learning took place through sharing stories and experiences. The group members shared similar experiences living with mental illness, which allowed them to offer empathetic understanding, advice, and suggest solutions. Participant 4 described how she taught the group members physical exercises and songs and how the group offered the members opportunities to learn from each other:

> *We were exercising. I was teaching them exercises and also songs… I showed them what I know and they did it… (Participant 1) was alright and he was also educated, so most of the time where I did not understand I would ask him and he would explain to me…*

Participant 5 explained how the group members offered him advice that helped him deal with his problems:

> …*this group helped me with advice after I explained to them about problems I'm experiencing where I stay… they told me not to be fazed by them and only look at my medical state…*

3.4.   Theme 4: mobilisation and stimulation

Theme 4 highlights the value of the fundraising project and other group activities. These activities mobilised and

stimulated the group members both mentally and physically. Two comprising sub-themes demonstrate this.

3.4.1. Group project and outing: opportunity for goal-setting, ownership, and reward

Participant 3 described how rewarding the group outing was for him, allowing him to travel somewhere new: *…like the trip we had of going to (mall), I have never been there, it was the first time going there…*

Participant 1 described a sense of autonomy brought about from being able to raise funds and go out with his peers. He expressed feeling a sense of accomplishment, despite his initial doubts that they would be able to successfully reach their goal:

> *We were travelling in a group—it was nice. It was like, exploring, like a journey. …'cause we did something… even though we never thought that it was something, but we reached that, we went there (to the mall) and then we watched the movie… in life people like to be free and do stuff on their own…*

3.4.2. Group activities: tools for physical and mental stimulation

When the participants were asked what they enjoyed about the group they mentioned the physical activities and games. Participant 1 mentioned: *…playing soccer, it was nice… We don't get bored, we keep ourselves busy with (group facilitators)…* Participant 2 said: *…we were playing cards, playing games and putting square blocks of wood on top of each other…*

3.5. Theme 5: the group as a link to professional services

The MHC service providers sometimes attended group sessions, which resulted in positive relationships with the service users. This was demonstrated by Participant 4. She included pictures in her collage that represented the mental health nurses and psychologist. She explained her experience of her follow-up interviews with the nurse when she was asked about the importance of the pictures:

> *I chose it [picture] because (mental health nurse) retired and she doesn't come anymore, so I remember her with it. Its importance is that when I came to the clinic to collect my medication she would ask me how I feel, am I sleeping well, is the medication treating me well, do I sleep well, do I eat well?*

Participant 4 also mentioned how the psychologist supported them in the group:

> *It [picture] reminds me of (psychologist), the time I was stressed and she called me to her office and asked me how I am and also asked me questions and gave me advice. She told me not to think too much, to remove old stressful things from my heart, the way I was living… It [picture] is important because (psychologist) was giving us advice and she was supporting us in the group…*

4. Discussion

The findings suggest that the group offered the participants a sense of belonging, a means of support, created opportunities for learning, encouraged mental and physical mobilisation and stimulation, and served as an additional link to professional services.

Theme one encapsulates the socialisation and sense of belonging the group offered the socially isolated participants. Participants shared experiences of stigmatisation that lead to their social isolation, often experienced by MHC users (Drake & Whitley, 2014; Tsai, Desai, & Rosenheck, 2012). This could lead to a deterioration of social skills and the construction of negative social identities as being unwanted, apart from other functional difficulties that might result from their mental illness (Crabtree, Haslam, Postmes, & Haslam, 2010; Shotter, 1997; Shrivastava, Johnston, Thakar, Stitt, & Shah, 2011). Participants indicated that the group offered them a space where they could socially engage with others and experience some sense of normality.

Theme two suggests the supportive value of the group, offering opportunities to share difficulties and concerns and provide emotional support. Social and emotional support services that promote social participation of MHC users in community-based settings are instrumental for maintaining positive mental health outcomes but are often limited (Arboleda-Flórez & Stuart, 2012; Drake & Whitley, 2014; Tsai et al., 2012). MHC users with psychosis often have small social networks and strained interpersonal relationships (Fleury et al., 2013). The supportive social networks offered by support groups are instrumental in the rehabilitative process as it restores a sense of normality and has the potential to increase MHC users' subjective quality of life (Fleury et al., 2013).

Theme three illustrates the various opportunities for learning afforded by the group setting suggesting that the group met the participants' need for information. Support groups are also a viable means to provide psycho-education to MHC users, a well-established rehabilitative intervention (Chadzyńska & Charzyńska, 2011).

Inactivity and difficulty with goal setting, coordination, and planning are characteristic of severe mental illness (Gard et al., 2014; Malchow et al., 2013). Theme four highlights the value of the group project and physical and mental group activities by providing group members with opportunities to increase their activity levels, and to learn goal setting through group projects. The project served as an achievement-focussed activity that assisted the members to regain a sense of autonomy which is instrumental in the recovery process (Drake & Whitley, 2014; Gard et al., 2014). The other activities such as singing, playing soccer, and board games offered opportunities to engage in pleasurable activities that stimulated positive feelings and combated boredom resulting from their inactivity.

Theme five demonstrates how group meetings allowed MHC service providers to have additional contact with the service users apart from their monthly follow-up appointments. The support networks of MHC users have been shown to be compromised and strained due to stigmatisation and social isolation they endure because of their mental illness (Tsai et al., 2012). As a result, they rely heavily on professional support. MHC service providers in PHC settings are challenged with high patient loads (Botha et al., 2008). Follow-up interviews with service users are important to monitor symptoms, treatment adherence, and early relapse identification. Due to staff shortages and high patient loads, sufficient time

for follow-up interviews is not feasible resulting in the required support or psycho-educational information being limited (Botha et al., 2008). The findings demonstrate how the group served as an extra link to professional rehabilitative services. It allowed the mental health nurses and psychologist to have additional contact with the service users, allowing for early relapse identification, and an opportunity to observe how the members functioned in a social setting.

These findings suggest that the group was supportive, educative, and empowering in nature and thus a viable means of offering additional community-based rehabilitative services to the service users (Becker, 2010; Sturgeon & Keet, 2010). It provided group members opportunities to offer support to others, regain a sense of autonomy, and engage in meaningful social activities. This is opposed to the stigmatisation and social isolation they endured in the community that deprived them from such opportunities and in turn negatively affected their internal dialogue and self-perception that they were not worthy, functional members of society (Shotter, 1997). It could be argued that the group context allowed the members a space where they could challenge the negative discourses about mental illness and themselves as not being worthy members of society and reconstruct more positive identities of themselves within their newly found social roles they created within the social interactions that took place in the group setting (Burr, 2003; Shotter, 1997).

5. Limitations

Social constructionism rests on the notion that people construct particular accounts of the world when they think and talk about the world (Burr, 2003). Based on this notion one needs to note the subjective nature of the participants' experiences reported here. These findings represent the participants' unique experiences within the specific context and are not generalisable to other MHC users or groups that took place in other settings. However, Gergen (1985) asserted that knowledge systems depend on communities of shared activity that is largely governed by normative rules, suggesting that these findings could hold merit in other contexts.

The value of this initiative was represented through meaning that was shaped by the unique social processes, discourses, and language of the particular setting and are thus relative to the study (Gergen, 1985). The social construction of the meaning are value-laden, uniquely influenced by the biases, interests, and power relationships between those involved in the research processes (Edvardsson, Tronvoll, & Gruber, 2011; Gergen, 1985). These findings are therefore not a representation of an objective truth as meaning is influenced by unique political and social agendas (Hoffman, 1990). Moreover, the sample comprised of majority male participants who suffered from chronic and severe mental illness. A different sample composition might have ascribed different meaning to their group experiences.

The small sample size is another limitation, however, the significance of these findings lies in the unique stories shared by the participants which offered some insight into their lived experiences. Qualitative approaches are not meant for generalisation, but rather to "give voice" to the unheard narratives of a marginalised group in the hope of inspiring and promoting social change (Stein & Mankowski, 2004). The participants' stories offer some motivation to promote the value of student-facilitated community-based support groups for MHC users as a cost-effective rehabilitative service.

6. Recommendations

The qualitative findings provide valuable insights and experiences of a small sample of MHC users. The group assisted MHC users to cope with symptoms, social integration, and meaningful activities as part of rehabilitation services. Additional research could help to determine the benefits and impact of support groups on the rehabilitative process of service users. Replication of similar research in other clinics and CHCs including larger sample sizes could further highlight the value of support groups for MHC users in PHC settings as a means of offering additional resources to assist overburdened service providers.

Research exploring group facilitators' and MHC service providers' perception regarding the feasibility and acceptability of these interventions could offer valuable insight into effective implementation strategies of student-facilitated group initiatives in PHC settings.

7. Conclusion

Offering support groups at PHC level is a requirement stipulated in MHC legislation. However, service providers in under-resourced mental health clinics do not have the capacity to make these services available (Kramers-Olen, 2014; South African Department of Health, 2002). These findings offer some evidence of the potential benefits of utilising student-facilitated community-based support groups as supplementary rehabilitative resources to strengthen the underdeveloped mental health resources in PHC settings to meet the service requirements for support groups stipulated in the MHC legislation (Mendenhall et al., 2014). Moreover, it contributes to the paucity of local research on psycho-social rehabilitation in community-based settings. MHC users are entitled to have access to community-based support services which is instrumental to the rehabilitative process. These findings offer valuable insights to those with a vested interest in MHC by highlighting the importance of offering social support to service users by means of student-facilitated group initiatives.

Role of the funding source

Authors' contributions

L.M. (University of South Africa) was the masters degree candidate and primary researcher, involved in drafting the paper. M.V. was the co-supervisor, assisting with the drafting

of the paper, reviewing, and final evaluation. N.T. was the supervisor, involved in the reviewing and final evaluation of the paper.

Acknowledgements

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