

Section on Special Initiatives Relevant to Person-centered Care

Three keys to a shared vision of diagnostic assessment: an initiative in person-centered care from the Department of Health in the UK

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Introduction

Diagnosis is the missing link in person-centered care. Person-centered care has covered many different aspects of such important areas as treatment, resource allocation, and ethical practice (particularly concerned with patient autonomy). But with important exceptions [1, 2], diagnosis has been widely assumed to be, somehow, reserved to the scientific and other skills of doctors and healthcare professionals, and hence as being beyond the relevant scope of person-centered approaches.

It is thus particularly exciting that the Department of Health of the UK government in London has included within a range of recent policy and service development initiatives under the broad banner of ‘personalisation’ [3, 4], a programme specifically concerned with diagnosis. This paper outlines this programme—called the 3 Keys programme [5]—and sets it briefly in context with the wider personalisation agenda.

What are the 3 Keys?

The 3 Keys are three aspects of assessment that a majority stakeholders in a wide-ranging consultation, including patients and carers as well as professionals, agreed are important:

- **Key 1** is *active participation* of the service user concerned in a shared understanding with service providers and where appropriate with their carers
- **Key 2** is that there should be input from *different provider perspectives* within a multidisciplinary approach, and
- **Key 3** emphasises the importance of building on the *strengths, resiliencies and aspirations* of the individual service user as well as identifying his or her needs and challenges.

These 3 Keys may seem obvious: surely, you may think, everyone approaches assessment in a way that actively involves the service user (or patient) concerned, that takes note of the views of other professionals, and that looks at strengths as well as problems. Yet our consultation showed that while many stakeholders had experienced or could give examples of one or more of the 3 Keys in action, there were very few instances where all three came together. Service users and carers, in particular, told us that if the 3 Keys could be used together more widely, they would feel more empowered and that this would make an important contribution to their recovery and to their chances of developing the skills for self-management.

In the report on the consultation, correspondingly, we focussed on practice rather than theory, giving a range of the many creative ways in which each of the 3 Keys were already being used, albeit separately.

Examples of the 3 Keys

One important finding from the consultation as a whole was that, overall, the more challenging the clinical context, the more creative service providers were in coming up with effective '3 Keys' approaches in partnership with service users and carers. This link between 'challenge and effectiveness' is reflected in the following examples from the report.

Key 1—active participation of service users

Active participation of service users in coming to a shared understanding of their problems, although perhaps relatively straightforward in many areas of practice, might be thought to be an unrealistic ideal in such areas as learning disability and dementia. In fact, these were both areas in which we found a number of innovative approaches to supporting service user participation.

Case Example: Group support for people with severe learning disabilities

A psychotherapy service for people with learning disabilities at Springfield Hospital in London developed a group approach to supporting individual service users in playing a full role in how their problems are understood. The key to this is that they are offered opportunities to discuss their assessment within a group that includes other people with learning disabilities as well as staff. This approach not only fully engages the person concerned but also helps professionals relate to group members as individuals in their own right with a positive contribution to make to how their problems are understood and managed.

Key 2—input from different provider perspectives

A further important finding from our consultation was the role that voluntary sector organisations may play in providing vital insights from different cultural perspectives.

Case Example: A culturally extended model of the multidisciplinary team

Sharing Voices, a voluntary sector organisation based in Bradford, a culturally diverse town in the North of England, has developed in partnership with the statutory sector, a number of innovative approaches to providing culturally appropriate services. One of these, 'The Listening Iman' project, proved to be particularly effective in overcoming cultural barriers and misunderstandings. In one example, a family of Pakistani origin had been told by a 'hakima' that their young son's perceived behavioural problems were due to possession by a demon. They were wholly unconvinced by the reassurances of professionals from the statutory services that their son's behaviour was normal for his age and were in great distress. However, the Iman, with authority as a religious leader, was immediately able to reassure them that the hakima was 'unlawful' and that their son's behaviour was indeed entirely normal.

Key 3—building on strengths, resiliencies and aspirations

As with the other Keys, a strengths approach to assessment was broadly endorsed in the consultation by a large majority of stakeholders. However, 'aspirations' was an exception to this general rule. Service users and carers believe that their aspirations were vital to recovery; while by contrast, many professionals felt that trying to meet people's individual aspirations, went well beyond what they could offer. It was thus particularly exciting to find in the consultation that support workers, i.e. members of multidisciplinary teams without professional training, had developed a previously unrecognised role in supporting aspirations.

Case Example: Aspirations for an ordinary life

Jenny Correia, a support worker with the Crisis Intervention and Home Treatment Team at a hospital in North London, was the first to point out the distinctive role of support workers in relation to aspirations. She and others gave us many examples of how attention to a person's aspirations could be a key step on the road to recovery and yet had been overlooked in assessments by professionals. Importantly, the aspirations in question were not unrealistic. Rather, they were for small but significant aspects of ordinary life, such as going for a walk in the park, which most of us take for granted. Assessments of more formal aspects of a person's problems are of course important

(in such areas as medication, housing and employment). But helping people to achieve their aspirations for ordinary life may play a vital role in giving them the confidence to start moving towards recovery.

Next steps: implementation

The 3 Keys programme is being implemented, not separately but in close partnership with other programmes directed towards the personalisation of services and values-based practice [6]. The implementation programme, which is being coordinated nationally by NIMHE East Midlands (the National Institute for Mental Health in England is part of the policy delivery side of the Department of Health), thus includes a research and development project with minority cultural groups, and an impact study in connection with a new care pathways policy [5].

It is early days yet. But the strength of support for the 3 Keys approach from service users and carers as well as professionals, gives us hope that the programme will be successful in bringing person-centered approaches in at the vital stage of assessment. As one service user put it, if we are to understand a person's problems, it is essential that 'everybody's voice is heard, including families and carers'.

Acknowledgements

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