Overcoming divisions and finding connection through ‘task sharing’ in mental healthcare: Exploring the potential of the ‘Friendship Bench’

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COVID-19 has amplified disparities in mental health and highlighted the distrust amongst marginalised populations towards healthcare systems. A 'task-sharing' approach developed in Zimbabwe, which seeks to connect isolated communities to mental healthcare by training lay people to deliver talk therapies, has achieved impressive outcomes and sparked interest in the field of global mental health. This article considers the potential of the 'Friendship Bench' for higher income settings. Drawing on the wider literature on 'task sharing' in mental healthcare, it will be argued that the success of this method relies on the commitment of mental health professionals to new ways of working, which challenge conventional divisions between 'professional' and 'lived' expertise. I posit that structural, political, and cultural developments in Scotland have created fertile ground for piloting this type of innovation, and that participatory research is needed to explore this further.

Keywords: Task-sharing; mental healthcare; talk therapy; community healthcare workers; marginalisation; disruptive innovation; Scotland

Introduction

Dr. Dixon Chibanda is one of only 18 psychiatrists and 6 psychologists in Zimbabwe, which has an estimated population of 14,030,368 (WHO, 2020). Fuelled by frustration at not being able to meet the needs of the one in four people experiencing depression and anxiety, Chibanda began piloting a new intervention, the 'Friendship Bench' (Kuhl, n.d.). In 2006, Chibanda and his team recruited a total of 14 mature women, who were rooted within communities and described as 'custodians of local culture and wisdom' (Chibanda et al., 2011; Woolston, 2020: para 1). The women, now known as 'community grandmothers' were trained to provide psychotherapy on wooden benches in the grounds of healthcare centres. Those referred to the bench are joined by a community grandmother, who begins by asking them if they wish to share their story. Thereafter, the person is invited to meet with the community grandmother once a week for a series of sessions. There is an emphasis on problem solving, on 'empowering' people to feel more able to cope with the issues they are experiencing (Chibanda et al., 2017: 150). The pilot was well received by the local communities and randomised control trials have concluded that the support provided by community grandmothers was effective in improving the mental health of those that engage (Chibanda et al., 2011; Chibanda et al., 2015). Moreover, research findings indicated that community grandmothers were in fact *more* effective in alleviating the symptoms of anxiety and depression than 'usual care' which included support from mental health nurses, psychologists, and the use of antidepressant medication (Chibanda et al., 2016).

The project has since been scaled up - there are said to be 700 community grandmothers, aged between 60-80, now working at 70 national health care centres; and it is regarded as a fundamental component in the mission to close the treatment gap for common mental health disorders (CMD) in Zimbabwe (Chibanda, 2017; Chibanda, 2018*a*). The Friendship Bench has gone on to receive global attention in recent years with projects emerging

in neighbouring countries (Brooks et al., 2019; Stockton et al., 2020; Doukani et al., 2021). Health service providers in a range of higher income countries (HIC), including Australia and the UK, have reportedly expressed an interest, and a pilot programme is now underway in New York (Chibanda, 2018*b;* Rosenberg, 2019). Chibanda has spoken of his vision to "create a global network of grandmothers in every major city in the world, who are trained in evidence-based talk therapy" (Chibanda, 2018*a*).

To better understand the potential of this project and the broader implications of implementing this approach, I seek to demonstrate that much can be learned from the wider global literature on 'task sharing' in mental healthcare. It will be argued that the Friendship Bench demonstrates the value in learning from LMIC when it comes to exploring innovations in mental healthcare. However, if the forewarnings contained within the existing literature are not carefully considered, attempts to pilot the Friendship Bench in HIC could put lay people at risk of exploitation and mistreatment, creating further divisions between healthcare systems and marginalised communities. Finally, I will argue that developments in health and social care in Scotland provide fertile ground in which to embed this type of innovation.

'Task Sharing' in low and middle income countries

The broader context: the development of 'task sharing' in mental healthcare

Whilst conceptually unique, the Friendship Bench shares many features with other 'task sharing' programmes seeking to connect communities in low resources settings with healthcare services. Community grandmothers form part of a global population of community healthcare workers (CHWs), mostly women, who have been a feature of healthcare landscapes in LMICs since the 1970s, playing a central role in responding to the AIDs pandemic (WHO, 2008; WHO, 2015). CHWS tend to be lay people, with limited education and a basic ability to read and write. They are recruited from settings in LMICs with limited infrastructure and/or HR

resource, and trained to deliver healthcare services typically provided by healthcare professionals (Peterson et al., 2012).

As concern about global mental health has grown, an increasing number of programmes have begun to train CHWs to deliver mental healthcare to people with CMD, such as depression and anxiety (Patel et al., 2010; Honikman et al., 2012). Using simplified tools and adapted methods of delivery, CHWs have been trained to conduct tasks previously 'off bounds' for those without academic credentials, for example, screening for mental illness and providing psychosocial treatments like talk therapies (Verdeli, 2003; Patel, 2008; Peterson et al., 2012). Vikram Patel, a lead figure in global health, has described this process as the "democratisation of medical knowledge" (Patel, 2012). CHWs, however, do not necessarily 'replace' professionals; the guidance and supervisory support provided by mental health professionals is shown to be critical to programme success (Nyatsanza et al., 2016). These structures also provide a referral route, meaning that CHWs can redirect anyone showing signs of more serious mental health problems for professional help (Shinde et al., 2013).

The impact of these programmes has been unprecedented, achieving high levels of engagement and sustainably improved mental health outcomes for communities (Joshi et al., 2014; Barnett et al., 2017; 2018).

Fostering shared understanding through formative research:

Connecting to cultural values, beliefs, and practices

CHWs in LMIC are usually from the communities within which they work, and therefore, tend to share cultural values, beliefs, and practices; drawing on this knowledge to engage and connect with people in need of support (Patel, 2008; Ngo, 2014). Task sharing programmes are often led by global non-government organisations (NGOs) and utilise

evidence-based methods developed in Western societies[1] (WHO, 2015). These are not always compatible with non-Western conceptualisations of mental illness and culturally specific concerns related to mental health stigma (Ngo et al., 2014; Chibanda et al., 2017). To counteract these issues, programme providers have invested time in formative research, working closely with CHWs and wider communities to reach shared understandings of what mental health means within the specific cultural context.

In rural Uganda, for example, 'depression' is conceived of as two syndromes, 'y'okwetchawa' and 'okwekubaziga', which share the same diagnostic criteria as the Western definition, with the addition of locally reported symptoms such as 'not responding when greeted' (Verdeli, 2003: 115). Rather than imposing Western definitions of mental illness, the project was shaped according to these local conceptions, including the creation of locally validated screening tools (Ibid). Training manuals for mental health professionals have been replaced with detailed scripts for use by CHWs; technical language is removed or simplified, and local conceptions are built into session outlines (Peterson et al., 2012; WHO, 2015; Nyatsanza et al., 2016; Atif, 2019). Formative research is also used to identify culturally appropriate solutions to mental health problems, which are built into the resources used by CHWs during sessions. In a programme for perinatal depression in Pakistan, qualitative research findings were used to produce vignettes and a card game based on problems commonly experienced by women in the community (Atif et al., 2019). The framing of a solution can also affect perceived acceptability; a pilot project in Vietnam modified the purpose of 'increasing pleasurable activities' from simply reducing depression, regarded as 'self-centred' within this context, to improving work and family functioning (Ngo, 2014:6). This appears to improve the accessibility of methods for CHWs. It also enables CHWs and

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[1] The 'Friendship Bench' programme in Zimbabwe for example has been supported by Grand Challenges Canada (*See*: https://www.grandchallenges.ca/who-we-are/)

communities to work within familiar frameworks of understanding, connecting evidence-based practice to the everyday meanings of community life.

During this formative stage, the cultural knowledge of CHWs has been fundamental in exploring potential practical and perceptual barriers to engagement. As a case in point, the Friendship Bench was originally referred to as the ‘Mental Health Bench’; it was the community grandmothers that suggested changing the name, arguing that nobody would want to come (Chibanda, 2019 *b*). Given the high levels of mobility amongst people in Zimbabwe, community grandmothers also proposed extending the first meeting, and shortening subsequent sessions (Chibanda et al., 2017). Despite requiring a ‘major shift in session content’ and challenging Western convention, this adaptation was ‘necessitated by the [community grandmothers’] desire to ensure that the client takes home a solution…after the first visit’ (Ibid: 149/150). These developments are the result of ongoing engagement with community grandmothers, who are encouraged to share their reflections during regular meetings with the wider programme team (Ibid).

This formative component within CHW programmes thus appears to be underpinned by the principles of participatory action research (PAR), which challenges conventional knowledge hierarchies, seeking to work *alongside* communities to find solutions to local problems (Baldwin, 2012). Participatory approaches recognise the value of drawing on lived and professional expertise to find new ways of working that are appropriate for the specific social, cultural, and economic contexts that shape the lives of community members (Chiu, 2003). They recognise that individual therapy in private settings can address the fear of stigma in one community (Nyatsanza, 2016), whilst the opposite format can provide a solution to this issue in another (Verdeli, 2003). It seems that formative research can allow NGOs to demonstrate their respect of local knowledge and commitment to facilitating community ownership, encouraging buy-in from CHWs and wider communities (Ngo, 2014). Given the

apparent significance of formative research, there is frustratingly little space given to this within the evaluative literature. We go on to explore how this participatory approach shapes the way in which support is provided by CHWs in the following section.

Humanising 'professional' practice and professionalising peer support:

Finding connection through shared experience

We have already established that CHWs in LMIC are usually part of the communities they support, and therefore, tend to share cultural frameworks for understanding. By removing jargon, evidence-based methods are effectively 'de-medicalised' and communicated in ways that appear to resonate with local communities (Patel, 2014). Whilst there is the sense that CHWs 'know how to talk to neighbours' (Surjaningrum et al., 2018: p.5), they are also taught professional techniques, such as recounting the client's story, which they can draw on to demonstrate understanding (Chibanda, 2019 *a*).

Programme providers have adopted a flexible approach, creating space for CHWs to incorporate cultural practices into therapeutic sessions. For community grandmothers, 'connecting with clients came in several forms… touching the hand and other culturally appropriate parts of the body…and praying' (Chibanda et al., 2017: 146). Yoga has been incorporated as a component of a CHW programme in India (Shinde et al., 2013), and singing has been introduced to group therapy sessions in Vietnam (Ngo, 2014). Evidence suggests that engaging in these synchronous acts with others supports the release of endorphins and facilitates social bonding (Launay et al., 2016). It brings a level of mutuality to the relationship of CHWs and clients, which appears to contrast the formal dynamic typically found between professional therapists and their patients (Atif et al., 2019).

Belonging to the same community means that CHWs often share the experience of living in poverty (Verdeli, 2003). As triggers of mental health issues are frequently economic

in nature, this lived experience can have both a supportive and practical quality, increasing empathy and trust (Chibanda et al., 2016). Most CHW programmes involve a problem-solving component; CHWs generally work alongside clients, supporting them to identify solutions to their own problems (Ibid). Whilst 'client-led' approaches are now commonplace in higher income countries, CHWs appear to be uniquely involved in the problem-solving process (Ibid). It is not unusual for CHWs to draw on personal experiences or make use of their own networks to help clients with issues such as finding employment (Verdeli, 2003; Chibanda et al., 2016). Therapeutic sessions often incorporate enterprising activities, which are completed together; Peterson et al. posit that these have the potential to break the vicious cycle of poverty and mental ill health…and promote social inclusion' (2011:10; Ngo, 2014). There are reports of CHWs applying the solutions discussed during sessions in the context of their own lives; another example perhaps of the mutuality underpinning this relationship (Verdeli, 3003; Ngo, 2019). This has been compared to the more 'paternalistic' and 'distant' relationship that can be found between communities and professionals, who are unlikely to share the same social background and can adopt a more 'instructive' approach (Shinde et al., 2013:51; Chibanda et al., 2017).

In some cases, shared experience of life events or health conditions has also been highlighted. Discussing the desirable characteristics of a CHW for a perinatal programme in Indonesia, service-users felt that CHWs should have experience of marriage and pregnancy (Sujaningrum et al., 2018). Community grandmothers would occasionally share their own experiences of HIV with clients. The quote below captures the power of this divulgence in building rapport and assuaging feelings of shame:

‘“When the counselor (CHW) told me that she too was living with HIV I felt an instant relief (kusununguka) and felt I could open up to her about my husband and his not wanting to use protection during sex”.’

[Client on the ‘Friendship Bench’ programme]

(Chibanda et al., 2017:149)

Here, it is not only having shared experiences, but the *sharing* of these experiences that allow CHWs to develop a reciprocal relationship that has the potential to inspire hope, provide practical support and address stigma. It is perhaps therefore unsurprising that service users have stressed the importance of age as denoting life experience and the credibility of advice giving (Nyatsanza et al., 2016). However, exactly how age is perceived to shape the abilities of CHWs differs across cultural settings; just as women in Zimbabwe reach the age where they are perceived to be wise enough to become a ‘Community Grandmother’, women of this age in Indonesia, ‘were seen as too old, less productive, … talk in a directive way and with a lack of empathy’ (Surjaningrum, 2018: 6/7).

Further supporting the significance of life experience, in modifications of the Friendship Bench recruiting young people as ‘counsellors’ to support adolescents, some counsellors felt that sensitive topics were difficult to talk about, as the client was ‘uncomfortable’ and they ‘lacked the knowledge to address the subject properly’ (Wallen et al., 2021: 5). Similarly, young service users in Indonesia felt that speaking to CHWs of the same age may ‘generate feelings of shame… because [it] would seem “just like talking to one’s own friends”’ (Sujaningrum et al., 2018: 6).

The emphasis on sharing life experiences to form ‘synergistic’ understandings of what is helpful, closely aligns with the principles and approaches of peer support work (Repper and Carter, 2011: 394/5). However, the existing literature suggests that CHW roles often cut across

the definitional groups of ‘peer worker’ and ‘healthcare worker’ common within HICs, making it difficult to place CHWs neatly within these categories (Jack et al., 2020).

Other desired characteristics of CHWs in LMIC: the gendered dimension to connection

Shared experiences appear to be a fundamental component in the connection formed between CHWs and communities; however, specific personal characteristics and skills are also emphasised. Given the wide range of contexts within which CHW programmes operate, it is somewhat striking to note the recurrency and alignment of these within the existing literature.

A wide range of stakeholders in LMIC have repeatedly emphasised the importance of patience and kindness, as well as strong listening and communication skills (Patel et al., 2008; Surjaningrum et al., 2016). As these are frequently perceived to be ‘maternalistic qualities’, more likely to be associated with women, this could partly explain the dramatically disproportionate gendered split within the CHW workforce (Najafizada, 2015; Ramirez-Valles, 1998). Chibanda, for example, applies this gendered framework to explain the failings of a pilot with ‘Community Grandfathers’, who ‘are often not capable of giving people the space to tell their stories [and] tend to be very instructive… listen briefly and then… tell you what to do’ (Kuhl, n.d.: para 17). Whilst this has created opportunities for women to earn an income for duties akin to those that they were already performing in their communities, it has been suggested that the lack of male representation could account for low levels of engagement amongst men, when compared to women, in CHW programmes (Chibanda et al., 2017).

There are two other desired characteristics which may explain this gendered dimension. It has been argued that women, who are generally less likely to be employed than men, are more readily available and more willing to accept voluntary or low paid work (Surjaningrum et al., 2016). We have already discussed the high probability of economic deprivation amongst

CHWs who can see the role as an opportunity to build marketable skills and lift their families out of poverty (Ochieng et al., 2014: 6). The issue of low pay raises questions around the value placed on tasks conceived of as 'women's work', and the contribution of CHW programmes to gendered exploitation (Ramirez-Valles, 1998; Daniels et al., 2012). It is important to acknowledge, however, that remuneration is not always a culturally appropriate indicator. In Indonesia, for example, monetary payment was felt to interfere with the religious meaning attached to the CHW role (Sujaningrum et al., 2018). In close knit communities within Pakistan, 'social investment' has been found to be more important to CHWs than financial payment; here, returns of kindness in times of need were understood as a form of currency (Atif et al. 2019: 5). This aside, the flexibility expected of CHWs has left many vulnerable to burnout. Concern over the working conditions of CHWs in some settings, who were found to be walking long distances and paying for their own supplies, has sparked a global policy response to better protect women working in such roles (Daniels et al., 2012; Bhatia, 2014). These developments appear to have been fuelled by the desire to sustain the impressive outcomes achieved by services provided by CHWs (Ibid).

However, participatory approaches to programme development appear to signify recognition amongst professional teams of the cultural and experiential knowledge of CHWs. Participatory approaches to mental health service development are increasingly common in HIC; what distinguishes these examples, however, is that CHWs in LMIC are given access to evidence-based methods usually 'off-bounds' to non-professionals (Jack et al., 2019). The simplification of diagnostic tools and therapeutic manuals has allowed CHWs to work autonomously whilst being supported by carefully designed supervisory structures and referral systems. Learning how to develop skills, such as delivering problem-solving therapy, has made CHWs feel useful to those they support and improved their status within their communities, in turn increasing CHWs' confidence and improving self-esteem (Atif et al., 2019; Chibanda,

2019 *b*). In a systematic review of research on the perspectives of CHWs, Shipton et al. found that the affiliation with health professionals provided 'social prestige and recognition', which has been 'particularly empowering for women' (2017:162) The flexible approach has created the space for CHWs to incorporate cultural practices into therapeutic sessions. Evidence suggests that these can strengthen the sense of connection between CHWs and their clients, whilst benefitting from the guidance of broader session outlines. CHWs are trusted to work autonomously, meaning that they can be the 'sole provider' of support in the eyes of the client (Barnett et al., 2018).

What I mean to demonstrate here is that CHW programmes, like the Friendship Bench, are powerful in their simplicity and humanise therapeutic interventions. However, they are underpinned by carefully designed structures, which rely on the technical expertise and guidance of mental health professionals, their acknowledgement of CHWs as experts and their commitment to working in new ways. This emphasis on collaboration is perhaps reflected in a shift away from the term 'task shifting' to 'task sharing' in recent years (Hoeft et al 2018; Jack et al., 2019).

'Task Sharing' in higher-income countries (HIC)

Connecting marginalised communities to mental health care in HIC

In the previous section, we discussed 'community grandmothers' as part of a wider workforce of 'community healthcare workers' (CHWs). Whilst much of the literature on CHWs is based on LMIC, the CHW role has existed in HIC since the early 1900s (Reiff and Riessman, 1965). CHWs are often women from ethnic minority populations, recruited to extend healthcare messages and services to marginalised communities (Ramirez Valles, 1998). The CHW role has seen somewhat of a revival in recent years; large-scale CHW certification programmes have developed across the US (Ibe et al., 2020), Canada (Torres et al., 2013) and

Australia (Bartik et al., 2007). The perceived success of these approaches reportedly inspired the Lay Health Trainer programme led by NHS England (Gardner et al., 2012: 1178; Najafizada, 2015).

Reviewing the literature on the utilisation of CHWs in HIC, there are striking similarities across different time periods. CHW programmes have been divided between two approaches. On the one hand, CHWs have been recruited into mainstream healthcare systems, receiving a combination of didactic and 'on the job' training. They have joined existing teams, often working alongside nurses and social workers conducting menial tasks and providing social support to clients (Roman et al., 2007; Richer et al., 2018). They represent their communities, highlighting potential barriers, encouraging engagement amongst people with little trust in professionals, advocating during appointments and translating health messages. These roles have created long-term, secure employment opportunities for CHWs experiencing economic deprivation, and led to increased engagement in healthcare for marginalised communities (Eyster and Bovbjerg, 2013; Ibe, 2020)

However, CHWs appear to have suffered the impact of hierarchical staffing structures and institutional cultures, leaving many vulnerable to exploitation and abuse. The mistreatment of CHWs by other entry-level staff members seemingly threatened by their recruitment is a longstanding issue; examples can be found from the 1960s (Halpern, 1969; Rogawski, 1971) and within more recent programmes (Waitzkin et al, 2011). Seemingly, CHWs under this model tend to work under the close supervision of healthcare professionals and complete clearly prescribed tasks (Anderson and Boubjerg, 2013). There have been ongoing concerns over poor working conditions and limited opportunities for career progression with one certification programme carving out a senior 'CHW' post to address this (Ibe et al., 2020). Perhaps unsurprisingly, CHWs have reported feeling like they 'don't belong' in professional teams. Lay Health Trainers in England, for example, described feeling like 'outsiders' and

emphasised their ‘low status’ within the NHS (Cook and Wills, 2012: 226), posing questions around how far lived expertise is valued within these institutional settings.

Another approach to recruiting CHWs appears to share more in common with the examples we have explored in LMIC. These community-based initiatives, often led by local organisations and academics, have tended to focus on cultural minorities, adopting participatory approaches that seek to improve the cultural feasibility of mainstream health messages and promote social inclusion amongst marginalised communities (Najafizada et al., 2015). Rather than endorsing and expanding mainstream health practices, here, CHWs play an active role in the creation of new resources and diffuse these through their own networks. There are many examples of creative projects, such as the development of a fotonovela for Latino populations (Unger et al., 2012). Qualitative research indicates that CHWs not only enjoy being involved in these initiatives, but can experience improved mental health and social connection (Ibid; Tran et al., 2012). However, initiatives tend to be short-term and are poorly funded (Koskan et al., 2013). CHWs generally work on a voluntary basis, and whilst some have argued involvement can be a ‘springboard’ to job opportunities (Ibid), qualitative research has revealed disappointment amongst CHWs seeking employment (Green et al., 2012). Critics have argued that the voluntary nature of such roles is the ‘price paid’ for having a voice (Grey, 2017), and that such approaches can limit the economic mobility of CHWs (Koskan et al., 2013).

Pausing to compare these findings to those discussed in the previous section, we see here that CHWs in HIC are either recruited to extend mainstream professional practice, or are peripheral to mainstream healthcare systems, working within their communities. Models like the Friendship Bench in LMIC appear to straddle this division; in effect, they might be described as integrated structures adopting community-based approaches. CHWs in HIC do not appear to have been trained to deliver evidence-based talk therapies, despite the wealth of

evidence supporting the effectiveness of this in LMIC, and requests by CHWs for counselling skills to better meet the needs of their communities (Jack et al. 2020).

The Friendship Bench pilot in New York could thus represent a 'breakthrough moment' in the field of global mental health, sparking recognition of the potential of innovations developed in LMIC for reducing health disparities in higher income settings (Najafizada et al, 2015). As the program is still in its infancy, published information is scarce; however, large orange slabs have been built outside of health centres across the city and a range of people with experience of marginalisation have been recruited as 'peers' (unlike in Zimbabwe this includes men and women). Peers are trained to screen people, collect demographic information, and have similar 'problem-solving conversations' to community grandmothers (Rosenberg, 2019). However, this is not referred to as 'therapy'; their main purpose appears to be 'to open a door into the system — which many clients see as cold, bureaucratic and judgmental — for other services' (Ibid: para 28). Tellingly, the authors state that community grandmothers provide therapy because 'there are few services, mental health or otherwise, to which they can refer patients' (Ibid: para 27). Whilst lack of resource may have been the initial driver for equipping community grandmothers with these skills, this reference is indicative of a particular cultural framing of task sharing, which seems to privilege access to professional support. It fails to recognise the capabilities of lay people with lived experience to deliver these types of services in ways that can feel more relevant, meaningful and empowering for communities than mainstream professional practice. The NYC Friendship Bench is an exciting development. However, if peers in NYC are not entrusted as the 'sole providers' of this service and equipped with the skills, structures and supervisory support given to CHWs in LMIC, an increasing number of marginalised people are likely to be referred to the services they perceive as 'cold' and 'judgmental', adding to the bottleneck (*e.g.* Acri, 2014).

Arguing that CHW programmes have revealed a ‘credibility gap’, rather than a ‘treatment gap’ in mental healthcare, Patel advocates a move away from what has been a ‘supply side’ narrative (2014:16). The recruitment of lay people is often described in operational terms as ‘a rapid expansion of the pool of human resources for health’ (WHO, 2007: 7). These discussions can centre around the enhancement or extension of existing provision, and how communities can help service providers meet the growing demand for mental healthcare (Ibid). Whilst ‘task sharing’ pilots have increased access to services, failing to pay due consideration to the qualitative aspects of programme evaluations risks undermining the role of connection in mental healthcare, the value added by CHWs, and the need for transformative change.

Considering the potential of the ‘Friendship Bench’ in Scotland

It could be argued that the growth of ‘peer work’ in Scotland over the last twenty years symbolises an acknowledgement of the value of connection amongst mental health policy makers and practitioners. The promotion of peer principles has largely been driven by the Scottish ‘recovery movement’, seeking to challenge divisive, ‘us and them’ attitudes, which stigmatise mental illness and improve the experience of people accessing mental health services (Christie, 2016). The Scottish Recovery Network (SRN) has been an influential force in this area. Echoing the principles underpinning programmes like the Friendship Bench, SRN created a framework of values for peer work based on ‘developing mutually empowering relationships’, ‘sharing personal experiences of recovery in a way that inspires hope’ and ‘offering help and support as an equal’ (SRN, 2020: 3). This work has been heavily supported by the Scottish Government, which has invested funding and been incorporating peer work initiatives into mental health policy since 2003 (Bradstreet and Mcbrierty, 2012). Interestingly, it has been suggested that Scottish devolution fuelled this endorsement of the ‘recovery

movement', an emergent area of work at the time, as an opportunity to take mental health care in a new direction, distinguishable from UK policy (Ibid). More broadly, this 'distinctive' approach has sought to overcome sectoral divisions, and support more collaborative working through the integration of health and social care services under regional partnerships, combining the strengths of professional and local expertise (HSCS, 2021). The voluntary sector has received significant investment when compared to other parts of the UK, and third sector organisations are said to be 'recognised as key players in delivering mental health care and support' (Gordon and Bradstreet, 2015: 162; Dayan and Edwards, 2018). The appetite for piloting innovations has been a historic part of Scottish culture, driven in part by the need to connect people living in rural and remote parts of the country (Jenkinson, 2000).

A range of formalised peer support roles have been introduced into local mental health systems over recent years (Christie, 2016). This has required a 'shift in values and practice', with services being encouraged to support and empower individuals, rather than simply 'provide care' (Bradstreet & Rona Mcbrierty, 2012: 67). Whilst the value of peer work is now said to be widely recognised, there is less certainty around how to integrate peer support roles in mainstream healthcare (Bradstreet and Pratt, 2010; Moran, 2020). Peer workers have been said to 'complement and add value to…existing activities' (Christie, 2016 :5). However, despite the emphasis on 'innovation', there appears to be limited examples of 'task sharing' that challenges current practice. It has been suggested that the development of peer work has reached an 'impasse'; meaningful progress is purportedly dependent upon the structural reconfiguration of mental health services, and a greater distribution of responsibility and power from service providers to communities (Gordon and Bradstreet, 2015: 165; Bradstreet and Mcbrierty, 2012). The role of peer work for marginalised groups, and the experience of poverty seems to have been neglected within existing research (Llewellyn-Beardsley et al., 2019; Moran, 2020). Meanwhile, mental health services in Scotland are increasingly overstretched,

people in poverty are twice as likely to experience mental health problems, and marginalised communities face multiple perceptual and practical barriers to engagement (Audit Scotland, 2012; NHS Scotland, 2017). These issues have been exacerbated during the COVID-19 pandemic (MHF, 2020).

Thus far, the development of peer work in Scotland (or recovery more broadly) appears to have been based on learning from international, rather than global research, with an emphasis on the United States and New Zealand (Bradstreet and Mcbrierty, 2012). Research has revealed implicit associations made by researchers and health professionals between 'rich countries' and 'good research' (Harris et al., 2017), and a more recent systematic review indicated that geographic bias against LMIC was impacting the peer review process (Skopec et al., 2020). Another qualitative research project identified a greater tendency to dismiss work in LMIC on the grounds of relevance with 'flimsy national stereotypes' being drawn upon to justify these decisions (Harris et al., 2015:6). In a recent review of evidence exploring the potential of peer work for perinatal healthcare in Scotland, models in rural Pakistan and India were not included because 'the social, economic and health context is not comparable to the UK' (Moran, 2020: 6). Authors have begun to contend that higher income settings have much to learn from task sharing programmes in LMIC, which have demonstrated the potential of lay people and the effectiveness of simple interventions (Menezes et al., 2015; Bolton, 2019). Greater consideration of what connects, rather than divides, us in the context of global health research, could force us to think differently, bringing us closer to the type of disruptive innovation necessary to achieve meaningful change.

It is, of course, important to acknowledge contextual differences in the application of this learning. It might be said that the recovery movement has laid the groundwork for an innovation like the Friendship Bench, encouraging recognition and acceptance of peer work values. Acknowledging the challenge posed to 'task sharing' by hierarchical attitudes in other

higher income settings, Dayan and Edwards' (2018) reflections that there is a more 'horizontal' culture within Scottish healthcare systems holds promise. However, implementation should be disruptive. The reported prevalence of fatigue amongst professionals following years of funding cuts, restructures, and now a global pandemic could create resistance to the role changes required to support this model (Bradstreet and Mcbrierty, 2012). Task sharing programmes globally have highlighted the importance of early conversations with professional stakeholders to discuss concerns and gain buy-in (Eyster and Bovbjerg, 2013; Ngo, 2014). Furthermore, the role of 'community grandmother' (or equivalent) might be compatible with the conceptualisation of peer work as a 'new professional role in mental health services' (Gordon and Bradstreet, 2015: 160). However, more research is needed to understand how communities feel about the blurring of this line between peer and professional, and the accordant division of tasks. Participatory action research, which starts with local communities and involves a full range of stakeholders, including health and social care professionals, would provide an opportunity to further explore these perspectives, the potential opportunities, and challenges presented by the Friendship Bench model. It has been argued that the process of watching, learning from mistakes, and 'fashioning a better Scots version' is central to Scottish cultural and political life (Bradstreet and Mcbrierty, 2012: 65). A participatory approach should provide the space to apply this principle to the existing task sharing literature, paying careful consideration to the risk of mistreatment and exploitation.

Conclusion

The Friendship Bench is one of many innovative approaches developed in LMICs that have been highly effective in connecting communities to evidence-based mental healthcare. Whilst powerful in its simplicity, evidence suggests that the success of the Friendship Bench is determined by several factors: formative research that starts with communities and involves

the full range of stakeholders; the expertise of multiple actors in health and social care committed to working in new ways; and financial investment that allows for proportionate remuneration. Rather than looking at how CHWs can ‘reduce the burden’ on mental health professionals (which of course they do), we should be looking at how systems, processes and roles need to change to create space for CHWs to support their communities effectively. In the Scottish context, this may involve challenging conceptual divisions between ‘professional’ and ‘peer’ workers.

Given the impressive quantitative and qualitative outcomes evidenced in LMIC, the groundwork accomplished by the recovery movement and the appetite for innovation, I would argue that participatory research is needed to further explore the potential of approaches like the Friendship Bench in Scotland.

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