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The Value of Togetherness Across Cultures

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Consideration of alternative ways of workings is necessary for inclusion and our aim of achieving greater collaboration across communities. This is something we feel passionately about—developing a shared vision of what services could or should look like through stronger partnerships and integration. For us, this means being creative about how we approach our work and considering alternatives, beyond the evidence base. This often leads to inventive ideas, drawing on some excellent examples of how other cultures engage with people, beyond the therapy room. Working in this 'innovative' way helps us to challenge the status quo and ask those accessing services what they want, what they need and what ideas they have for how psychological support (in any guise) could be different, or better. Who wouldn't want to work in this way?! New ideas and ways of working involve developing aptitude to be sensitive, and listening and responding to the silent voices in society.

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In June 2016, as part of our doctoral training at Lancaster University, we undertook an innovative[1] placement in Malawi, a country located in the South Eastern region of Africa. This placement was facilitated in collaboration with St John of God Hospitaller Services and the Umoza Trust Charity.

This placement had a profound effect on our learning and development in both a professional and a personal capacity. Specifically, we began to consider cultural influences on the ways in which we conceptualise mental health and how families and communities form part of these conceptualisations. Furthermore, this placement provided us with first-hand observations of how mental health services can excel in spite of the limited financial resources.

Wealthy countries generally have more services to combat mental health problems in comparison to lower-income countries. McKenzie et al. (2004) reported that there are limited number of mental health resources, medications and practitioners working throughout lower-income countries. Given this disparity, it is easy to conclude that there is little that can be learned from lower income countries in relation to mental health service provision, but this is not the case (McKenzie et al., 2004). While greatly under-resourced, our placement taught us that there is a lot to learn, born from the ingenuity of necessity and cultural knowledge. This chapter aims to share some of these observations and learning points, drawing on our reflections and considerations of how mental health services can utilise creativity, community-centred approaches and togetherness in a way that supports people experiencing psychological distress.

[1] 'Innovative' in the sense that this placement was outside the traditional parameters of working within the National Health Service in the UK. Rather, this placement was organised in collaboration with a charity, Lancaster University and a local organisation supporting mental health in Malawi.

Setting the Scene

Malawi has a population of approximately 17 million, and currently there are just two clinical psychologists working throughout the country. According to the World Bank (2017), at least 50% of Malawi's population live in poverty, and as such, it is regarded as one of the poorest countries in the world. In 2005, the World Health Organization (WHO) reported that 70% of African countries contributed less than 1% of their health expenditure to mental health resources. From our observations, we learnt that there are limited services in the country generally, but there appeared to be a good structure around what was offered via St John of God (SJOG).[2]

SJOG is an international Catholic-based organisation which endeavours to provide support to vulnerable people, namely those experiencing physical and mental health difficulties. SJOG currently provides support to people in over 50 countries. The order in Malawi was initially established in the northern city of Mzuzu, in 1993. The organisation in Mzuzu provides a number of services to local people including mental health inpatient wards, a drug and alcohol rehabilitation unit, a child development centre (for children with physical and learning disabilities), a street children programme, older people's community centres, women's groups, vocational colleges, community outreach, drop-in centres and in-reach services for those detained in prison. In 2016, SJOG extended its strategic plan to begin to offer support to other people within the country, and as a result, a further inpatient unit was built in Lilongwe, the capital of Malawi, with the vision to replicate the services in Mzuzu. During our placement, we were based in Mzuzu and had regular input into the SJOG mental health inpatient wards, older adult services and the child development centre.

SJOG has developed an infrastructure for primarily supporting mental health needs. SJOG endeavours to do this through the promotion of specific values, namely hospitality, respect, compassion, justice and excellence, which are noticeably aligned with core values of the UK National Health Service.[3] These SJOG values were certainly apparent throughout our placement; we were made to feel extremely welcome and the hospitality, compassion and

[2] It is important to note that while SJOG is a Catholic-based organisation, there is no expectation that employees, clients or volunteers identify as Christian. Further, individuals who do not identify with the Christian faith are not excluded from services. Furthermore, SJOG services are not run by Catholic priests or Brothers. Lay people or co-workers of SJOG are fully in-charge of the operation of the organisation, with its mission being to continue the work of hospitality and compassion John Ciudad started in the 1400s.

[3] The NHS core values centre upon working together for patients, doing so with respect and dignity, being committed to providing quality of care, demonstrating compassion and valuing each individual.

respect shown to us by people of the organisation and further afield were heart-warming. Indeed, Malawi is known as 'the warm heart of Africa' and many residents expressed their pride towards this sobriquet and were eager to demonstrate this aspect of their cultural identity. Many local people made contact with us and were enthusiastic to make friends.

While we were extremely grateful to receive such warm and welcoming greetings, we could not help but compare our experiences to those who may visit the West, and we were hit with a sense of humility at how their experiences are likely to have been very different to our own, particularly in the wake of momentous political shifts to the right. We were therefore struck with how the values of SJOG, as an organisation, were united with the values which seemed to be embedded within Malawian culture. 'Umoza' is a word used in Malawi meaning 'togetherness' or 'oneness'. During our placement, we quickly came to learn that 'umoza' is more than just a word; it is a felt sense of connection, community and belonging underpinned by acceptance and genuine compassion. Trying to convey the power of this felt sense is, however, extremely difficult to achieve via written format, but it is safe to say that we felt included and part of a community, and regardless of how temporary this was, it felt genuine and honest. By 'community', we mean we felt a strong sense of shared motivation and ethos to support one another, as part of a society that believed it should take responsibility for caring for others.

As psychologists, we were interested in how we both shared this profound connection with a culture that felt very different to our own. We spent time reflecting and questioning each other about the mechanisms at play. We considered the role of our demographics in this experience, yet similar discussions with other visitors, in particular, left us to conclude that there was a very real and powerful hospitable nature to the culture, which meant that adjusting to life back home in the UK was extremely challenging.

From returning home it became quickly apparent that a sense of disconnection and isolation were commonplace in our familiar society. Furthermore, we were struck by the emotional impact that this had on us both. We considered how societal influences can have a significant impact upon one's psychological well-being and, as relatively healthy individuals, it highlighted to us just how much society can influence well-being and how this influence may be much more profound for vulnerable people living in this context. Indeed, the milieu of austerity, neo-liberalism and social inequality brings with it a sense of dividedness and segregation. Our aim for this chapter is to, therefore, explore the ways in which 'umoza' may be integrated within services that are set up to support vulnerable citizens. Furthermore, we hope to draw upon the values of community psychology to consider issues related to social justice around the experience of distress and provision of mental health services.

Service Provision in Malawi

The sense of community, connection and togetherness featured strongly throughout SJOG service provision and development. As outlined earlier, SJOG offers a range of services that were set up in an attempt to support the needs of people in the local area. One of its most recent initiatives involved the development of an older adult service, which was initiated when programme managers became aware of loneliness affecting this population. The loneliness and isolation experienced by many older adults has been suggested to be a result of the HIV epidemic, where there was said to be a 'lost generation' following the deaths of many citizens in the 1990s. As a result, many of the older adults lost their children and are now experiencing isolation due to diminished family networks. It is worthwhile reflecting that stigma surrounding HIV in congregational settings remains an issue for many across the world, bringing shame and casting blame. Derose et al. (2016) discuss this as being associated with religious taboos surrounding homosexual contact between men, perceptions of individuals having multiple sex partners and drug use, which are likely to be viewed through a moral lens. While the role of religion is an important factor to consider with regard to context, empathy and provision of care, we experienced of SJOG as holding high levels of compassion for those affected by HIV and/or AIDS.

The older people's services operate from within the same grounds as local schools and within village centres; this was done to make use of available resources that were cheap whilst simultaneously integrating older people within their communities, aiming to reduce isolation. Integration within communities is further enhanced via community awareness events coordinated by SJOG and service users, which aim to educate communities on the needs of older people and challenge stereotypes and stigma. This is often done via the media of song, dance and drama as a way of engaging people in accessible and creative ways, drawing on personal interests, strengths and talents. We witnessed a community event, whereby service users wrote and performed a play that challenged historical narratives disseminated by witchdoctors, suggesting that older people were witches and wizards, which had a residual stigmatising effect for some older people. The aim of the play was to relieve the burden experienced by older people and provide alternative accounts of their experiences that stepped away from narratives that may increase fear. It is noteworthy that our observations of this run alongside acknowledgement that 'witchdoctors' may be regarded as healers, and it is not our intention to demonise traditional cultures, but recognise some of the stigmatising impact

historical narratives had on the older people we met. Individuals working with SJOG supported local communities to challenge deep-rooted assumptions around causes of dementia being related to witchcraft (ActionAid, 2013), with a view to reducing fear, discrimination and social isolation (Mkhonto & Hanssen, 2018).

The emphasis on improving community connections features prominently within SJOG and as such they facilitate a programme, called Self-Help, which aims to empower women, many of whom are parents/guardians of service users across the services and formerly depended on unsustainable handouts from the Saint John of God Brothers[4] and Social Work department. This project enables small groups of women to come together to share financial resources in a means tested way, in order to invest and stimulate economic growth within the group. Any profits are then shared equally amongst the group and the process is repeated, with all members benefitting as the investments and profits gradually increase. The results of Self-Help have been further shown to have significant benefits for the wider communities as many women in the group choose to invest in more community-based projects.

Simultaneously, this mobilisation of women challenges gender-biased discourses and gives women the influence to make positive changes for themselves, their families and, as has been found, their communities. Similarly, people residing within the SJOG inpatient facility are provided with opportunities to learn and develop skills, and the vocational programmes offered by SJOG are also done to provide people with the necessary skills and knowledge to achieve financial independence. This is pertinent given historic models of aid have only served to magnify many people's dependency.

SJOG therefore works in a way that is congruent with the Chinese proverb, 'You give a poor man a fish and you feed him for a day. You teach him to fish and you give him an occupation that will feed him for a lifetime'. (The irony that this proverb uses a masculine object is not lost on us, but we hope that it offers an example of the motives behind such programmes.) Nevertheless, it remains important for communities to challenge the discourse that donations are the best way to help those experiencing poverty; instead it is the provision of opportunities to help people acquire skills and knowledge that will help communities to thrive. Indeed, while in Malawi we were introduced to a film (*Poverty, Inc.*) that reflected on how non-governmental organisation donations and charities can have a negative impact on the local economy. The

[4] Throughout Malawi, there are also God Sisters within the Catholic community. The basis for supporting individuals to increase their financial independence was described to us as being related to the teaching, 'teach them how to fish rather than giving them the fish'. This is also fuelled by a wider context that requires individuals to be self-sufficient to some extent since no financial support is provided by the State.

filmmakers argued that while 'free handouts' are well intentioned, they have a damaging effect on long-term development. As we witnessed locally, partnerships can better support empowerment through providing small financial relief initially that enables individuals to take ownership and develop their own business through their unique skills. Of course, this remains a strong area of debate, with organisations such as GiveDirectly presenting strong evidence to indicate the positive longer-term impact of direct cash transfers in supporting health, future income generation, food security and mental well-being. Perhaps wider reflection on structural inequalities and Western influences of models of economic growth are required to challenge the factors maintaining poverty (such as structural adjustment programmes by the World Bank and International Monetary Fund), rather than the notion of 'handouts' to support communities.

In the UK, in particular, it seems that opportunities for development are significantly decreasing. This may be as a result of the so-called austerity measures, whereby reductions to welfare spending are made whilst also increasing taxes. As a result of the austerity measures, there have been reports of increased job cuts and thus financial insecurity due to more people being employed with 'zero-hours' contracts, alongside increases in people working in roles which require a lower skill set (Trade Union Centre, 2015). Due to financial pressures and increased job insecurity, alongside the rise in university tuition fees and abandonment of bursaries (e.g. nursing), more people are now facing marked barriers to developing their skill set, ultimately reducing the career prospects for specific groups of people (Trade Union Centre, 2015). It was interesting to note that in spite of the financial constraints encountered by the people of Malawi, the importance of skill development remains to be viewed as a priority.

Conceptualisations of Mental Health in Malawi

Throughout Malawi we learned that there is a wide range of cultural beliefs surrounding mental health, both traditional and emerging. Historical and spiritual beliefs often featured in formulations of people's mental health difficulties. Chilale et al. (2017) found that individuals in Malawi attributed their poor mental health to sociocultural factors including witchcraft, spirit possession and curses as being important factors and that individuals still show a high preference for traditional healers. Assad et al. (2015) suggest that within developed nations, there is a higher prevalence of individuals attributing their experiences to biological and psychological cause, while in

developing and collective cultures, individuals are more likely to attribute this to supernatural and sociocultural causes.

While our experiences of compassion were commonplace, we heard accounts that some people were subjected to abuse and torture as a result of their distress, with people chained to trees. Certain people within local communities held onto historical beliefs that the experience of mental health difficulties may be as a result of witchcraft or was a form of punishment from God or ancestors. Indeed, we witnessed a protest against the killing of albino people, which is a story very often featured in the Western news. It is not our role as psychologists to determine the 'truth' of these beliefs but merely to acknowledge their presence in people's cultural contexts and the further impact this may have upon psychological well-being. If people are struggling with their mental health and subsequently internalise beliefs that they are in some way to blame, this could exacerbate experiences of distress. While religion and spiritual beliefs are rarely explored within Western clinical contexts (Bracken & Thomas, 2005; Gilbert & Parkes, 2011), giving us scope for development, the role of 'blame' throughout conceptualisations of mental health seems somewhat significant across the contexts.

In the West, methods of labelling, diagnosing and 'treating' mental health problems often infer individual responsibility for the experiences of distress, concurrently neglecting wider systemic influences. Indeed, many people in the West are subject to stigma in relation to their mental health problems, which may be as a result of the tendency to individualise and therefore covertly 'blame' people for their difficulties. These negative social attitudes are therefore significant factors to consider, across cultures, given that many people often internalise negative social attitudes which again holds the potential for psychological distress to be exacerbated (e.g. Pemberton et al., 2015).

The Western influence of the dominant biological model was further apparent in aspects of mental health care in Malawi, and there was a sense that this may increase over time as technology and access to Western influences prevail. While the roots of care in Malawi may be linked with genuine compassion and an understanding of wider contexts, there does appear to be a danger that these Western influences may serve to create an added perspective which continues to individualise mental health problems. Timimi (2010) has suggested that a failure to engage with alternative non-Western perspectives has resulted in 'Western' narratives about mental illness dominating over local understanding in low- and middle-income countries (LMIC).

Within high-income countries, there is a prevalence of the 'biopsychosocial' model in addressing difficulties related to mental health; however, this has been criticised by many as neglecting psychological and social factors

(Read et al., 2009). There are calls for broader conceptualisations and the acknowledgement of the role that sociocultural factors play in the experience of distress (White et al., 2014). Moreover, they highlight that allopathic medicine is only one approach that exists in a broad spectrum of other therapeutic approaches including various forms of indigenous medicine and traditional healing. Generally speaking, these systems seek to 'restore harmony, balance and equilibrium, not only by alleviating physical symptoms, but also by re-integrating the person with his or her community, the earth and the spiritual world' (Ross, 2010, p. 45).

The differences between our approaches to discussions around mental health were also noticed at the very outset of our placement. There was a sense that discussions around mental health in Malawi were more direct and steadfast. One observation which struck us was that explicit and emotive pictures were painted onto the walls of therapeutic rooms, which were accessed by children. These pictures included a woman and child being beaten by a male figure, a road traffic accident and a depiction of suicide as someone hanged from a tree, amongst others. Strikingly, all of the pictures were of specific situations or events. While the pictures were primarily considered as an aid to help children and vulnerable people articulate sensitive topics they may have encountered, we also considered how they implicitly offered an external rationale or narrative behind the emotions that people may experience. Within a biological framework of mental health, which continues to be highly regarded in the West, there is often a sense that mental health difficulties are a result of biological malfunctions within the brain that need to be altered with medication. The underlying connotations of having these pictures displayed therefore helped to introduce the role of external difficulties, which is likely to provide people with a sense of validation and togetherness, which is often overlooked in Western cultures.

What We Can Learn

From our observations and experiences, it was clear that key themes emerged which may be incorporated into Western mental health service provision to bring about a sense of community and 'umoza'.

1. **Co-production**: Within the female empowerment groups and the older adult's service, in particular, we were struck with the level of co-production. The older people accessing the services were heavily involved in the organisation of community events, which seemed to provide people with a sense

of purpose and occupation. The need for rehabilitation, including opportunities for skill (re)acquisition, has been highly valued by older adults in LMIC (Modie-Moroka, 2014) and fosters increased financial security through employment, greater independence and promoting involvement in the wider community (Skeen et al., 2010). Indeed, SJOG took a step back when encouraging women to come together to enhance their finances. While co-production is often advocated in Western cultures, we have yet to see it thrive in the way we saw in Malawi. SJOG, by virtue of its existence and prominence in the local area, held a level of power, but what was interesting was that the service as a whole did not seem overly eager to hold onto this power and instead worked in a way which appeared to communicate trust and acceptance towards service users, giving them the freedom and opportunities to use their skill set and to come together to deliver awareness-raising events.

2. **Creativity and flexibility**: As SJOG is a charity, there was a need to ensure that services offered remain 'efficient'. The drive to work in efficient ways did not however hold the same implication as it seemingly does in the UK, and instead it seemed that creativity and the need to be flexible with services was key. Offering outreach services to those who needed it, using cheap but easily accessible buildings and volunteers, all seemed to ensure that the services continued to thrive in spite of economic hardship. With this, rooms were used for older adults' services in local schools which inadvertently gave way to intergenerational working which seems to be gaining more attention in the West. One such example is a research project bringing together younger and older adults to create and develop play, which was found to increase confidence, increase generative learning, reduce ageism/fear of ageing and increase social networks (Anderson et al., 2017). Importantly, the researchers reported a shift in attitudes by participants about the other generation and increased perception of their own tolerance of diversity.
3. **Community-based work**: A theme throughout services in Malawi, and indeed their culture, was one of togetherness, which featured prominently throughout services. Services worked to prevent more people requiring services by offering awareness projects, for example, events were held to address societal problems including excessive drinking and drug use. The community awareness projects created another reason to bring people together, to make links, ultimately reducing isolation and loneliness, which has been found to contribute to low mood (Cacioppo et al., 2011).

Additionally, SJOG conducted a broad range of outreach work to promote its services in hard to reach areas. This included obtaining buy-in

from those in a position of power (usually the village chief) to increase awareness around mental well-being and was usually accompanied by opportunities for those already accessing the service to share their experiences through the medium of dance, drama and art. Similarly, SJOG operates an Umoza Street Children Project that offers a variety of centre- and community-based support services to children and their families, including offering material support and scholarships to enable children to start or return to school (Silungwe & Bandawe, 2011).

4. **The use of the arts**: The use of art, drama, music and in particular dance featured prominently throughout the entirety of our visit. We regularly ensured we were around the SJOG campus on Thursday afternoon to watch children from the Umoza project practise their dance routines. Dance was a regular activity within the inpatient ward and throughout the older people's services. It was clear to see the power of dance in psychological well-being and the connections this created between the staff and service users who danced together. Research has found that the benefits of dancing help with mental health (Froggett & Little, 2012). Within the West, individualised therapy has been shown to be difficult to access for people from lower socio-economic status and is deemed to be middle-class concept (Appio et al., 2013; Kim & Cardemil, 2012; Levy & O'Hara, 2010). However, it seems that using the arts as a way of creating connections and delivering powerful messages about well-being may be a useful strategy in creatively ensuring services are accessible to all citizens.

   Within the West, art and creativity often feature in anecdotal and individual recovery journeys (Spandler et al., 2007) despite research suggesting that participatory art has a broad spectrum of positive therapeutic benefits for people with mental health needs (Heenan, 2006) across all age groups (Anderson et al., 2017). While events such as the DCP Fringe Festival and #Psygrafitti have begun to work in this way, it seems that the West can learn a great deal from Malawian culture to shift power differentials, create connections and engage in fun and meaningful activities to educate and inspire others as a means of bringing about psychological wellness.

Overall, in Malawi, a lot of the services which were offered were done from a sense of compassion, genuineness and common sense. While we can easily relate their services to an evidence base to potentially explain their success, it was interesting to note that instead of coming from the evidence base to the service, the opposite was done. People's needs were thought about in a direct way and addressed with practical solutions. In Western cultures we can be overly focused on the risks, the potential for harm and problems. This is

understandable in an age of compensation claims, but how do we move forward if we continue to think about service delivery and innovation from a place of fear and rigidity? We must consider new ways of working to ensure that the ever-changing needs of our citizens are met in a compassionate, creative and person-centred way.

How Can We Get There?

For us, a key step is to broaden our approaches to mental health and to engage in wider discussions about 'what works' or has the potential to. Anecdotally, we experienced the power of the arts and suggest that a recovery approach to mental health must recognise the potential contribution of arts and creativity within social care and mental health provision. Winnicott (1971) argued that creativity has the potential to increase agency and hope through instilling a sense of meaning in one's life. This recognises individuals' cultural experiences and promotes transgressions from personal boundaries to a shared and felt connectedness with others. Ventevogel (2014) highlights the need to promote community-based recovery-oriented interventions within mental health. Indeed, it is important that while the wider social inclusion agenda prioritises participation in 'mainstream' settings, we look to expand these other ways of working and seek out opportunities to work alongside community settings that offer mutual support in less formal settings. One such novel example is the use of the 'friendship bench' whereby a trusted and respected member of the community is utilised as a lay person to open discussions about distress with the local community, whilst also offering opportunities for individuals to discuss their struggles as they await access to routine primary health care (Abas et al., 2016). A similar concept to the idea of mutual aid has recently been piloted and adopted in London for mental health awareness week by the OWLS social enterprise. During this initiative, make-shift 'problem solving booths' were set up to encourage members of the local community to come together and talk about difficulties and help normalise problems whilst offering support to each other (Tavistock and Portman NHS, 2017). In an age where we as a society are more inclined to 'watch friends and neighbours over making friends with our neighbours' (Russell, 2018), it is schemes like this which may be imperative in re-building communities and enhancing well-being. Attempts to include members of the community to support one another, listening and offering solutions, would also aim to increase accessibility to support across cultures and/or religious/spiritual beliefs. Developing ways in which to build connections and increase dialogue around mental

health would hope to strike a balance between curative interventions and preventative actions to address the social determinants of mental health problems.

There is a growing body of research to support the use of arts, drama, dance and meaningful activity being integrated into 'therapy' and recovery (Van Lith, 2015). For us, this is a significant aspect of our learning from Malawi that we try to integrate into our work and feel strongly that broadening our ideas of 'therapy' to something beyond the therapy room and more traditional talking therapies may be beneficial in aiding communication, coping and connection. For example, Ørjasæter et al. (2017) report how the use of a music and theatre workshop in an inpatient hospital fostered opportunities for individuals to gain a sense of belonging and expanded their identity. These creative ways of engaging those in distress through less formal settings are, in our view, a helpful way of also reducing the idea of 'us and them', as professionals are encouraged to take part and share in the activity. We have heard anecdotal stories of psychologists knitting, engaging in yoga or cooking with those they support and the positive impact this has had on not only the therapeutic relationship, but increasing their capacity to engage in wider social, community groups. A recent systematic literature review however reported that the quality of trials for studies examining the impact of creative arts therapy in PTSD was poor (Baker et al., 2018). It is postulated that difficulties in gaining funding to support the research may be hampered by a lack of buy-in, knowledge about the use of creative arts therapy and interdisciplinary working. Thus, perhaps a significant role for psychologists is to support the development of robust proposals to aid further research as a way of evidencing this work and extending the parameters of what it means to engage in 'therapy'. However, this also reflects wider issues of epistemic injustice—that greater value is given to Randomised Controlled Trial (RCT's), and power over what is deemed more 'valid' as an area of therapeutic intervention, warranting research funding or investment. Within, we must also question and reflect upon issues relating to co-production and structural barriers to this, which means the involvement of citizens in public services may be idealised. There is a challenge for us to ensure that coproduction *means* co-production and that patients and experts by experience do not occupy a passive recipient role or, importantly, are not excluded from opportunities, due to system factors (e.g. ideas that it is too time-intensive or other organisational barriers) and that we question where the power lies in deciding who is involved in voicing their thoughts/ideas (Vennik et al., 2016). Both the Psychologists for Social Change (2018) and Community Psychology movement aim to draw attention to the idea of mental health and well-being services being 'too

individualised' in UK society and aim to enhance a community-led approach that incorporates collective responses to an individual's needs, appreciating their social, political, economic and cultural influences.

Additionally, an approach we strongly value is the Tree of Life (ToL), within narrative therapy, which might be a useful approach for sharing stories and fostering connections across communities. Pioneered by Ncube-Mlilo and Denborough (2006), ToL is a tool that uses different parts of a tree as metaphors to represent the different aspects of our lives and aims to give language to people who may otherwise struggle. The approach aims to enhance social inclusion and community cohesion (White & Epston, 1990; Billington, 2000; White & Morgan, 2006) and facilitates discussions of strength, peace, solidarity and determination. ToL has been used worldwide with different groups of children (Woods, 2010), adolescents (Yuen, 2009) and adults (Denborough, 2014). There have also been extensions of this idea, supporting Muslim women (Elhassan & Yassine, 2017), in London Hackney community projects with adults with HIV (Iliopoulou et al., 2009) and with African and Caribbean men who have experienced mental distress (Byrne et al., 2011). Importantly, the tool has also been used powerfully in exploring inequalities including racism (German, 2013). Western psychology is often critiqued for its lack of recognition and acknowledgement of culture, and our connections and heritage that are central to psychological well-being (Crooks, 2008). Consequently, ToL might facilitate explorations of these factors and increase discussions around mental health, whilst also enabling individuals to make connections in a group or collection (Denborough, 2008).

In order to better support those in distress, we need to recognise the limitations of our current ways of understanding this and the social, political, cultural context within which we work. Our current mechanism of focusing on the individual acts to perpetuate isolation and despair, rather than, as Verhaeghe (2014) argues, focusing on fostering bonds and belonging. This can be achieved by supporting communities to respond to their own needs (Nelson & Prilleltensky, 2005). One such approach is Open Dialogue that provides a safe space for families, carers and communities to support individuals experiencing distress, embracing the view that they can bear the emotional pain of a loved one and are best equipped to support them. Similarly, the Hearing Voices Network serves as an indicator that communities and services led by experts by experience can be extremely empowering, supportive and healing. Thus, while much of our traditional approaches for responding to mental distress are influenced by Western, individualised models, we propose that a greater focus on the community, and drawing upon the knowledge and experience of those in distress, is perhaps the best starting point for any

intervention(s). By adopting the view that communities are most likely to know what they need, what will be helpful and/or what changes are required, we believe psychologists are perfectly placed to begin this dialogue and draw upon the resources in the communities we serve, to support projects that take a community-based approach to mental health. Herein lies the challenge; the conflict between collective community responsibility taking to accept shared accountability for distress, whilst working and existing within a Western paradigm that pushes for 'fault' lying with the individual. Summerfield (2008) calls for the decolonisation of the global mental health movement, arguing a fundamental opposition to the medicalisation of human distress and universality of Western diagnostic categories, viewing this 'as a kind of cultural imperialism' (Summerfield, 2012). Rather, Summerfield posits that distress can be understood as a 'normal' response to difficult, harsh living conditions and highlights the importance of social connectedness as a way of increasing well-being and resilience. Of course, this also brings to question wider issues that have seen the gradual decline in community infrastructures and spaces, including privatisation of community spaces and hospitals. Austerity and social inequalities have seen structural changes that increase isolation and have the potential to decrease well-being. Webb (2013) calls for strategies to 'counter individualisation with social understanding' (p. 646) and those in positions of power to challenge the status quo of social injutsice, through a shared vision and commitment.

In the West, we are arguably able to draw upon an array of mental health approaches, at times, at the expense of giving consideration to traditional methods of care that could be used alongside these approaches. As such, reciprocal learning is paramount between organisations and countries and facilitating this between the Global North and the Global South will be essential to moving forward (White et al., 2017). For example, Swancott et al. (2014) discuss how an NHS trust is working jointly with local charities and universities in Ethiopia to engage in knowledge exchange to promote shared approaches to mental health and increase dialogue, without privileging one perspective or position. It is this shared learning opportunity that will enable us to integrate traditional approaches with more recent developments, in a way that promotes HIC (High Income Countries) in critically reflecting on health and the further acknowledgement of the cultural context and impact (and protective role) on well-being.

Perhaps an important way forward is to look to our clinical psychological doctorate training programmes (and other advanced training for professionals), urging them to be more inclusive of this paradigm and encouraging greater opportunities outside of the traditional NHS placements. Rhodes and

Langtiw (2018) propose that increasing diversity in training programmes and teaching on the philosophy of community psychology is fundamental, requiring a collective address of structural issues. This not only will serve to enrich understanding and experiences but may foster thinking around the scope of our professional roles and broaden opportunities for social justice and social inclusion to be a focus. Additionally, focus on doctoral programme towards empowering marginalised individuals and communities through co-production and training opportunities to promote diversity may also be of benefit, in keeping with the values and ethos of community psychology.

Potential Challenges

While there is increasing interest in the concept of 'recovery', by both the service user movement and policy drivers (NIMHE, 2005), Spandler et al. (2007) highlight the difficulties of an agreed-on conceptual model and clarity on the process of recovery or indeed what the outcomes of recovery should be (Ralph & Corrigan, 2005). In an age of increased pressure to demonstrate clinical outcomes within the NHS and Payment by Results, opportunities to implement some of the practices from other cultures may be hindered. Similarly, in a culture where there is a strong drive to 'get people back to work', the recovery journey of individuals may not be prioritised. Moreover, the drive for cost-effectiveness has increased demand by policy drivers for researchers/organisations to demonstrate the successes of interventions within given time periods (Staricoff, 2006). Consequently, while practitioners may intuitively recognise the benefits of working creativity and flexibility, funders want empirical results to demonstrate programme benefits to individuals and communities (Currie, 2010; De Medeiros & Basting, 2014; Hancock, 2007). Thus, since interventions are primarily appraised according to clinical outcomes (Froggett & Little, 2012), without initial support from those in positions of power, these initiatives may never get off the ground. Despite these challenges, there are opportunities to think outside of the box and perhaps develop novel approaches to supporting those who experience mental distress. As Ventevogel points out, 'in order to build holistic primary mental healthcare systems, policy-makers and health workers need to embrace a public mental health approach' (p. 676).

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