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Exploring partnership: reflections on an international collaboration

Abstract:

This paper explores some of the challenges involved in a collaborative mental health partnership, drawing on the reflections of two project members from Chainama College of Health Sciences in Zambia and Leeds Metropolitan University, England. The aim of the project was to support the education and training of the mental health workforce in Zambia as services shift from institutional to community-based care. The discussion is located within Gray's (2005) 'three-pronged dilemma' and debates concerning the internationalisation agenda in social work and higher education. The conclusion emphasises the benefits and tensions of partnership working between 'developed' and 'developing' countries.

Key words: partnership; mental health; internationalisation; social work; Zambia

Introduction:

The aim of this paper is to explore some of the challenges in partnership working experienced during a collaborative British Council funded project involving a Zambian college and a British university (2009 – 2012). 'Partnership' and 'partnership working' have been increasingly emphasised over the past decade, with strong partnerships being expected by a range of agencies and funders. Some of the impetus may be to act as a corrective to the assumed unequal power relations in collaborations between countries in the global north and south, but it may also be recognition of the simple fact that projects work better when a 'good' partnership is in place. The 'partnership paradigm' is seen as a means to ensure a greater sustainability of initiatives and to 'make a difference' (Ijsselmuiden et al, 2004; Gedde, 2009). The experiences of a number of partnerships have been distilled into various good practice guides for higher education (Van de Water et al, 2008; Wannan et al, 2010).

However, there is still relatively little discussion of the realities of partnership working and even fewer honest accounts of the challenges of North-South partnerships.

The project described here was designed to provide support for the education and training of the mental health workforce in Zambia during a period of transition from institutional to community-based mental health care. Some of the challenges that were encountered by the partnership will be examined using Gray's 'three-pronged dilemma' (2005:31) involving concepts of imperialism, universalism and indigenisation. This takes the level of discussion beyond merely using the benchmarks for 'good' partnerships provided by various good practice guides and thus attempts to theorise the workings of North-South partnerships. Learning from the project will then be reviewed, emphasising the importance of dialogue, relationship and reciprocal learning. Some of the tensions and ambiguities inherent in such a project will also be acknowledged. Finally some suggestions for future developments will be noted. Firstly, the situation in Zambia will be briefly outlined. It will be clear from this account that one impetus for the project was humanitarian, whilst the second impetus can be related to the drive within higher education in the UK, including social work, for greater internationalisation. The latter will be explored before outlining the key features of the project itself.

Context

Zambia gained independence from Britain in 1964 and since that time has benefitted from a relatively stable political system based, since 1990, on a multi-party democracy. In 2010 it was estimated that 74% of the country's estimated population of 14 million were in poverty, living on less than one dollar/day (WHO, 2014a). The economy is heavily dependent on copper production and subject to international market forces and monetary policies which in turn impacts on the resources for the underfunded health services (Mayeya et al, 2004).

Approximately one in eleven children die before their fifth birthday (UNICEF, 2015) and life expectancy is 57 and 58 years for men and women respectively (WHO, 2015). In 2013 the prevalence of HIV infection within the adult population was estimated at 12.5% with the highest rate of death from AIDs in adults aged 20 – 34 years (WHO, 2014a).

Currently no comprehensive national baseline data exists regarding the incidence and prevalence of mental illness although schizophrenia is recognised as a priority. In addition to the main psychiatric hospital, seven provincial general hospitals have allocated psychiatric beds. Mental health remains a low priority and '*receives inadequate attention.*' (Mwape et al, 2011:3) recent data (WHO, 2014b) indicates that there were only 0.03 psychiatrists in government practice, 1.36 mental health nurses and 0.15 social workers per 100,000 population. Clinical officers (psychiatry), with two years training in psychiatry and registered by the Health Professions Council of Zambia, provide the backbone of mental health services. In 2008 the Ministry of Health (2008) set out the intention to move towards community-based care although progress to date has been limited. Additionally a Mental Health bill to replace the 1951 Mental Disorders Act is in draft form reflecting human rights concerns and issues of capacity and consent (Mental Disability Advocacy Center /Mental Health Users Network of Zambia, 2014). An estimated 64% of countries in the African region are lacking legislation or have legislation that is outdated, emphasising involuntary treatment and the criminalisation of people experiencing mental health difficulties (MHaPP, 2008).

Greater attention to mental health is prompted by the increase in homelessness, alcohol and drug use, forced migration from neighbouring countries and an estimated 1.2 million orphaned and vulnerable children (UNICEF, 2014), in addition to the mental health implications of HIV and AIDS. There is also concern regarding women's mental health.

There are positive developments in user and carer involvement and initiatives to promote employment and tackle homelessness. The opportunity for collaboration with traditional healers is recognised with an estimated 70% people consulting traditional healers before turning to mental health services. Stigma towards people experiencing mental health difficulties is widespread although there is the potential to transfer strategies, successful in combating prejudice on the grounds of HIV/AIDs, to mental health.

The international agenda in higher education and social work

As noted above, one impetus for the project was the growing emphasis within the UK's higher education sector on 'internationalisation', a term frequently used to denote those processes that seek to provide an 'internationalised student experience'. This includes '*a curriculum that is robustly informed by a broader world view and opportunities to study and work in different environments and countries...*' (HEA, 2013). Reference is also made to the need to equip student for their future '*as citizens in an increasingly interdependent / globalising world*' (Killick, 2008: 2). Fielden (2011:8) draws a distinction between internationalisation abroad, involving staff and students moving in and out of the UK, and internationalisation at home, concerning the internationalisation of the curriculum and enhancing the quality of the international student experience, raising the question as to the extent it is possible to 'think globally' while 'staying local' (Dixey, 2012). The partnership described in this paper falls within the broader concept of internationalisation in higher education whereby the involvement of staff in an international project has the potential to contribute to the internationalisation of the curriculum in the UK, as well as in Zambia.

Aspects of this internationalisation process are clearly relevant for mental health and social work education located within the Higher Education sector in the UK. In particular there is a need to prepare students for practice in diverse communities where there may be different

cultural perspectives, for example, on parenting or mental health. Such developments are also supported by a growing interest in international social work, described by Hugman as: ‘practice and policy concerning situations in which professionals, those who benefit from their services or the causes of the problems that bring these two actors together, have travelled in some way across the borders between nations’ (2010:20). For educators, negotiating such borders requires a critical analysis regarding the tendency towards the one-way transmission of professional practices from the global North to the global South, repeating patterns of colonial and post-colonial relationships.

However, despite some developments (SWAP, 2011), there are only limited examples in social work education in the UK of ‘internationalisation abroad’ (Fielden, 2011:8) involving international partnerships for teaching, research and student exchange. Such activities may also present their own tensions and challenges as will be described in this paper.

The Project

Chainama College of Health Sciences is the national centre in Zambia for the education of mental health nurses and clinical officers in psychiatry and general medicine, as well as providing training for environmental health technologists and medical licentiates. The College also shares a campus with the main psychiatric hospital. The origins of this project lie within a pre-existing relationship between Chainama College and Leeds Metropolitan University, England. Since 2004 Leeds Metropolitan University has delivered a Masters in Public Health and Health Promotion in Zambia, with academic staff from Leeds regularly travelling to Chainama College to deliver blocks of teaching (Dixey & Green, 2009). This established link and the associated regular contact between the two educational institutions led to ‘spin-off’ projects, including the initiation of new contacts between mental health educators in both institutions. A visit to Zambia by the UK-based author of this paper

facilitated discussion concerning the potential for a collaborative project to support the development of mental health education and training in Zambia, in response to the move to community-based services. This objective formed the basis of a successful application for a three year British Council Development Learning Partnership (DeLPHE).

The specific aim of this project was to support the development of the mental health workforce in Zambia to meet the demands of a new mental health policy with an emphasis on reciprocal and mutual learning for both partners. The project was led by a co-ordinator in Zambia supported by Zambian and UK-based colleagues.

In each year of the project three two-week visits took place involving two staff from each institution, with one visit from Zambia to the UK and the other two visits from the UK to Zambia. Attention was paid to continuity of contact and relationship-building, an inclusive approach and the need for orientation in each country. Email communication ensured continuing contact between visits. A number of stakeholders, including representatives from the University of Zambia, the Ministry of Health mental health policy unit and the Mental Health Users Network of Zambia, were involved throughout the project from early planning through to a final conference. Although the project included activities to support curriculum redesign and alignment, the main focus of this paper is on work to support practice development.

The interprofessional nature of this project is a key feature. UK project members with backgrounds in nursing, psychology, occupational therapy and social work, shared a commitment to interprofessional working in mental health and mental health education, drawing on psychological and social perspectives to promote recovery and social inclusion (HM Government, 2011; NIMHE, 2005). All were involved in delivering mental health education within and across professional areas including mental health nursing and social

work. Within the project the main emphasis was on the training and education of clinical officers and mental health nurses at Chainama College. Although social work education is not offered at the college there are placement opportunities within the adjacent hospital and social workers attended workshops for practitioners.

Project activities included a series of workshops for practitioners and educators in Zambia addressing community mental health practice and drawing on psycho-social models of care. Additionally a two day workshop was provided for volunteer carers, previously trained as HIV counsellors, who were now supporting people with mental health difficulties. This offered basic mental health awareness and skills in working with individuals and their families, reflecting similar work undertaken elsewhere (Basic Needs, 2009a). This was in line with the recognition that in low income countries such as Zambia, the future development of mental health services rests on increased capacity at the primary care level and the integration of mental health care alongside other health care provision (WHO, 2008; Mwape et al, 2010).

Visits to the UK included meetings with mental health practitioners and visits to statutory and non-statutory services. Seminars on cultural beliefs and practices in relation to mental health in Zambia were presented to UK students, educators and practitioners.

Methodology

This paper presents some aspects of the reflective journey experienced by the authors during and following this project. This is therefore a narrative account, grounded in 'reflection-on-action' (Schon, 1983) although the individualistic nature of this approach is recognised (Humphreys, 2008). Fook (2002) identifies different discourses underpinning reflectivity and reflexivity with the former based on professional and educational practice and the latter

originating from the social sciences, particularly ethnographic research. Fook also highlights the potential of reflexive processes for emancipatory practices including challenging domination in relation to external structures, social relations and the construction of knowledge, through communication and dialogue. These processes have informed the reflections on the experiences of the project that are discussed in this paper.

Within this approach the positioning of the narrator is crucial (Pease, 2010; Ramazanoglu, 2002). It is therefore important to acknowledge how the authors' individual experiences have brought both commonalities and differences to our relationship, inevitably shaping our perceptions and understanding of our work together. One author of the paper is a Zambian Black African woman who was project co-ordinator in Zambia throughout the life of the project. She holds a senior academic post in the college and has previous experience as a clinical officer (psychiatry). The other is a white British woman, based in the UK and with extensive experience in social work and mental health practice and education. She was involved in the initiation of the project and remained a project member throughout. During the life of the project her role in the UK included responsibility for interprofessional mental health education and mental health teaching for qualifying social work students.

The reflections that informed this paper were gathered as part of a continuing process of dialogue and discussion between the two authors that took place throughout the project. The paper was initially drafted by the first author and then passed between the two authors for comments and review. Other project members were also offered the opportunity to comment on the paper.

Discussion

As already noted, the experience of an international project, such as that described here, may bring its own tensions and challenges. These will be explored here using Gray's (2005) three-pronged framework, as we have found it to be a useful heuristic device in highlighting the dilemmas inherent in international social work and the 'paradoxical directions or contradictory processes' (Gray: 2005:231) involved in cross-cultural dialogue and exchange, creating shared and universal understandings whilst, simultaneously, resisting the imposition of a form of professional imperialism. Gray (2005) frames these processes respectively as indigenisation, universalism and imperialism. Indigenisation refers to the grounding of practice in the local context, paying attention to multiple voices and ways of knowing whilst questioning universal claims regarding knowledge and experience. Universalism refers to the search for commonality across contexts, in order to arrive at shared understandings.

Imperialism points to the privileging of Western perspectives and the one-way transmission of ideas and thinking from the 'North' to the 'South', replicating colonial and post-colonial relationships. The risks of professional imperialism have also been highlighted by Midgley (1981), who grounds analysis of the internationalisation of social work in an understanding of historical relationships rooted in colonialism and the uncritical transfer of welfare practices from the countries of the North to the global South.

Within this debate, the central importance of culture will also be acknowledged, recognising that this is not static and fixed but fluid and dynamic in its meaning (Gray, 2005; Midgley, 2008), and endorsing Gray's assertion that culture is 'central to questions about international social work' (Gray, 2005:237). The discussion will develop the main themes of this paper, firstly, the risk of reinscribing colonial relationships between partners who could be designated as donor and recipient and, secondly, the importance of dialogue and relationship in working together.

Firstly, Gray's definition of imperialism as: *the dominance of Western world views over diverse local and indigenous cultural perspectives* (2005:231) is found in the history of mental health services in Zambia. Services are based on a model of Western psychiatry including the dominance of a medical perspective and a reliance on pharmacology and in-patient treatment. The development of care and support in the community remains limited. Recent policy changes place a strong emphasis on delivering care as close to the family and community as possible, offering new opportunities for professionals and new roles and responsibilities for community-based health workers. This shift from institutional to community care also creates the potential for rethinking the emphasis on a medical model and acknowledging the potential contribution of social and holistic approaches.

The workshops delivered as part of this project were intended to offer an alternative to Western medical models and concepts of mental ill-health, drawing instead on a social perspective that included recognising the importance of cultural and spiritual beliefs and practices. However it was recognised, by both the facilitators and participants, that this objective contained an inherent tension, in possessing the potential for being interpreted as yet another example of the imposition of dominant Western views, by virtue of the involvement of members of the UK project team.

These tensions were openly acknowledged with the facilitators working to create a safe environment for critical discussion and dialogue, emphasising sensitivity and openness to different perspectives including a critique of Western models and resources. This enabled Zambian cultural beliefs and practices regarding mental health to be explored for their potential contribution to creating new and relevant ways of thinking about mental health practice in the Zambian context. Participants were invited to share their own experiences of working with traditional healers and this was linked to relevant policies (Ministry of Health,

2008; National Mental Health Services Unit/Directorate of Public Health Research, 2007).

The facilitators also worked to 'decentre' a Western medical perspective by referring to other models of mental health emphasising culture and spirituality (Fernando, 2002; Campbell-Hall et al, 2010; Sorketti et al, 2010) and to developments in mental health provision in comparable low and middle income countries (Basic Needs, 2009b). Reference was also made to the involvement of traditional healers in South African health care systems (Carbonatto, 2009), offering the potential for positive alliances building on trusted community resources.

The opportunity for Zambian colleagues to visit mental health services in the UK could also be interpreted as containing the implicit message that these services offer a model of best practice to which others should aspire. However this was addressed by creating a balanced programme that included community-based third sector organisations with a strong emphasis on service user and carer involvement, alongside statutory mental health services.

Secondly, certain aspects of this project suggested some shared experiences between Zambia and the UK in line with Gray's definition of universalism as finding: ... *commonalities across divergent contexts* (2005: 231). For example, the stigma and discrimination experienced by people with mental health difficulties can be found in Britain and Zambia as well as elsewhere in the world. The importance of user involvement and participation also offered common interests and points for discussion. However it was important to avoid superficial comparisons in an attempt to claim commonalities. Further in-depth discussion of the issues relating to stigma in Zambia revealed more nuanced meanings related to individual shame and honour which may not easily transfer to the overall British context, although these may be highly relevant in certain communities. Similarly, although the discussion amongst the women involved in the project highlighted many shared experiences, it would be a mistake to

have allowed this to obscure the ways in which experiences diverged, reflecting continuing patterns of inequality embedded within colonial and post-colonial relationships.

Critical examination of some seemingly apparent 'givens' in values and practices was also required. Notions of individual self determination and confidentiality, fundamental to practice in the Western world, may not have universal application and indeed have been seen as irrelevant to practice where wider familial and community systems and relationships are emphasised (Silavwe,1995). There may also be different ways of viewing emotional and psychiatric problems outside a conventional 'Western' health paradigm (Thomas, 2006). In one workshop with a group of community health workers, the distinction between thoughts and feelings was unrecognizable to the participants who explained that these were seen as originating from the heart and were indistinguishable. This required some rethinking of the content of the workshop by both UK and Zambian project team members, in order to respect the participants' views. Issues such as these challenge over- simplistic notions of universal understandings and provide the stimulus for further debate, seen by Hugman (2010:135) as the challenge that must be faced if the 'legacy of professional imperialism' is to be overcome.

The need to be sensitive to context, as described above, relates directly to Gray's third 'prong' of indigenisation. This is understood as fitting practice to local contexts and recognising the significance of traditional beliefs and practices (Gray, 2005; Yunong & Xiong, 2008). The workshop for community health workers commenced with asking participants to tell stories about their experiences, offering a rich resource for subsequent discussion, grounded in the local context. Traditional beliefs and practices regarding mental health were also explored, recognising their continuing power and influence and the need for a constructivist approach incorporating the personal narratives of workers, those affected by mental health difficulties and their families and communities. These included recognising the

significance of witchcraft, evil spirits and ancestors in addition to aspects of Christian beliefs and practices offering the healing potential of prayer, as well as the view that mental ill health may be a punishment for sin.

Fernando (2002) comments that attempts at collaboration between Western psychiatry and traditional beliefs are faced with reconciling fundamentally different world views as well as the contradictions implicit in recognising both universal and culturally-specific aspects of mental health. The co-facilitation of workshops by Zambian and UK project team members provided a positive model of collaboration and mutual respect. This supported the facilitators in maintaining attention to the structures and dynamic process of the workshop and working to avoid the imposition of Western values and systems. This required hearing the beliefs and experiences of participants and responding in a respectful, flexible and at times tentative fashion. Language and visual metaphors, commonly used in the UK, were reviewed for their acceptability and, where appropriate, replaced.

Developing mental health systems that are relevant and sensitive to the local context is another facet of indigenisation. Patel (2008) comments that tackling the treatment gap in developing nations requires innovative solutions that do not resort to imitating the West. He, and others, propose that non-specialist healthcare workers offer front line mental health care, tackling stigma within overall health and well-being (WHO, 2008; Saraceno et al., 2007).

Whilst helpful, the concepts of imperialism, universalism and indigenisation also raise further questions. Firstly a fundamental challenge to the notion of cultural sensitivity rests in the potential for indigenous beliefs and practice to be in conflict with fundamental values and human rights (Midgley, 2008). At the same time such concepts in themselves can also be understood as inherently Eurocentric reflecting the European philosophical tradition (Hugman, 2010: 125). Notions of cultural diversity are then understood as a modification of

the 'norm' grounded in the majority world with corresponding notions of 'othering' those whose practices and experiences are embedded in alternative cultural systems. Yunong and Xiong (2008) also offer a critique of the indigenisation discourse, highlighting the risks of re-enforcing oppressive practices in the name of cultural sensitivity. They challenge the assumption that Western practitioners do not address issues of local and cultural context in their practice, suggesting that this is fundamental to all practice, rather than specific only in 'other' contexts.

The juxtaposition of human rights with mental health and social work practice can be understood as part of an over-arching framework accommodating a variety of contextually sensitive practices. This includes ensuring that communication and confidentiality are handled in ways consistent with cultural values, respecting rather than challenging diverse understandings of emotional health and wellbeing and grounding practice in communities rather than professional discourse. This needs to be accompanied by a commitment to challenge the violation of human rights of those with mental health difficulties and to build alliances with progressive movements such as user and carer groups.

It is also necessary to unpick the dichotomous thinking that lies beneath much of the debate in this area. Some aspects of this can be found in the north-south / developed-developing divide that mirror the distinction between resourced and resource-challenged societies and associated notions of scientific-rational-medical discourse versus cultural beliefs and traditional healing. Such distinctions obscure the complexity of mental health practice in any setting, including the 'west', as well as failing to recognise the global context within which all such practice is taking place. Evidence of dichotomous thinking may also be found in the assumption of homogeneity regarding mental health in Zambia or in the UK, further compounded by the difficulty, referred to by Gray & Fook (2004), in tracing the extent to

which dominant '[Western] cultures have been infused into [their] ways of thinking and being' (2004:632).

Furthermore, despite a concern that a project of this nature may simply reinscribe post-colonial relationships of domination and exploitation, questions have been raised regarding 'the transfer of ideas and practices in the other direction' (Hugman, 2010: 143). Although this has frequently been seen as retaining a differential between the development of services and / or training at the broad level for the 'developing' partner and increased cultural knowledge and curriculum development on the part of the 'developed' partner, there is increasing recognition of the 'mutuality of benefits, and 'two-way flow' of energies, expertise and knowledge (Syed et al, 2012:8). However Syed et al's (2012) review of the advantages of international partnerships for developed countries concludes that the understanding of potential for 'reverse innovation' remains 'fragile' and limited to less tangible benefits.

For this Zambia – UK partnership the potential learning for the 'developed' country includes increased capacity for working with diverse communities whose understanding of mental health are located within distinct cultural practices and beliefs not easily accommodated within Western psychiatry. Interest in spirituality and religion within the UK may also have more in common with, and much to learn from, traditional mental health practices. Similarly the notion of professional roles in mental health may be evolving with primary care mental health workers offering new configurations of what is generally understood to be the 'professional' role. Community development activities, often in partnership with user and carer groups, have also been initiated to promote the mental health of black and minority ethnic groups in Britain (NIMHE, 2003). Overall these issues contribute to increasing awareness of global mental health and the ways in which this is embedded in complex power relations.

A key aspect of learning from this project concerns the central importance of dialogical processes (Gray & Fook, 2004:626), creating opportunities to explore commonality and difference throughout the project. At the core has been a shared commitment to mental health, recognising the different contexts that shape experience in either country, requiring the ability to ‘tread lightly’ (Gray, 2005: 236) in each other’s worlds.

Additionally, the emphasis on reciprocal and mutual learning challenges the dichotomous thinking that can characterise north/south partnerships and highlights the need to avoid the repetition of patterns of exploitation. For the members of the UK team it has prompted further learning about mental health practices within a wider global perspective, with associated benefits for curriculum development across a range of professional programmes. In particular, a broader global perspective has now been embedded within the UK author’s teaching of mental health to qualifying and post-qualifying social work students.

Furthermore, the tensions between a remedial / residual model of care focused primarily at the level of the individual, and a model grounded in social development working towards macro level interventions with communities to address inequalities and promote social justice, have been highlighted with students (Hall & Midgley, 2004; Morrison, 2010). These tensions help to draw attention to the contested definition of social work as understood and practised in Zambia and the UK and promote the ‘decentring’ of dominant Western approaches and models (Bywaters et al, 2009).

As in other projects of this kind, a level of ambivalence remains concerning the extent to which the two-way learning process fundamentally challenges underlying structural inequalities in the partnership (Hokenstadt, 2003; Connell, 2007). In this example, the UK team were anxious not to be seen as purveyors of yet another version of Western culture and

approaches to mental health, whilst, at the same time, maintaining a holistic approach grounded in human rights, involvement and participation. There was also recognition of the limited resources available for mental health care and education in Zambia whilst acknowledging the impact of wider global systems, in which the UK is, and was, complicit. These tensions echo the fundamental question posed by Fook (2002) in relation to social work: ‘How can we simultaneously locate ourselves in situations and at the same time work to change them?’ (2002:164). In this partnership, a shared commitment to respectful working practices that also challenged underlying inequalities enabled the containment rather than the resolution of these tensions, recognising the complex, multi-layered and sometimes contradictory nature of the work.

Conclusion

The project described in this paper has demonstrated the potential of working across boundaries to build sustainable partnerships, bringing together mental health and social work practitioners, educators, students and stakeholders including users and carers, to develop the workforce for the future. This included the creation of new spaces for dialogue with stakeholder meetings and a final conference in Zambia as well as seminars and visits in England. These in turn have contributed to generating ‘new analytical lenses’ (Harrison & Melville, 2010:3) in terms of the understanding of the global interconnectedness between social work and mental health practice and education, and wider social and economic inequalities.

In terms of the stated objectives, feedback from the project stakeholders indicated that the partnership made a positive contribution to supporting educators in their commitment to educating the mental health workforce for future practice in the community (British Council,

2010). Additionally this work has contributed to the internationalisation of the English social work curriculum 'at home' (Fielden, 2011:8).

The project described here points to the continuing need to develop the thinking and practices associated with international partnerships as part of the internationalisation agenda in higher education (Wanni et al, 2010). This includes exploring the potential, in future projects, for replacing bi-lateral with tri-lateral arrangements in order to build relationships between two partners from low income countries. There is also a need to devote greater attention to the longer term sustainability of successful project outcomes.

The use of Gray's (2005) 'three-pronged dilemma' has provided a helpful framework to critically reflect on the complexities involved in international partnership of this kind. These include developing a means of navigating the 'three-pronged' dilemma within a relational framework of partnership and a heightened awareness of the need to locate practice within the wider social, cultural and economic context.

The experience of this project also highlights the importance of time and resources to build relationships, offering a challenge to any 'quick fix' internationalisation agenda in which student curricula are superficially adjusted and efforts are made to recruit international students. However such work offers considerable support for promoting an international and inter-cultural perspective for social work and mental health in both practice and education, based on the opportunities offered by dialogue and mutual learning.

Acknowledgements: To follow

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