A Cultural Consultation Service in East London: Experiences and Outcomes from Implementation of an Innovative Service

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Executive Summary

1. In the context of the increasing challenges facing mental health services and in line with existing equalities guidance (including the NHS Tower Hamlets Mental Health Promotion Strategy 2008-2011), the Cultural Consultation Service (CCS) was commissioned by Tower Hamlets NHS with support from the National Mental Health Development Unit to provide cultural consultation in East London. The CCS was designed to work at multiple levels of service delivery and commissioning with an additional focus to promote recovery and facilitate high quality clinical learning.

2. The cultural consultation model has its foundations in social science and anthropological principles in the assessment, engagement and treatment of patients. The intention is that person centred narratives are considered in the assessment and treatment plan and in therapeutic communications. It consists of a clinical cultural consultation to help ascertain the complexities of care, to understand service user narratives, and to evaluate therapeutic processes and their cost effectiveness.

3. The broad aims of the service were to:

- improve clinical outcomes, service user outcomes, and the experience of mental healthcare for patients from black and ethnic minorities.
- improve the cultural capability of mental health professionals.
- work at a strategic level with commissioners to inform the process of development and improvement of services.

4. The CCS was launched in 2010 and originally commissioned for a period of three years. During the course of the first year to 18 months, the CCS aimed to develop and pilot the service specification whilst embedding itself within the local commissioning and health care systems. However, due to the financial constraints in the current economic climate, the CCS commission was modified to come to an end after an 18 month period resulting in the amendment of service aims and timelines.

5. Over 900 clinically related contacts were provided. The CCS received a total of 99 referrals for in-depth consultation over a period of 18 months. Qualitative findings were collected from 46 cases which had in-depth consultations. Quantitative outcome measures were available for 36 of these in-depth consultations both at baseline and follow-up at least 3 months following a clinical cultural consultation.

6. Overall, service users referred to CCS had high levels of clinical needs. The Health of the Nation Outcomes Scale (HoNOS) was particularly high with an average score of 15.9.

7. After the cultural consultation contact, clinicians rated service users as having significantly higher overall functioning. Although no significant changes were found in service users' perception of their overall health, levels of depression and anxiety, objective scores did indicate some improvement.

8. The level of service receipt (and by implication associated costs) significantly reduced after CCS intervention, with a significant reduction in use of A&E services, psychiatrists and CPNs/case managers. Overall,

- GAF scores improved, indicating better functioning levels.
- Cost analysis indicates that savings amounted to £497 per patient, taking account of service use costs (which go down after intervention) and costs of CCS provision to this group. Therefore, CCS intervention costs NO MORE than usual care, and was shown to actually reduce spend per patient over a three month follow-up.

9. Clinicians found CCS helpful as it provided a richer clinical perspective and allowed service users to share issues about life and illness experiences that were not previously known to staff. More specifically, clinicians had felt the cultural consultation service had helped to provide: changes to treatment plan (71%); improved engagement (50%); increased medication compliance (21%); and earlier discharge (7%). Forty-five per cent of those clinicians who responded wanted to have a cultural consultant permanently based within their team and cited lack of resources as the main obstacle to implementing the recommendations of the CCS.

10. Training sessions were delivered to five community mental health teams within Tower Hamlets, the Voluntary Sector Network, and there was a one day training on the Barts Explanatory Model Interview. In addition, there were monthly Cultural Consultation Club meetings where case presentations took place to a wider audience. Overall there was positive feedback, as clinicians reported that they had gained new knowledge with regards to ways of working with culture and in engaging with patients' often complex narratives. This was objectively supported by significant improvements in cultural competency as reported from a validated self-evaluation quantitative questionnaire completed by clinicians which indicates that workforce cultural competence as an aggregate measure improved over time.

11. The CCS provided six organisational consultations through a series of workshops on culturally competent commissioning focusing on increased awareness of the context of local services and identifying priorities for future direction.

12. Having a tertiary service of cultural consultation may offer a privileged point of observation of teams' cultures, functions and dysfunctions. It may clarify where the problems lie, rather than to offer simple solutions. Cultural consultation can therefore be conceptualised as both an effective and direct clinical intervention which improves functioning, met need, cultural competency, and it reduces costs per patient. It can also be used as a tool to analyse the scale of a clinical or organisational dilemma and what the solutions might be.

1. Introduction

This is the final report of the Cultural Consultation Service (CCS) which was originally commissioned by NHS Tower Hamlets and the National Mental Health Development Unit (NMH DU). Launched in 2010, the CCS was commissioned to improve the delivery of culturally capable mental health care by mainstream services within East London. The service was designed to work at multiple levels of service delivery and commissioning to tackle the complexities of cultural diversity and health inequalities. In addition, there was a focus on promotion of recovery and facilitation of high quality clinical learning. The first commission ended in December 2011, with some exciting and significant findings that will be used to inform future commissioning, workforce development, as well as the on-going work of CCS.

1.1 Background

Recent research has consistently highlighted unfavourable ethnic inequalities of health care experiences and outcomes. These disparities are compounded by poverty, poor quality housing and physical health problems. Consecutive governments have attempted to deal with race and ethnic inequalities in mental health care. However, currently, there is still over representation of some black and minority ethnic (BME) groups as detained inpatients, within assertive outreach services, and the criminal justice system.

The Delivering Race Equality (DRE) programme, set up by the Department of Health in 2005, established a five-year action plan for reducing inequalities in black and minority ethnic patients' access to, experience of, and outcomes from mental health services. One of the 12 main targets of DRE was "a workforce and organisation capable of delivering appropriate and responsive mental health services to BME communities."¹ The CCS attempted to address this outstanding need.

The Equalities Boards in NIMHE and NMH DU before their closure, as well as the work proposed in the Marmot review on health inequalities (www.marmotreview.org/), have all played a role in guiding commissioning boards to find effective models of commissioning, managing and care provision that not only promote equality but are also evidence-based care. The most recent public health white paper² tackles poor mental health in order to reduce overall population disease burden. The white paper places emphasis on appropriate access and positive outcomes, through focusing on employer responsibilities, reducing and remedying inequalities, and promoting resilience in the wider population.

The cultural backgrounds of service users, carers and clinicians necessarily cultivate a set of preconceptions that serve as barriers to effective utilisation of mental health services. These cultural complexities may account for and perpetuate inequalities for BME groups. For

¹ Wilson, M: Delivering Race Equality in Mental Health Care: A Review. Department of Health, 2009.

² Healthy Lives, Healthy People, Department of Health White paper. November 2010

example, different perceptions of the causes and consequences of, and treatments for, illness can lead to conflict in the therapeutic relationship, complaints, poor experiences and outcomes, and a lack of engagement related partly to a failure of shared decision-making. These issues tend to be overlooked and given less priority than containment of immediate risk and the need for efficient use of resources available to service providers. Part of the solution lies in developing the clinical skills of staff so as to improve on the quality of the relationship and interaction with patients thus ensuring accessibility of effective care, and take-up of care through good therapeutic relationships. This would result in better service user outcomes, irrespective of the financial climate and alongside careful and considered risk management.

Consequently, in the context of the increasing challenges facing mental health services, and in line with existing equalities guidance (including the NHS Tower Hamlets Mental Health Promotion Strategy 2008-2011 which recognized 'culturally appropriate mental health promotion' as one of its initiatives), the CCS was commissioned to provide cultural consultation in East London by Tower Hamlets NHS³ with support from NMHDU.

1.2 Cultural Consultation: The Service Model

Cultural consultation is both a clinical process and an evaluative tool that enables the understanding of the complexity of assessment, diagnosis and treatment in healthcare settings. It takes a broad and encompassing definition of culture drawing on social science, specifically anthropological principles, in the assessment, engagement and treatment of patients. This ensures that therapeutic communications and person centred narratives are considered in the assessment and treatment plan. The CCS service specification was primarily adapted from a good practice model in Canada⁴ that showed the importance of cultural consultations in improving diagnostic accuracy, culturally relevant care planning, and workforce satisfaction. In addition, it highlighted the training needs of professionals. Our adapted model was also informed by work undertaken in the national race equality programme, EPIC⁵, which highlighted the importance of strong clinical and managerial leadership, along with organisation-wide commitment to clinical teams to contribute to better service user outcomes as well as positive pathways into and out of care.

1.3 Local population and mental health service provision

London has the most ethnically diverse population in the UK. Within London, Tower Hamlets is a unique borough having a high index of ethnic and religious diversity. Inequities in healthcare and mental wellbeing are major challenges, in part due to over-crowding, high unemployment, homelessness, poverty, high rates of substance misuse and poor physical health. On the Index of Multiple Deprivation 2004 (Office of the Deputy Prime Minister), Tower Hamlets is the fourth most deprived area in England and Wales. Cultural barriers may

³ Tower Hamlets Primary Care Trust. Tower Hamlets Mental Health Promotion Strategy 2008-2011. 2008

⁴ Kirmayer L, Groleau D, Guzder J, Blake C, Jarvis E. Cultural Consultation: a model of mental health service for multicultural societies. *Canadian Journal of Psychiatry* 2003; 48(3): 145-153.

⁵ <http://www.wolfson.qmul.ac.uk/psychiatry/epic/>

influence identification of mental disorders and access to appropriate services within the borough. This may partly explain the lower than expected prevalence of depression while the prevalence of schizophrenia is similar to the national average. On the other hand, the incidence of all psychoses is generally higher in London when compared with Nottingham and Bristol, but specifically higher in some migrant groups.⁶

The East London NHS Foundation Trust (ELFT) is a specialist mental health trust which provides specialist mental health services to the boroughs of Tower Hamlets, City and Hackney, and Newham, in addition to other community service provider roles. The CCS was commissioned to work closely with specific mental health teams from the ELFT to provide cultural consultation. The service aimed to enable the trust to work towards its vision of ensuring equality and valuing diversity, developing a capable workforce and promoting social inclusion and recovery oriented care.

1.4 Cultural Consultation Service - Aims and Objectives

The broad aims of the service were established in consultation with NHS Tower Hamlets and were to:

- Improve clinical outcomes, service user outcomes and the experience of mental healthcare for service users from BME communities
- Improve the cultural capability of professionals working with mental health service users from BME communities
- Improve the cultural capability of health systems and organisations, and enable their reorientation towards social inclusion and recovery-oriented approaches.

The CCS's broad aims were to be delivered through the achievement of the following specific objectives:

- **Clinical Cultural Consultation:** to work as a tertiary service and provide expert specialist consultation and advice to maximise culturally capable clinical care for mental health service users. CCS expertise was to apply clinical and research evidence as well as draw on specialist international and national resources to improve patient outcomes.
- **Learning and teaching for service user benefit:** through the provision of consultation, advice and support at the level of the clinical team, to: a) develop the attitudes, knowledge and skills of mental health staff, thereby enabling clinical teams to be culturally capable; b) to develop mental health services that are more culturally capable and responsive to local need; and c) to develop mental health services that are more socially inclusive and recovery orientated
- **Organisational analysis and consultation:** to work at a strategic level with commissioners, to inform the process of development of and improvement of mental health services such that these are effective in meeting the needs of the BME communities in general, and more specifically, the local community.

⁶ Coid JW, Kirkbride JB, Barker D, Cowden F, Stamps R, Yang M, Jones PB. Raised incidence rates of all psychoses among migrant groups. *Arch Gen Psychiatry*. 2008; 65(11):1250-8

2 Audit and Evaluation Process

The CCS was originally commissioned for a period of three years. During the course of the first year to 18 months of the commission, the original brief of CCS was to develop and pilot the service specification whilst embedding itself within the local commissioning and health care systems. This change management process reflected the time needed to change complex systems and for local leads to take forward such changes. However, due to the financial constraints in the current economic climate, the CCS commission was modified to come to an end after an 18 month period resulting in modified service aims and timelines. The current report reflects CCS achievements and findings from a period of 18 months service delivery. Qualitative and quantitative outcomes were collected as part of the service activity. As the CCS work was part of an NHS commissioned service, all the audit or evaluation data were sought with the consent of any participating patients and staff. Staff were aware of the pioneering nature of the service and the need to identify and disseminate knowledge about the processes that positively impact on patient care, staff development, and corresponding health-systems change.

2.1 Qualitative Evaluation and Analysis

In line with the principles of the cultural consultation service models, the qualitative evaluation methods used were based on an anthropological approach. Cultural Consultants employed ethnographic methods in the delivery and evaluation of the service including participant observation, document analysis and unstructured as well as semi-structured interviews. CCS staff collected narratives as verbatim accounts of illness, care processes and outcomes at patient, staff, team, service management and commissioner levels.

Our qualitative evaluation included a narrative analysis and synthesis of the data and focussed on: a) key consistent narratives found across all teams; b) themes and narratives unique to specific referrals and teams, but which informed the overall body of evidence about how cultural consultation works, for whom it works and for which sorts of problems; c) unexpected challenges within clinical and organisational systems. Narratives of care experiences and the work of CCS were anonymised and analysed using NVivo 9 software by an independent data analyst.

2.2 Quantitative Evaluation and Analysis

Quantitative outcome measures were collected at first contact with both service users and clinicians (baseline), and at a minimum of three months following the final contact with CCS (follow-up). The outcome measures were completed by service users and clinicians.

Staff-rated clinical outcomes

Clinicians were asked to fill out three outcome measures, including the Global Assessment of Functioning (GAF)⁷, the Camberwell Assessment of Needs (CANSAS)⁸ and the Scale to Assess

⁷ American Psychiatric Association. *Diagnostic and Statistical Manual of Mental Disorders-III-R* (3rd edn, Revised). American Psychiatric Press. 1987; Washington, DC.

Therapeutic Relationship (STAR)⁹. In addition, Health of the Nation Scales (HoNOS)¹⁰ was collected from the Rio database for each of the service users.

Service user-rated outcomes

Service users were asked to rate their general health (EuroQol)¹¹, level of depression and anxiety (CORE-10)¹², needs (CANSAS), and relationship with their clinician (STAR). In addition, they were asked to describe the explanatory model for their illness experiences using the Barts Explanatory Model Inventory (BEMI)¹³. BEMI captures socio-cultural beliefs, values, and practices around illness experiences. The narratives elicited could enable the practitioner to identify the important issues for the service user.

Cultural competence

Over the course of the Cultural Consultation Service, staff were asked to report on their own level of cultural competence using the Tool for Assessing Cultural Competence in Training (TACCT). The TACCT¹⁴ was administered separately and distributed across all three participating teams at two time intervals: December 2010 and July 2011.

Service level outcomes

To measure the extent of service use and cost consequences, the Client Socio-demographic and Service Receipt Inventory – European version (CSSRI-EU)¹⁵ was used.

2.3 Service evaluation from service users and clinicians

Service users and staff were asked to provide feedback about how CCS affected care and what were the most critical factors for improved outcomes and better care experiences.

⁸ Phelan, M., Shade, M., Thornicroft, G., Dunn, G., Holloway, F., Wykes, T., Strathdee, G., Loftus, L., McCrone, P., & Hayward, P. The Camberwell Assessment of Need: the validity and validity of an instrument to assess the needs of people with severe mental illness. *British Journal of Psychiatry*, 1995; 167: 589-595.

⁹ McGuire-Snieckus, R., McCabe, R., Catty, J., Hansson, L., & Priebe S. A new scale to assess the therapeutic relationship in community mental health care: STAR. *Psychological Medicine*, 2007; 37: 85-95

¹⁰ Wing, J.K., Beevor, A. S., Curtis, R. H., Park, S. B., Hadden, S., & Burns, A. Health of the Nation Outcome Scales (HoNOS). Research and development. *The British Journal of Psychiatry*, 1987; 172: 11-18.

¹¹ Evans, C., Mellor-Clark, J., Margison, F., Barkham, M., McGrath, G., Connell, J., Audin, K. 2000, Clinical Outcomes in Routine Evaluation: The CORE-OM. *Journal of Mental Health*, 2000; 9: 247–255.

¹² Connell, J. & Barkham, M. CORE-10 User Manual, Version 1.1. CORE System Trust and CORE Information Management Systems Ltd., 1997.

¹³ Rüdell, K., Bhui, K., & Priebe, S. Concept, development and application of a new mixed method assessment of cultural variations in illness perceptions: Barts Explanatory Model Inventory, *Journal of Health Psychology*, 2009; 14 (2): 336-347.

¹⁴ Lie, D., Boker, J., Cleveland, E. Using the Tool for Assessing Cultural Competence Training (TACCT) to Measure Faculty and Medical Student Perceptions of Cultural Competence Instruction in the First Three Years of the Curriculum *Academic Medicine*, 2006; 81(6): 557-64.

¹⁵ Chisholm, D., & Knapp, M. Development of the CSSRI-EU. In Thornicroft et al (Eds). *International outcome measures in mental health. Quality of life, needs, service satisfaction and impact on carers*. Royal College of Psychiatrists. 1997.

2.4 Learning and teaching activity

Feedback from staff and from the learning and teaching events was collated.

2.5 Organisational narratives

Organisational consultations and narratives were subjected to thematic and descriptive analyses.

3 Results

The results are presented at the three levels of the Cultural Consultation Service: clinical cultural consultation activities and outcomes; narratives and outcomes of workforce development; and organisational narratives and insights.

3.1 Clinical Cultural Consultation – Service Activity and Findings

3.1.1 Service Activity

Over a period of 18 months, the Cultural Consultation Service team conducted over 900 clinically-related contacts which included over 350 face-to-face contacts with staff, over 300 face-to-face contacts with service users, and more than 250 contacts with staff at team meetings.

Of 99 referrals of complex cases, forty-six complex clinical consultations were completed, of which 38 were direct and 8 indirect consultations.¹⁶ For the 46 complex clinical consultations, quantitative outcome measures were collected for each service user at two points in time: at baseline (either prior to or shortly after the first interview), and at follow-up (a minimum of 3 months following the cultural consultation intervention). Direct clinical consultations consisted of face-to-face meetings with both service users and clinicians, whereas indirect clinical consultations were conducted with clinicians only.

¹⁶ The CCS received a total of 99 complex case referrals, 84 of which were accepted for consultation over a period of 18 months; 11 referrals were resolved by the provision of important information, and 4, when discussed with the referring clinician, were deemed inappropriate for an in-depth CCS consultation. A further 38 were not completed due to practical constraints of accessing service users and ensuring consent was carefully considered, especially for service users who were largely out of contact with services. Of these 38 that were not completed, 53% did not wish to receive an in-depth CCS assessment, 25% could not be completed as the commissioned service was coming to an end, in 13% staff did not have time to work effectively with us, in 3% service users were discharged to their GP before we had completed our work, and in 6% other practical constraints were evident.

3.1.2 Demographic Characteristics

Of the 46 in-depth consultations, 45.5% were referred by the Assertive Outreach Team, 34.1% by Bethnal Green CMHT, 18.2% by Home Treatment Team and 2.3% by Isle of Dogs CMHT.

Fifty eight per cent (58%) of CCS service users were male and 42% were female. With the exception of one person, all of the service users had an ethnic background other than white British, with the majority being Bangladeshi (39%). In comparison to the Tower Hamlets population, service users of black origin as well as those from 'other ethnic background' were proportionally overrepresented in use of the Cultural Consultation Service (see Figure I below).

The average age was 39 (sd=10.48), with the youngest person being 21 years old and the eldest 70. The vast majority of service users were heterosexual, 87.8% were unemployed, and 88.6% were reliant on state benefits.

For 38.1% of the cases an interpreter was required. Languages most often spoken were Bengali (34.1%), English (15.9%), Somali (13.6%) and Arabic (13.6%).

In terms of their mental health, 47.7% had a primary diagnosis of schizophrenia, with 61.3% having a diagnosis within the wider spectrum of schizophrenia, schizotypal and delusional disorders. The second most common diagnosis was mood disorder (29.5%). The high proportion of service users diagnosed with schizophrenia appears to be a reflection of the high proportion of service users referred by the Assertive Outreach Team. In total, 57.5% of the service users considered themselves to have a mental disability, while 40% said they did not have a disability.

Figure I: Demographic characteristics of referrals

3.1.3 Qualitative findings

The independent data analyst analysed the narratives from 46 referrals which had in-depth consultations. The dominant themes that emerged are discussed below, divided into the main reasons for referrals and the recommendations following case consultations.

The main reasons for referral

1. Perplexing and complex clinical presentations, lack of sufficient knowledge or lack of comprehensive understanding about the cases:

- Diagnostic clarification to gain a better understanding of illness presentation. Related to this some clinicians wanted a second opinion to confirm diagnosis or that treatment methods they had adopted were resonant with the service users' culture.
- Identification of possible cultural factors influencing an unclear clinical presentation
- Exploration and clarification of previous traumatic history (divorce, war, domestic violence, torture, forced marriage, rape), pre and post migratory experiences, migration history, previous experience, and how these impact on current presentation.
- Exploration of multiple frameworks in order to engender explanations of the factors that impede recovery of service users and offer creative ways through which complexities around recovery and disengagement could be managed.

2. Racism and discrimination:

- Exploration of service users' experience of racism and discrimination and evaluation of possible impact on current symptoms presentation and engagement.
- Exposure to violence and police arrests and previous coercive experience with mental health services in the UK.

3. Lack of engagement or progress and failed treatment alliance:

- Exploration of possible cultural barriers to engagement and treatment adherence.
- Examination of causes of disengagement from services / treatment teams and how to establish a long-term recovery oriented treatment plan.
- Request for mediation between family / carers and services to improve treatment alliance and outcomes.
- Exploration of cultural factors influencing family dynamics and difference between culturally appropriate family structures and pathological family constellations.

4. Exploration, and resolution, of cultural conflicts, and the impact of social changes on service user's recovery:

- Exploration of conflict between sexual orientation and culture of origin.
- Exploration of and guidance for resolution of conflict between culture of origin and UK culture.
- Resolution of intergenerational conflict between immigrant patients and step children.
- Exploration of the potential impact of sudden changes in service users' circumstances e.g. getting married, divorce, etc.
- Resolution of family dynamics, particularly when family involvement was seen as impeding service user recovery, and / or engagement with the team.

5. Information requests:

- Requests for information on culturally appropriate community links, support groups, and other resources.
- Requests for information on migration agencies and procedures, or international organisations, for instance, supporting parents whose children have been abducted by partners and taken abroad.
- Requests around identifying cultural support organisations in specific areas of service user needs, for instance, culturally appropriate family mediation, trauma psychotherapy, counselling, etc.

6. Defensive practices:

- Requests for generic involvement in care planning alongside other agencies for particularly risky cases

It is worth noting that some referrals were retracted, often when it was thought that CCS involvement might 'complicate' the case. In addition, some cases which could have benefited from an in-depth cultural consultation were not referred because it was feared that CCS involvement might delay discharge.

The main themes from clinical cultural consultation outcomes

The recommendations provided by CCS following clinical cultural formulations were specifically tailored to meet the requests of the team as well as the needs of the service user. In most cases recommendations broadly went beyond the teams' requests and were guided by the emergent narratives. The overall themes which arose from recommendations are discussed below:

1. Minimising miscommunication: The narratives of patients and providers often highlighted conflicting views. At best miscommunication led to feelings of dissatisfaction and frustration and in some cases contributed to misdiagnosis, dissatisfaction with services, feelings of lack of autonomy and choice, coercion with treatment, and disengagement. Clinical cultural formulations using the conflicting service user and clinician (and team) narratives were core to navigating the conflicts. The common practice of non-use of interpreters during clinical meetings, and in some GP practices, was highlighted as barrier to comprehensive engagement with service users.

2. Provision of links with third sector and statutory bodies for support: Whilst the need to acknowledge, and where possible support the practical needs of service users is expected, there are areas clearly outside of the remit and expertise of clinical teams. However engaging, and supporting individuals, with practical issues such as isolation, unemployment / skills training, housing, reunion / contact with abducted children, and immigration (children being in countries of origin abroad and unable to immigrate) through involvement of voluntary organisations that might be much better placed to offer support can lead to establishing trust and building of better therapeutic relationship as well as minimising disengagement.

3. Further interventions / assessments: The narratives exposed areas that could benefit from further or more structured assessments. CCS made suggestions of relevant avenues

that could be used in an endeavour to build a more accurate picture of the service users' illness experiences with concomitant solutions that would enhance recovery.

4. Psychological interventions: CCS made recommendations for psychological interventions where appropriate and identified organisations that were able to provide culturally appropriate counselling services. There was low uptake of psychological therapies among black and ethnic minority patients even though the needs were indicated, for instance, in cases of PTSD, and depression. The inaccessibility was mainly due to lack of knowledge of existing services (both by service users and clinicians), incomplete assessments, lack of culturally appropriate psychological services and unwillingness to negotiate with the service user the best mode of treatment.

5. Education, empowerment, autonomy and choice: The consultations highlighted the need for education as it was indicated from narratives that many service users and their families could benefit from learning more about their particular diagnoses, the need for, and effects of, treatment, and also about mental health in general. Promotion of autonomy and choice would reduce the feelings of powerlessness and commonly perceived coercion with treatment, even in the community, by service users.

6. Family engagement and mediation: Where families and partners were involved in the service users' life and care it was imperative that their role was not viewed as peripheral to that of mental health services. Many service users relied on their families' perceptions to guide their decision making, and thus their involvement in treatment programmes was highlighted as a major influence on their (service users) recovery. The narratives also highlighted the need for clear communication with families to avoid conflict which potentially impedes recovery and engagement with services.

7. Diagnostic clarification: In some cases CCS made diagnostic suggestions for teams. Some referrals were extremely complex with service users having a range of conflicting and competing narratives. CCS through clinical cultural formulations provided multiple frameworks in an attempt to enable clinicians to better understand service users' illness experiences and help-seeking behaviours. As well as providing a clear understanding for a particular diagnosis, at times CCS recommended for additional diagnosis.

3.1.4 Quantitative Findings: clinician and service user outcomes

A limitation of the audit and evaluation data is the small sample size and relatively low response rate from both clinicians (78% at baseline and 46% at follow-up) and service users (61% at baseline and 35% at follow-up). Only for the service level outcomes was data collected at a consistent number at baseline and follow-up (n=36). However, these findings suggest some interesting trends.

Clinician-rated clinical outcomes (n=36 at baseline; n=20 at follow-up)

Overall, clinicians considered CCS service users to have a high level of clinical needs. The Health of the Nation Outcomes Scale (HoNOS) was particularly high with an average score of

15.9 (sd=5.8), which seems higher than average scores around 10 in clinical samples found in the literature^{17, 18}.

After the cultural consultation process clinicians rated service users as having significantly higher overall functioning compared with ratings before the CCS work (see Table I, below).

Table I: Global assessment of functioning at baseline and follow-up

Global Assessment of Functioning scale	Mean	SD
Baseline (n=36)	47.3	16.0
Baseline (n=20)	42.5	14.9
Follow-up (n=20)	55.2*	16.8

*Wilcoxin Signed-Rank Test : $z=-2.32$; $p<.02$

No significant changes were found in the needs of service users (measured using the CANSAS), nor the clinician's rating of the therapeutic relationship (measured using the STAR).

Service user-rated outcomes (n=28 at baseline; n=15 at follow-up)

As the number of completed follow-up cases for service users was very low (n=15), it is not appropriate to test for statistical significance, but general trends are worthy of observation. When we compare the average score on the CORE-10 at baseline (mean=23.5, sd=11.3) and follow-up (mean=20.8 sd=11.8), there is a suggestion that scores do improve. Similarly service users indicated a small increase in met needs between baseline (mean=2.3; sd=1.4) and follow-up (mean=3.2; sd=2.1).

No significant changes were found in service users' perception of their overall health (EuroQol), or relationship to their clinician (STAR).

Quantitative Cultural Competence Assessment

In addition to qualitative feedback about teaching and learning, the overall cultural competence of clinicians within the clinical teams was also quantitatively evaluated using the TACCT, a self-evaluation tool for cultural components. Overall, 67 clinicians responded to the TACCT questionnaire at baseline and 28 at follow-up. When looking at the proportion of positive answers on the TACCT (agree to strongly agree), there was a significant improvement in how clinicians rated their level of cultural competency between baseline (mean=90.21; sd=19.11) and follow-up (mean=95.4; sd= 18.87) (Mann Whitney U= 635.5;

¹⁷ Wing, J.K., Beever, A.S., and Curtis, R.H. Health of the Nation Outcome Scales (HoNOS). Research and development. *British Journal of Psychiatry*, 1998; 172:11-18.

¹⁸ Sugarman, P., Walker, L., Dickens, G. Managing outcome performance in mental health using HoNOS: experience at St Andrew's Healthcare. *The Psychiatrist*, 2009; 33: 285-288.

$p < .02$, see Table II, below). At an aggregate level among those who responded, CCS seems to have improved attitudes, knowledge, and skills of clinicians that are invaluable in caring for patients from diverse socio-cultural backgrounds as well having the potential for addressing persistent inequalities in health. It is possible that our responders at the second measurement point were those who had benefitted the most, or had always scored highly. We could not exclude this source of potential bias, as we were attempting to measure aggregate levels of cultural competency in a representative sample of teams rather than track changes for individual clinicians.

Table II: Self-rated cultural competence levels of clinicians at baseline and follow-up

Tool for Assessing Cultural Competence training (TACCT)	Mean	SD
Baseline (n=62)	90.2	19.1
Follow-up (n=28)	95.4*	18.9

*Mann Whitney U= 635.5; $p < .02$

Service level outcomes (n=36 at baseline and follow-up)

The level of service receipt (and by implication associated costs) significantly reduced after CCS intervention, with a significant reduction in use of A&E, psychiatrists and CPNs/case managers (see Table III).

Table III: Service receipt at baseline and follow-up: mean number of contacts & standard deviation (SD)

Use of outpatient services in past 3 months (n=36)	Baseline		Follow-up	
	Mean	SD	Mean	SD
A&E	0.36	0.72	0.06 ¹	0.23
Psychiatrist	1.50	1.92	0.58 ²	0.84
CPN/Case manager	12.86	11.12	5.03 ³	4.74

¹ Wilcoxin Signed Rank Test $Z = -2.33$; $p < .02$

² Wilcoxin Signed Rank Test $Z = -2.60$; $p < .01$

³ Wilcoxin Signed Rank Test $Z = -3.38$; $p < .00$

No significant difference in hospital admissions were found, but as this was measured over a 3 month period, this would have been highly unlikely.

Cost of improving outcomes

The average length of the total face-to-face contacts for a full cultural consultation was 6.86 hours, costing £37.32 per hour. Looking at the improvement in outcome found on the Global Assessment of Functioning (GAF) scale, the average cost of cultural consultation associated with an improvement in one point on the GAF is £20.15 per service user (see Table IV below).

Table IV: Cost savings associated with reduced service receipt at follow-up, compared with the costs of the cultural consultation.

Cost savings after Cultural Consultation (n=36)	Mean difference in contacts (pre and post CCS)	Estimated costs per visit	Total savings in spending (per service user)
	Mean difference		
A&E	0.30	£45.00	£13.50
Psychiatrist	0.92	£157.00	£144.44
CPN/Case manager	7.83	£76.00	£595.08
Subtotal			£753.02
Cultural Consultation	6.86	£37.32	-£255.87
Total savings per service user			£497.15

Cost savings associated with reduced service receipt

Using the cost calculation procedure for the CSSRI¹⁹ to estimate the costs for A&E, psychiatrist, and CPN contacts, associated cost savings were calculated. In comparison to the costs of the cultural consultation process, cultural consultation reduced the costs of care for these 36 cases by £497.15 per service user (see Table IV above).

3.1.5 Evaluation of the Cultural Consultation Service by service users and clinicians

In total, there are 14 narrative evaluations from clinicians (including one based on the experiences of the entire team) and 15 narrative evaluations from service users. All of the evaluations indicated they had found the cultural consultation process helpful. Some of the themes identified from these evaluations were:

Service users said that talking to the Cultural Consultant was helpful because they felt listened to and not judged. In addition, the process helped them to identify what was going on for them in more detail. Some service users said that though they had found the cultural consultation helpful, they felt that their social circumstances inhibited their recovery.

¹⁹ Knapp, M. & Beecham, J. Costing mental health services. *Psychological Medicine* 1990; 20: 893-908.

"I feel like she understood me. She listened and didn't judge, she got me. Advice she gave was good, and it helped to talk. The release of talking felt good." **Service user**

Clinicians said they found CCS process helpful as it provided a richer perspective, and allowed service users to talk about things they had not talked about before. More specifically, clinicians had felt the cultural consultation service had helped to provide:

- Changes to treatment plan (71%)
- Improved engagement (50%)
- Increased medication compliance (21%)
- Earlier discharge (7%)

"My patient had never engaged with any mental health services/care coordinators and had been left untreated properly. Now she is engaging and taking meds." **Clinician**

When clinicians were asked whether they had any suggestions for improving the service, 45% of those clinicians who responded indicated that they would like to have a cultural consultant permanently based within their team. One common theme that emerged was the lack of resources within teams / services to enable clinicians to implement some of the recommendations.

3.2 Learning and Teaching / Workforce Development- Activity and Findings

Learning was modelled to take place at various levels through in-service training during encounters and engagements such as:

- training delivered to clinical teams.
- outreach through attendance of clinical referral meetings.
- case consultation process with clinicians and / or service users.
- outreach and phone consultation with individual clinicians.
- reflective practice / learning sessions with teams and / or individual clinicians.

Workforce development activities included over 900 clinically-related contacts, in addition to specific training events over the pilot period of the service. Although we refer to training, this actually means a more interactive and in-depth exploration of issues rather than didactic lectures or rote learning.

3.2.1 Training Sessions

A total of 15 training sessions were delivered to the pilot clinical teams: Tower Hamlets Early Intervention Service, Tower Hamlets Assertive Outreach Team, Bethnal Green and Globe Town Community Mental Health Team, and the Isle of Dogs Community Mental Health

Team. Some of the teams received additional training tailored to their specific clinical settings and needs. During follow-up trainings, feedback was given on specific cases through case presentations. A training session was also delivered to Voluntary Sector Network (network of many voluntary organisations in Tower Hamlets) at one of their meetings. The training aimed to provide a broader understanding of the cultural consultation model, the principles underpinning the intervention, the CCS understanding of culture, its aims and objectives, the expected outcomes, and processes of working and the evidence of its effectiveness. The training also encompassed the cultural formulation process, clinical cultural consultation pathways, measuring of the impact through service users' clinical outcomes, service user satisfaction, and staff satisfaction. The training provided to the Voluntary Sector Network was further supplemented by outreach work with local voluntary organisations. As well as introducing the service to these organisations, we also identified the specific resources they were providing. This in turn contributed to workforce development as clinicians and care coordinators were made aware of these resources with specific reference to service user needs.

A one day-training on the Barts Explanatory Model Interview (BEMI) was delivered to which many of the teams sent representatives. In addition, there were monthly Cultural Consultation Club meetings where case presentations took place to a wider audience including members from the clinical teams, and individuals from multiple disciplines within and beyond the local mental health provider. This tool is also being piloted with people with eating disorders, dementia, and hepatitis, as well as common mental disorders, and so these issues appear to have relevance to other sectors of health care.

All the training sessions were evaluated immediately by asking for feedback from attendees. The comments after the training were positive as attendees felt that they had gained new knowledge with regards to ways of working with culture and in engaging with patients' often complex narratives. As one team manager said:

"I would like to see the project carry on as many of the patients have benefited. I do not have criticisms".

Most of the participants in the trainings felt that they had learnt about:

"...different ways of asking service user questions".

3.2.2 Learning Outcomes Through the Clinical Case Consultation Processes

The service, as well as engaging with the clinicians' and teams' narratives also created an opportunity to collaborate with individuals and teams to identify gaps in their cross-cultural knowledge and skills base or practices. These areas also formed part of exploration during the cultural consultation process where learning opportunities took place at various levels. There were over 350 direct one-to-one face contacts with staff (care coordinators), over 250 group face-to-face contacts with staff during clinical team review meetings, and more than 300 face-to-face contacts with service users. Our overall work with care coordinators who referred patients for case consultation was evaluated following the case closures.

Evidence through narrative evaluations by care coordinators and clinicians indicate that learning and professional development took place during the consultations. Examples of the feedback are:

"I learnt about in-depth assessment on social / family and cultural issues".

"I learnt about the importance of culture to an individual's mental health and found the skills used by the consultant helpful".

"I learnt that it is important to dig deep into patient's history in order to understand them better. By doing this, the intervention would be effective. Culture and social background and history of clients are important. I will try to focus on my patients broadly, rather than their illness alone. I know that recovery is influenced by many factors outside of the symptoms".

"...learning took place. [Gaining better]...awareness of patients who might present with unfamiliar symptoms. Understanding of the cultural implication to marriage, as a patient considered divorce but could not carry on with it as it was an expectation on her part that it is the man who should initiate divorce. The team became aware of the dynamics in the marriage, and the fact that was culturally appropriate for the man to initiate the divorce and not the woman".

"I learnt how to explore cultural beliefs and how they affect the behaviour of the client and family in regards to mental illness".

Some clinicians noted that the process of cultural consultation led to their gaining of skills on managing complexities in healthcare, especially how:

"...patients' views around treatment are complex and requires delicate teasing out"

"...[they] sometimes dismiss issues rather than looking for alternative explanations. We tend to narrow things to psychosis even where there are other underlying issues".

3.3 Organisational Consultancy – Service Activity and Findings

3.3.1 Organisational Consultations

The CCS provided six organisational consultations through a series of workshops and individual consultations on culturally competent commissioning. One organisational consultation was provided to Tower Hamlets Primary Care Trust (PCT). The consultation focussed on understanding culturally competent commissioning at a national level and its future directions, increasing their awareness of the local context of the services, improving their cultural capability as a team and identifying priorities for an action plan. The CCS also delivered one commissioning workshop for a wider London audience including commissioners from NHS Tower Hamlets. In addition, CCS provided four organisational consultations to both local and national organisations, namely to: Tower Hamlets on

commissioning for elderly services; a solicitor firm on domestic violence and sexual violence and its cultural determinants; a forensic psychiatric service trying to improve its work with ethnic minorities by setting up a cultural consultation service; and a private hospital seeking to set up a specialist service like CCS. Others focussed on how to improve dementia services for black and minority ethnic people, and also on the implementation of CCS in the private sector as a focus on managing divergent beliefs whilst undertaking an organisational analysis was congruent with the principles of managed care.

The CCS also delivered organisational outreach to the Mental Health Equality Board (National Mental Health Development Unit) who was interested in learning about the cultural consultation model and how it could be implemented to address inequalities in mental health services.

3.3.2 Managerial and Organisational Consultation for East London NHS Foundation Trust and NHS Tower Hamlets

As indicated above, the CCS worked closely alongside five community mental health teams through clinical cultural consultation, teaching and learning, and organisational consultation. However, CCS did not receive formal requests from the mental health teams for organisational cultural consultancy, conflict mediation or support to improve intercultural communication among diverse staff. Although referrals were not submitted for this third level of service delivery, through close collaboration with care coordinators, team leaders and clinicians as well as attendance at team meetings, we were able to work with narratives about how culture is conceptualised as well as how it is acted upon individually by health and social care professionals, and collectively by specialist psychiatric teams and care systems. The common emergent narratives and themes about culture, ethnicity, race and their perceived place and meaningfulness in clinical care demonstrate underlying assumptions and covert rules for approaching, negating or removing dilemmas and difficulties in the presentation and expression of mental distress. The narratives reveal an overall “culture of culture” as a necessary focus of therapeutic intervention in order to then achieve improvements in staff cultural competency and clinical outcomes for service users.

A specific issue of importance emerged from the narratives elicited from staff, teams and their work, particularly minority staff, about their position within the organisations, their hierarchies, and their cultures. The narratives illustrated staffs’ experiences at work in terms of burn-out, depersonalisation contributing to a loss of empathy, fatigue, stress, isolation and alienation from a supportive culture.

Staff did not raise the issue of how their own cultures affected the therapeutic relationship with a service user from a different cultural background. The question of how to bridge the cultural gap between service user and care coordinators were always asked, but with emphasis on the service user’s culture. Staff narratives on cultural capability or cultural competence revealed assumptions that these concepts only related to clinical practice with ethnic minority patients; that the clinicians’ or the organisational culture did not matter and was not to be analysed; that the clinicians were somewhat “culture free” (a surprising finding, given the cultural diversity of the staff in the teams we worked with).

The service user's culture was seen as the locus of pathology and the place where all the complexity lies rather than the systems of care and professional practice showing complexities that need to be understood. This perception may be fuelled by an over-reliance on diagnostic coding, evidence-based interventions, adherence to practice guidelines and an excessive degree of risk aversion, all of which are important but these can not replace or be valuable in isolation from therapeutic relationships. Staff also felt that the system of care was not easy to change, and they felt a lack of agency within any proposed improvements.

The current financial climate in the UK and the necessity for the services to meet the targets might result in an excessive pressure on managers and clinicians to divert their attention to the quantitative, rather than the qualitative aspects of care and service provision, potentially to the detriment of the delivery of personalised, tailored, culturally capable care. In times of financial constraint one of the dominant objectives of the services becomes meeting the set targets to justify their own existence, creating a reversal of the service user-clinician relationship, whereby it is the service in need of the service user. The community teams we worked with experienced a climate of uncertainty and continuous redefinition of their remit, structure, staffing levels, targets and budgets, due to the current financial situation and the cuts that are affecting the NHS. This impacted on their level of engagement with CCS. Nevertheless, achieving positive outcomes was still possible, as detailed in previous sections of this report.

Cultural Consultation can therefore be conceptualised as both an effective and direct clinical intervention, and as a methodology and tool borrowed from organisational anthropology to analyse the scale of the problem and solutions. As such, it can encourage reflective and person centred care, workforce development, and the consideration of complex competing and divergent narratives about healthcare system improvements, whilst taking account of the best levels of evidence from research and managerial as well as clinical experience.

4 Recommendations

The evaluation findings and service user and clinician feedback indicate that the existing CCS model of care improved service user experience and recovery, workforce development, and saved costs on outpatient contacts, whilst improving on overall functioning in the most complex cases. In addition, it led to reduction of work stress amongst staff related to the management of complexities in care. Clinicians indicated that cultural consultation service involvement provided changes to service users' treatment plan, improved medication compliance and levels of engagement, and earlier discharge.

Based on these findings, and in consultation with a wide range of stakeholders (including policymakers, practitioners, commissioners and service users) both locally and nationally, CCS developed a number of recommendations, in part, through workshops in a national conference organised in January 2012 which over 140 delegates attended. Many issues CCS identified were reinforced by workshop participants. In addition, issues emerging only from the workshops are presented and do provide an additional perspective from stakeholders.

4.1 CCS Recommendations

Improving service user experience and recovery

1. Service user narratives about existing care practices revealed feelings of powerlessness and lack of control in their lives. The cultural consultation process highlights that engaging with service user narratives is an invaluable source of support. The service users felt they were being listened to, gained confidence when both their mental health and practical needs were supported.

There is an urgent need to promote real autonomy of service users and treatment choices through appropriately skilled and supported staff, so they can fully engage with service user narratives around their illness experiences, bring out their stories of resilience and facilitate a conversation focussed on person-centred recovery.

2. Most of the service users referred to CCS for case consultation stated a need for more holistic assessments that truly take culture into consideration, as well as paying attention to how the team / clinician cultures influence disengagement and poor therapeutic relationship.

Assessment methods and training in assessment of mental health problems require re-evaluation to ensure patient narratives and shared decision-making are a reality rather than an aspiration.

3. The majority of service users referred to CCS (often with complex presentations and needs) were with the Assertive Outreach Service. Importantly, the improvement in engagement and cost savings were found after the CCS interventions.

Cultural consultation should work with all assertive outreach services or where engagement and impasse prevent further active management in order to facilitate shared decision making around patient narratives leading to a more satisfactory resolution; this is likely to save later service costs and improve met needs and function.

Future evaluations may be able to test whether admissions are reduced if the service can run over a longer time period.

Workforce development

4. Staff expressed a preference for the CCS model of in-house training on cultural competence through clinical case consultations and suggested to have a cultural consultant permanently based in their teams.

Rather than providing one-off mandatory training on cultural competence, staff should be trained, supported and offered supervision on incorporating culture in all aspects of their work and by learning and teaching in the context of their daily work. CCS offered this and seemed more relevant and effective as the knowledge was applied in care practices.

The CCS recommends staff's suggestion of having a cultural consultant permanently based in their teams to provide expertise in managing complex cases thus contribute to efficiency and cost savings.

5. Service users' negative experiences with the existing assessment processes and staff not feeling empowered to use a social recovery model seems to reflect a lack of time and resources (financial and professional competencies).

Service providers and commissioners should ensure that staff are skilled and resourced to undertake assessments based on service user narratives to determine their explanatory models around their illness experiences, help seeking behaviour, and notions of recovery.

6. Staff in general expressed high levels of work stress and frustration with lack of support. In addition, staff feel powerless, overworked, and inadequately trained yet were expected to manage the most complex service users. This was compounded by the uncertainty occasioned by constant reorganisation and reconfiguration of services and teams. These factors have a differential effect on the BME staff who make up the majority of the workforce in inner-city London, yet BME staff lack representation in management and key bodies so they cannot contribute to decision-making. The discrimination within the NHS affects both staff and service users. The disempowerment led to apathy that not only constrained recovery oriented practice but also leads to a lack of willingness to engage with complexity in care including service user narratives.

There should be appropriate support mechanisms for staff in general, and BME staff in particular, to enable them to engage with complexity in care in their endeavours to provide culturally and recovery oriented care, and to reduce stress and increase productivity amongst staff.

Organisational development & commissioning

7. While there was a reluctance to consider cultural consultation at an organisational level, the difficulties staff were facing and their high levels of stress seemed mainly related to systemic issues.

In order to improve on staff stress levels, reduce absences and high turnover rates, as well as improve service user experiences, organisational analyses should be applied to identify areas for improvement and methods of improving quality and efficiency.

8. The current differentiation between structures of commissioning and service delivery seems problematic. There is a lack of anticipation of challenges in the implementation process, which will undermine any innovation.

The commissioners should implement models of commissioning that are informed by and stay involved with service implementation, for example those in New Zealand, are proven to be more efficient and effective.

4.2 Recommendations from the CCS Conference workshops

1. Both primary and secondary care clinicians do not seem to be supported or perhaps have the skill set / knowledge to promote wellbeing rather than just treat illness. Clinicians need more information on, and knowledge of, the populations they work with and training around how they can adapt approaches to different groups and link them into the appropriate community support organisations or systems. Clinicians need support around how they could redefine health and wellbeing to reflect group experiences and social issues rather than pathologising behaviours and ascribing them to the individual in isolation. Getting closer to people's experiences and aspirations within their communities were identified as an important avenue that could inform a starting position for public health interventions at both the level of the community and the individual.

For public health and wellbeing interventions to be effective, staff need to be culturally competent and with the right skill mix, including those working in inpatient services.

Clinicians need more training around how to suspend their assumptions about patient needs and problems.

Clinicians need public mental health skills and knowledge

2. The conference participants felt that commissioning process lacks transparency as well as not being inclusive. It was felt that Commissioners buy services "blindly" as they do not have the input from the managers, clinicians, and service consumers. In another vein, the managers are also hardly listening to the clinicians. In addition, commissioners lack local knowledge, expertise, and experiential knowledge of the products they are commissioning. The CCS was seen as being a bridge for this deficit, but also of that between the third sector and the commissioners.

Commissioning process should be transparent and inclusive of the input from clinicians, professionals, carers, family, and service users.

CCS should continue to provide input by leading in project implementations and by acting as a link between the third sector and the commissioners and that this would provide value for money through better service commissioning and delivery.

There is need for continued existence of CCS as there is value for working within wider contexts as well as engaging with community networks and third sector organisations.

Commissioning processes should include adequate resources that would enable the service organisations to support staff to not only reduce stress levels attributed to organisational structures and ways of working, but also enable them to work in ways that would enhance recovery, improve on service user experiences, patient outcomes, and service efficiencies and cost savings as CCS evidenced.

The new GP-led commissioners should find a balance between allocating resources to generic services and to culturally appropriate services to increase on uptake of services by BME and other marginalised groups.

3. There still exists a differential access to psychological therapies based on ethnicity with BME service users having a poor access. In addition, GPs hardly refer BME service users / patients to primary care psychological services.

It was therefore recommended that there should be a drive to racial / ethnic equality of access to treatment opportunities, especially psychological therapies.

It was recommended that the new GP-led commissioners should allocate resources to culturally appropriate services to increase on uptake of services by BME and other marginalised groups.

In addition, there is a need to raise awareness of mental health services amongst BME populations and the relevance of mental health problems in primary care.

4. The definition of wellbeing was felt to be too narrow. The wellbeing agenda should not just be led by the NHS, rather there is need for interagency working and partnerships to improve on signposting, and communication among agencies. In addition, health organisations need to take responsibility by investing in knowledge of the communities they work with better. Right now the blame for poor outcomes related to inequalities seem to be put on communities labelled as 'hard to reach'. In light of the localisation bill, there is debate on whose responsibility it would be in terms of holding local authorities accountable in a way that ensures that ethnic minority populations are receiving targeted / appropriate public health interventions that addresses inequalities in health outcomes. There should also be recognition that individuals would define wellness differently, and that wellbeing means different things for different people. At present, public health initiatives are focused on the general population and not reflecting needs of specific groups in deprived areas or those suffering from mental illness.

There should be integration of all aspects of life (housing, education, faith, money, healthcare, culture, employment, leisure) in the definition of wellbeing and the interventions aimed at improving on peoples' wellbeing.

As such public health and wellbeing should adopt an individualised approach as individuals would identify their own needs, thus focussing on peoples' resilience by adopting a person-centred care and health promotion approach.

The discourse on public health and wellbeing should be shifted to a broader social-science base rather than only a bio-medical focus on disease, risk, and treatment.

Public health and wellbeing should be inclusive and as such should incorporate people admitted into mental health hospitals and those in forensic mental health units.

Public health and wellbeing interventions should also focus on children and young people by addressing child poverty, youth unemployment, and investing in family interventions and promoting emotional intelligence at schools.

Outreach needs to focus not just on learning needs of different communities but also their strengths.

Organisations in particular need to be realistic about how much time outreach takes and need to realise it is a long term investment.

Public health and wellbeing agencies should actively lead public education on stigma and put in place interventions that could improve on early contact and engagement with services.

Public health and wellbeing agencies should work together with religious institutions to identify when and where religion and spirituality could provide support.

6. Organisational cultural competence could be improved through "communication" and "partnership". The envisaged partnerships would emerge through co-working and learning in the context of meaningful multi-professionalism and multi-agency involvement in patient care.

There is a need for establishment of a clear framework for working, and engaging, with appropriate third sector organisations and specialist community services by clinical teams to enable the maximisation of the available resources by service users to enhance their recovery. In most referrals CCS recommendations involved the provision of contact details of specialist community groups, third sector organisations, and other relevant support organisations.