A cultural consultation service in East London: Experiences and outcomes from implementation of an innovative service

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Abstract
This paper reports on a feasibility study and evaluation of a new type of cultural consultation service (CCS). This multi-component and systemic complex intervention was offered over 18 months to specialist mental health providers in one of the poorest regions of the UK. The service received 900 clinically related contacts and 99 in-depth consultations. Service users who were referred to the CCS had high levels of clinical needs with an average score of 15.9 on the Health of the Nation Outcomes Scale. Overall, Global Assessment of Function scores improved and there were trends for improvements in symptoms. The level of routine care (and by implication associated costs) significantly reduced after CCS intervention, due to a reduction in use of accident and emergency (A&E) services, psychiatrists and community psychiatric nurses (CPNs)/case managers. Cost analysis indicates that savings amounted to £497 per patient. The cost of intervention was no greater than usual care, and may reduce spend per patient over a 3-month follow-up and perhaps longer. More specifically, clinicians felt the cultural consultation service helped to improve the treatment plan (71%), engagement (50%), medication compliance (21%) and earlier discharge (7%).

Introduction
Recent research has consistently highlighted ethnic inequalities of healthcare experiences and outcomes for people with mental illness.(Bansal et al., 2014; Bhui & Harding, 2012; Cooper et al., 2013; NIMHE, 2003). These disparities are compounded by poverty, poor quality housing and physical health problems (Karlsen et al., 2002; Mangalore & Knapp, 2012; Nazroo, 2003). Consecutive UK governments have attempted to deal with race and ethnic inequalities in mental healthcare. 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 (Bansal et al., 2013; Bhui et al., 2003; Grote et al., 2007). Concerns remain that the manner in which the UK government constructs such disparities may be driving a widening of inequalities (Vernon, 2011), and that consistent, confident and mature leadership is essential if ethnic inequalities are to be reduced (Bhui et al., 2012). The history of colonialism and studies of exotic mental illnesses in isolated peoples around the world has also given rise to discomfort about an appropriate bio-ethical lens with which to apprehend what is at stake if more or less attention were given to this subject (Rentmeester, 2012).

The Delivering Race Equality (DRE) programme, set up by the UK Department of Health in 2005, established a 5-year action plan for reducing inequalities in BME patients’ access to, experience of, and outcomes from mental health services (Department of Health, 2005). 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.’ The evidence base on cultural competency or training interventions is limited (Bhui et al., 2007). One innovative approach to improving patient care is cultural consultation (Kirmayer, 2003). This approach adopted social science and anthropological concepts and methods to improve assessment and treatment.

In order to address the needs of ethnic minorities, migrants, and socially excluded people in East London, we expanded from a model that relied on an individual patient referral and assessment, to a systemic one in the form of a new cultural consultation
service (CCS). The CCS was commissioned by NHS Tower Hamlets and the National Mental Health Development Unit in the UK as a new way of improving service outcomes, delivering in-situ training, and addressing structural determinants of inequalities for people in contact with mental health services. The service was designed to work at multiple levels of service provision and commissioning to tackle the complexities and structural and individual determinants of health inequalities. The Equalities Boards in the National Institute of Mental Health in England and the National Health Development Unit, before their closure, as well as the work proposed in the Marmot review on health inequalities (Marmot et al., 2010) have all played a role in guiding commissioning boards to find more effective models of commissioning, managing and providing care that not only promotes equality but are also evidence-based. More recently, guidance on commissioning for ethnic groups and migrants has emerged with emphasis on good practice models that mostly have not been decommissioned (Joint Commissioning Panel – Mental Health, 2014). Furthermore, the most recent public health White Paper tackles poor mental health in order to reduce overall population disease burden (Department of Health, 2010). The White Paper places emphasis on appropriate access and positive outcomes, through focusing on employer responsibilities, reducing inequalities, and promoting resilience in the wider population. The location of ethnic inequalities within a wider commitment to reducing intersectional health inequalities and social inequalities for a fairer and healthier society has not been realized. The cultural heritage, beliefs and expectations of service users, carers and clinicians can serve as barriers to effective use of mental health services. These cultural complexities may account for and perpetuate inequalities for BME groups. For 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 poor outcomes, and a lack of engagement related partly to a failure of shared decision-making (Kilshaw et al., 2002). At the same time, as reported in preliminary evaluations of the CCS, the culture of care in psychiatric services may not lend itself to consider culture-, ethnicity-, migration- and race-related concerns nor the cultural heritage of the clinicians and how this impacts on care (Ascoli et al., 2012).

Although the definition of a culture as the shared world view, practices and beliefs of a group of people is popular, in the context of services and the real world, there are multiple sub-cultures and varying levels of granularity (Helman, 2002). Culture includes notions of power relations, and is as important in all peoples irrespective of their migrant, ethnic, religious or conspicuous cultural heritage.

Cultural 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 in order to improve on the quality of the relationship and interaction with patients, to ensure accessibility of and take-up of effective care, through therapeutic relationships (Bhui et al., 2013). 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, the CCS was commissioned to provide cultural consultation in an inner London borough.

This paper reports findings of 18 months of service delivery. Qualitative and quantitative outcomes were collected as part of the service activity and some have already been reported alongside our model of promoting cultural competency (Ascoli et al., 2012; Owiti et al., 2014). As the CCS work was part of a National Health Service (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 service innovation and aspirations, reported in aggregate and without personal identifiers. The participants, staff and patients, 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.

**Methods**

**Cultural consultation as a 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 (Ascoli et al., 2012; Kirmayer et al., 2003). 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 observed behaviours, therapeutic communications and person-centered narratives are considered in the assessment and treatment plan. The CCS service specification was primarily adapted from a good practice model in Canada (Kirmayer et al., 2003). This early work showed the importance of cultural consultations to improve 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 which highlighted the impor-
tance of strong clinical and managerial leadership, along with organization-wide commitment to better service-user outcomes and positive pathways into and out of care (Bhui, 2009; Moffat et al., 2009). Specifically, the inclusion of family, friends, and wide social systems, are mechanisms of improving the quality of care within public services.

Service location

The London borough of Tower Hamlets is the fourth most deprived area in England and Wales, and has a high index of ethnic and religious diversity. Inequities in healthcare and mental well-being are major challenges, in part due to overcrowding, high unemployment, homelessness, poverty, high rates of substance misuse and poor physical health. Cultural barriers may 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 (Coid et al., 2008). 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 (Coid et al., 2008).

The East London NHS Foundation Trust (ELFT) is a provider of mental health services to several East London Boroughs, including Tower Hamlets. 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 ELFT to work towards its vision of ensuring equality and valuing diversity, developing a capable workforce and promoting social inclusion and recovery-oriented care. CCS specifically aimed to improve clinical outcomes, service-user outcomes and the experience of mental healthcare for service users from BME communities, the cultural capability of professionals working with mental health service users from BME communities, the cultural capability of health systems and organizations, and reorientation towards social inclusion and recovery-oriented approaches.

Data collection

In line with the principles of the cultural consultation service models, the qualitative evaluation methods used were ethnography and participant observation (Reeves et al., 2008; Zhao & Ji, 2014). The evaluation captured explanatory models of illness experiences using the Barts Explanatory Model Inventory (BEMI) which was developed in East London to assess health beliefs in people of diverse ethnic back-ground presenting in primary care (Bhui et al., 2006). The BEMI has recently been adapted for use with people with diabetes, memory impairment, and hepatitis. It includes a set of inventories and an open-ended enquiry. The narratives that were elicited could enable the practitioner to identify important issues for the service user. Among the data collected as part of our evaluation were observations, field notes and records of meetings, unstructured as well as semi-structured interviews, narratives as verbatim accounts of illness, care processes and outcomes at patient, staff, team, service management and commissioner levels. For clinical recommendations for each patient we produced a personalized report; these reports were treated as data in the evaluation.

We collected quantitative data through the following outcome measures.

1. Staff-rated clinical outcomes. Clinicians were asked to fill out three outcome measures, including the Global Assessment of Functioning (GAF) (Jones et al., 1995), the Camberwell Assessment of Needs (CANSAS) (Dobrzynska et al., 2008), and the Scale to Assess Therapeutic Relationship (STAR) (McGuire-Snieckus et al., 2007). In addition, the Health of the Nation Scale (HoNOS) (Slade et al., 1999) was collected from the routine clinical databases for each of the service users.

2. Service user-rated outcomes. Service users were asked to rate their general health (EuroQol) (Carr-Hill, 1992), level of depression and anxiety (CORE-10) (Evans et al., 2002), care needs (CANSAS), and relationship with their clinician (STAR).

3. Cultural competence. Over the course of the CCS, staff were asked to report on their own level of cultural competence using the Tool for Assessing Cultural Competence in Training (TACCT) (Lie et al., 2006). The TACCT was administered separately and distributed across all participating teams at two time intervals: December 2010 and July 2011. The results of TACCT are separately reported in Owiti et al. (2014).

4. Service level outcomes. To measure the extent of service use and cost consequences, the Client Socio-demographic and Service Receipt Inventory – European version (CSSRI) was used (McCrone et al., 2005). Service users and staff were asked to provide feedback about how the CCS affected care and what were the most critical factors for improved outcomes and better care experiences.

The quantitative outcome measures were collected at first contact with both service users and clinicians (baseline), and at a minimum of 3 months following the final contact with CCS (follow-up). The outcome
Learning and teaching activity
Feedback from staff and from the learning and teaching events was collated and included organizational narratives collected from organizational consultations; these were also subjected to thematic and descriptive analyses (Mays et al., 2005).

We presented the outcomes and recommendations to stakeholders over a one-day conference and sought their interpretation and suggestions.

Data analysis
Qualitative data were analysed using the method of narrative synthesis (Murray, 2000; Viney & Bousfield, 1991). The synthesis of the data and focused on (1) key consistent narratives found across all teams, (2) 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, and (3) unexpected challenges within clinical and organizational systems. The narratives were anonymized, coded and analysed using NVivo 9 software by an independent data analyst.

Ethical considerations
As the CCS was a NHS-commissioned service, all the data obtained were for the purposes of audit and service evaluation. Therefore, CCS did not require formal ethical approval to collect data for evaluation according to UK National Research Ethics Service (NRES) guidelines (see http://www.nres.nhs.uk/about-the-national-research-ethics-service/building-on-improvement/). Consent was secured from all patients, carers and managers so that the data could be grouped and shared without any personal identifiers. Patients who consented were required to sign a consent form, with an option for withdrawal at any stage of the consultation process. The participation of staff was also based on informed consent through service level agreement and individual agreement.

Results
The evaluation findings are presented at two levels: clinical cultural consultation activities and outcomes, and organizational narratives and insights.

Service activity
Over a period of 18 months, the CCS 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.

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 four, 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.

For complex clinical consultations we aimed to collect quantitative outcome measures 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.

Patients: demographic characteristics
Of the 46 in-depth consultations, 45.5% were referred by the community Assertive Outreach Team, 36.4% by two Community Mental Health Teams, and 18.2% by the Home Treatment Team. Of the patients referred to the CCS, 58% were male and 42% were female. There was one white British service user, with the majority being Bangladeshi (39%). Black and ‘other’ ethnic background service users were overrepresented in the CCS compared with the proportion of residents in the London borough of Tower Hamlets (see Fig. 1). The average age was 39 years (SD = 10.48), with the youngest being 21 and the eldest 70. Most service users were heterosexual, 87.8% were unemployed, and 88.6% were reliant on state benefits. For 38.1% of cases an interpreter was required. Languages most often spoken were Bengali (34.1%), English (15.9%), Somali (13.6%) and Arabic (13.6%).

In diagnostic terms, 47.7% had a primary diagnosis of schizophrenia, and 61.3% had 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.

Qualitative findings

An independent data analyst examined the narratives from 46 referrals that had in-depth consultations.

Reasons for referral

Perplexing and complex clinical presentations, lack of sufficient knowledge or comprehensive understanding about the patients’ presentations. The clinicians made referrals for diagnostic clarification to gain a better understanding of illness presentation. Some clinicians wanted a second opinion to confirm diagnosis or to assure themselves that the treatment methods they had adopted were resonant with the service user’s culture. Some clinicians also wanted the CCS to identify cultural factors, including exploration and clarification of previous traumatic history (divorce, war, domestic violence, torture, forced marriage, rape), pre- and post-migratory experiences, migration history, and how these impact on current presentation and how to improve recovery and minimize disengagement.

Racism and discrimination

Some clinicians wanted the CCS to explore service users’ experience of racism and discrimination and to evaluate the impact on current symptoms and engagement. This also included requests to explore patients’ claims of exposure to violence and police arrest and previous coercive experience within mental health services in the UK.

Lack of engagement or progress and failed treatment alliance

Reasons for referral included requests to explore cultural barriers to engagement and treatment adherence, to examine causes of disengagement from services/treatment teams and how to establish a long-term recovery-oriented treatment plan, mediation between family, carers and services in order to improve treatment alliance and outcomes, and exploration of cultural factors influencing family dynamics, and for advice on difference between culturally appropriate family structures and pathological family constellations.

Exploration and resolution of cultural conflicts, and the impact of social changes on service users’ recovery

Reasons for referrals under this theme encompassed requests by clinicians to explore conflict between sexual orientation and prevailing attitudes in the culture of origin, exploration of and guidance for resolution of conflict between attitudes found in the cultures of origin and UK culture, resolution of intergenerational conflict between immigrant patients and children, exploration of the potential impact of sudden changes in service users’ circumstances (e.g. getting married, divorce), and resolution of family dynamics, particularly when family involvement was seen as impeding service-user recovery, and/or engagement with the team.

Information requests

Some clinicians made referrals to request information on culturally appropriate community links, support groups, and other resources, and to identify support organizations, for instance, culturally appropriate family mediation, trauma psychotherapy, counselling. Some requests were made for information on migration agencies and procedures, or international organizations that support parents whose children have been abducted by partners and taken abroad.
Defensive practices
Some requests for generic involvement in care planning alongside other voluntary sector agencies were made by clinicians for risky cases. In some cases some referrals made for these purposes were retracted, often when it was thought that CCS involvement might ‘complicate’ the case by providing conflicting or multiple opinions. In addition, some cases that 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 the 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 team’s requests and were guided by the emergent narratives. The overall themes, which arose from recommendations, are discussed below.

Minimizing 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.

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 that are 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 organizations was effective, and can lead to establishing trust and building of better therapeutic relationship as well as minimizing disengagement.

Further interventions / assessments
The narratives exposed areas that could benefit from further or more structured assessments. The 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.

Psychological interventions
The CCS made recommendations for psychological interventions where appropriate and identified organizations that were able to provide culturally appropriate counselling services. There was low uptake of psychological therapies among BME patients even though the needs were indicated, for instance, in cases of post-traumatic stress disorder, 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.

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.

Family engagement and mediation
Where families and partners were involved in service users’ lives 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.

Diagnostic clarification
In some cases the CCS made diagnostic suggestions for teams. Some referrals were extremely complex, with service users having a range of conflicting and competing narratives. The CCS provided multiple frameworks through clinical cultural formulations 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 the CCS recommended additional diagnosis.
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, the 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 (Bech et al., 2006).

After the cultural consultation process clinicians rated service users as having significantly higher overall functioning compared with ratings before the CCS work (see Table 1). 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).

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 2). 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 total face-to-face contact for a full cultural consultation was 6.86 h, costing £37.32/h. Looking at the improvement in outcome found on the GAF scale, the average cost of cultural consultation associated with an improvement in one point on the GAF is £20.15 per service user.

Cost savings associated with reduced service receipt

Using the cost calculation procedure for the CSSRI (Knapp & Beecham, 1990) 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 3 above).

Evaluation of the CCS 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 as follows.

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.

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 the 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 based permanently 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.

**Organizational consultations**

The CCS’s contribution to workforce development has been elaborately described and reported in another article (Owiti et al., 2014). However, in this article we report the organizational consultancy activities and findings. CCS provided six organizational consultations through a series of workshops and individual consultations on culturally competent commissioning. One organizational consultation was provided to Tower Hamlets Primary Care Trust (PCT). The consultation focused 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 organizational consultations to both local and national organizations, namely to Tower Hamlets on commissioning for elderly services, to a firm of solicitors on domestic violence and sexual violence and its cultural determinants, to a forensic psychiatric service trying to improve its work with ethnic minorities by setting up a cultural consultation service, and to a private hospital seeking to set up a specialist service like the CCS. Others focused on how to improve dementia services for BME people, and on the implementation of CCS in the private sector as a focus on managing divergent beliefs, whilst undertaking an organizational analysis was congruent with the principles of managed care.

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

As indicated above, the CCS worked closely alongside five community mental health teams through clinical cultural consultation, teaching and learning, and organizational consultation. However, CCS did not receive formal requests from the mental health teams for organizational 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 conceptualized 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 cultural consultation service in East London

Box 1. 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. Service users felt they were being listened to and 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 focused on person-centred recovery.

2. Most service users referred to the 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 the 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 having 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. The 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 seem 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 reorganization 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 constrains 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.

Organizational development and commissioning

7. While there was a reluctance to consider cultural consultation at an organizational 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, organizational 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.

Recommendations from the CCS conference workshops

1. Neither primary and secondary care clinicians seem to be supported or perhaps have the skill set/knowledge to promote well-being rather than just treat illness. Clinicians need more information on, and knowledge of, the populations they work with and training on how they can adapt approaches to different groups and link them into the appropriate community support organizations or systems. Clinicians need support for how they could redefine health and well-being to reflect group experiences and social issues rather than pathologizing behaviours and ascribing them to the individual in isolation. Getting closer to people’s experiences and aspirations within their communities was identified as an important avenue that could inform a starting position for public health interventions at the level of both the community and the individual.

   - For public health and well-being 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 input from the managers, clinicians, and service consumers. In another vein, the managers are also 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 between the third sector and the commissioners.

(Continued)
A specific issue of importance emerged from the narratives elicited from staff, teams and their work, particularly minority staff, about their position within the organizations, their hierarchies, and their cultures. The narratives illustrated staff experiences at work in terms of burn-out, depersonalization contributing to a loss of empathy, fatigue, stress, isolation and alienation from a supportive culture (Ascoli et al., 2012).

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 culture patients, that the clinicians’ or the organizational culture did not matter and was not to be analysed; that clinicians were somehow ‘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 cannot 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 personalized, tailored, culturally capable care. In times of financial constraint, one of the dominant objectives of services becomes meeting 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.

Cultural consultation can therefore be conceptualized as both an effective and direct clinical intervention, and as a methodology and tool borrowed from organizational 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.

Conclusions

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 plans, 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 at a national conference organized in January 2012; over 140 delegates attended. Many issues that CCS identified were reinforced by workshop participants. In addition, issues emerging only from the workshops are listed.

This method of workshop dissemination of the findings was aimed at engaging the stakeholders, refining future recommendations and optimizing the implementation of the recommendations (see Box 1). We have not sought to refine these, but leave this for consideration by readers as to their relevance and suitability for local use. Overall, the CCS seemed acceptable and the implementation and use of the service by patients showed feasibility for future work. Some outcome measures were collected successfully, suggesting these should be used in future studies and trials. We have also secured estimates of effect where there were changes in outcome status. Future studies need to be multi-centred and of a trial design, although adaptation to local contexts and systems of care is still important and requires an additional translational stage compared with simple and single-component interventions.

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References


