



## Transcript of SPARK Talk on “Person-Centered Care”

**Speaker: John Draper, PhD, Director of the Suicide Prevention Lifeline Network**

I want to talk with you about the critical role of person-centered care in suicide prevention. What is person-centered care? Person-centered care is really putting the person in the middle of the care. It's actually where they're as much the decision maker as the doctor is. In fact they make decisions anyway, so including them in that care, those decisions about what kind of care they want, how they want it, and when they want it is actually a good way to get them to engage in care because as we know, the best kind of care is care they're actually going to use.

Now, how crazy is this notion of person-centered care? How are we doing with it, in mental health care? Not so good. About 2/3 of the people who have mental health problems are never going to see a mental health practitioner. So basically, our system is not delivering care to the people that need it. It's broken.

How do we make it more person-centered? How do we make it easier for the person to engage in and keep them there, in a way that they feel like they can benefit from this service? Basically we give them choices. And for people who are suicidal, they often feel like they don't have any choices. And our system doesn't treat them like they do have any choices. We tell them what they need to do, what they must do, and what they can't do, but we don't get a sense of what they're capable of. They don't feel like they have any strengths and we don't treat them like they have any strengths. But what if we actually centered our care around making them co-experts, and helping engage them around, basically empowering them to believe that they can take care of themselves and their life is worth something.

So what are the challenges? What's preventing systems from adopting these more person-centered approaches? There's three, really that I can think of. One is that they're not really considered by many to be practical; secondly, they're not reimbursable in many cases; and, thirdly there's a fear that we're not going to be able to track down persons who are suicidal that we're serving in these non-traditional methods. So let me talk about each one of these briefly.

Practicality—um, ‘I don't want to work 24/7, I don't want to work at three in the morning, if it's at the behest of the individual who's in suicidal crisis that means that I gotta be there for them at 2 in the morning.’ Just set up your system to make that work. We do it at crisis centers, we do it at emergency departments. That is something that is easily surmountable. It's just different from the way we've been doing things.

What's the second thing? The second thing is it's not reimbursable. That's a big thing because if there are no CPT codes or ways in which we can go to health plans and say ‘reimburse me for this text and chat that I'm doing with these individuals’ then they're not, then we may not do it. But these are very cost-efficient methods that can, that that can actually supplement the clinic services and the other reimbursable services which..if you use a more cost efficiently then when you see the people in the clinics, they're gonna get the care that they need in the right place, and you keep the people out of the clinics who don't necessarily need it. ...and also keeps them more as we would call it ‘compliant with treatment’ because it's treatment that they want.



The third thing is being able to track persons who are suicidal down. Now it is certainly distressing to not be able to find them if we believe that they have taken an overdose or something like that so we can use IP addresses and that sort of thing and we can pull out those stops but the main thing is is that engaging them in some way, in a way that we think could work is better than no way at all, and if that's the way they want to be engaged this is our only shot, and let's make the most of it.

Look at what you're doing well...and also ask the people that you're serving about what you're doing well, and what you're not doing well, and in terms of engaging them, and giving them a sense of hope and meaning and feeling like they're, they're a part of their treatment. So ask 'em: it's a good place to start is really surveying your system asking your providers and the people that are getting care, or the people who are inconsistently getting care, what can we do about it?

If you can't do it all, and a lot of these things I'm saying to you may sound extremely foreign, they're not foreign to other partners. There are other people that are doing this kind of work locally whether they are our crisis call centers, whether they are our mobile outreach services, whether they are our public education services, whether they are our peer-run organizations, these are all organizations that are expert in new ways and different ways and non-traditional ways of engaging people, so look in your environment and see who you can partner with.

Convince funders that these non-traditional approaches that are have a growing evidence base are reimbursable. We should have insurance companies, Medicaid, Medicare, funders basically get behind this and say, 'If this is the way that we're going to engage people...' and it does suggest that it's not only an effective way of engaging people but also providing care that can reduce distress and suicidality, 'Why don't we fund it?'

So all of these are things that we have to be thinking what are the strengths, what are the supports, what are the ways in which they're comfortable in being engaged, because it is all about engagement. We have got to bring care to people in the way that they want it; that's what person-centered care is.

