Academy of PHYSICAL MEDICINE

Transcript

Safeguarding
With Jack Newton

Cast List

Steven Bruce	SB
Jack Newton	JN

SB: Now this evening I am joined in the studio by Jack Newton. Jack has a military career behind him, some 20 years in the army. He's had many years now as a counselor. He has an MSc in Psychotherapy, and he's also studying for a post grad qualification in Clinical Supervision. So he has a lot to say about a subject which has interested a lot of our members. We've had numerous inquiries about safeguarding over the last, probably nine or 10 months. I think it's become more a part of the news. It's more part of the headlines these days. And a lot of people worrying about what we should know, what are our responsibilities and so on. And frankly, I haven't got a clue, so I needed to get someone in who did know this. He refuses to let me call him an expert, but let me introduce Jack Newton anyway.

Jack, thank you very much for standing in, particularly for standing in at such short notice, because our previous speaker had had to call off for personal reasons. We had you clocked in for I think later in this year. So let's start anyway with what is safeguarding?

JN: Firstly thank you for inviting me. Safeguarding is a very broad term, and when we talk about safeguarding, people have particular understandings based on maybe their own professions. But in general terms, safeguarding is about ensuring that we have principles, procedures in place to protect people that may be vulnerable.

SB: When I look it up online and I generally do a little bit of research before these broadcasts, pretty much the only thing that comes up is safeguarding relating to children. Do you find that's what everybody imagined safeguarding is about is protecting young people?

JN: Very often the average person in the street may safeguarding has to do with children isn't it? But actually if you look under the Care Act, 2014, safeguarding is very clearly defined and there are some principles in place there. But it's about understanding that we want to protect anyone that may be at risk. We used to refer to vulnerable adults. The term that we would more likely use now is adult at risk or person at risk, because the vulnerable part suggested maybe they was partly responsible, if there was any kind of abuse perpetrated against them. So it's person or persons at risk.

SB: Okay. So is that change in terminology for the benefit of the adults at risk, rather than for the practitioner of safeguarding or whatever?

JN: It's part I think of a move, generally to change the way we engage with people that maybe at risk of exploitation or abuse, because again the idea that they're vulnerable, suggests that maybe they're partly responsible for what's happened. So it's person or person's at risk, and that that applies to two young children as well.

SB: So about the Care Act, who does that apply to?

JN: Well the Care Act really just lists guiding principles. I mean there's a lot to the Care Act, but in terms of what we're talking about now is safeguarding, it lists the principles under how safeguarding might apply. And one of the things that has changed now really in terms of safeguarding, is we are now more open to the idea that actually safeguarding isn't just the responsibility of police, social services, health care professionals, safeguarding is everyone's responsibility. And maybe that's why it's particularly relevant for this discussion now.

SB: I suppose the reason I asked the question is to satisfy my members' curiosity over whether they have a legal obligation to be safeguarding aware, if that's an appropriate term, or whether it's just something which applies to the the NHS or people in named professions.

JN: Certainly there is a more clearer legal responsibilities for particular professions, but under again, the Care Act, 2014 it talks about safeguarding being everyone's responsibility. So although there may not be legal responsibility, there is a moral responsibility.

SB: Funnily enough, I was discussing a similar... I was talking about first aid to a chiropractor a few weeks ago, and neither of our governing bodies, the General Chiropractic Counsel, General Osteopathic Counsel say that you must have a first aid qualification. They simply say you must adhere to the law. So

in that case, the Health and Safety Act. I would guess that in this regard, and I am guessing here, but I'm pretty confident about this, there is no requirements on us to do any safeguarding training. But they would say you must adhere to the law. And what you're saying is the law does apply to us and that we do have a responsibility, because we have people coming to our clinics to do... What must we do? What must we know?

JN: I guess maybe the first thing is have an understand about what safeguarding is, and how does it affect our individual roles. As a psychotherapist, I often think that I have a responsibility to be aware of safeguarding issues, and to be aware of somebody that may be a client of mine that may be a person at risk, and that could be... I work with young people and adults, so that could apply to either of them. So it's having safeguarding, an understanding of safeguarding, what it is, how it may impact me as a professional, but maybe what avenues there would be for me if I had any concerns in relation to safeguarding and the client?

SB: But it's easy to imagine why you would be involved in safeguarding issues. People come to you with mental health concerns in your psychotherapy role. They come to us with a sore back or a sore shoulder, so really, we're off the hook aren't we?

JN: Well... So let's have a scenario. I come to see you, and in order for me to have treatment I might have to disrobe. I might strip down, depending on what I'm wearing, I might have on a robe. You might see me for the first time. You might've seen me over a period of weeks, and maybe as you've got to know me and we've built up a relationship, maybe there's been some chit chat as you ask questions and make me feel comfortable as you start to assess me. Maybe you notice some marks on me. Maybe you ask about bruises that you've seen on me. And maybe one day I disclose that those have been inflicted on me.

Can you see now how that might actually then raise a concern as to, okay... And let's say that I'm maybe 16 and a half, 17, 17 and a half, 18, the age really doesn't matter greatly, it's the fact that maybe I'm at risk, maybe I'm being abused, exploited. If you become aware of that information, where's the duty of care? Is there a duty of care for you?

SB: Well, I guess there is. So what is the duty of care? What do we do? I mean, if you don't want me to... Let's say I say, "Well these have been inflicted upon you by somebody. That's not acceptable. I need to report this." And you say, "No, I don't want that to happen."

JN: So talking to the individual, if we feel comfortable to do so. But very often a lot of people may not feel that comfortable. And what they may do is once the person has left, they may want to seek advice. Now depending on where you live, there's a number of different avenues, but very often the social

services, they operate a phone line, often referred to as MASH, Multi-Agency Safeguarding Hubs. And you can phone these lines and a consultation line. And if you have concerns, you could talk to somebody, and you could say that you have concerns about a person. You could explain why you have concerns, and they can offer you some advice as to maybe what your options are. At that stage you're not making a safeguarding referral, you're merely talking to another professional about concerns that you may have.

SB: Who mans those safeguarding hubs?

JN: It's a variety of people. Very often they may be social workers, they could be health care personnel.

SB: Right. But they're going to have the expertise to be able to give you some authoritative advice on what course of action you should adopt.

JN: Absolutely. They will help you to decide what it is you've heard, what it is you're thinking, where your thought process is, and they can offer you advice as to, "Okay, this sounds like it's something that we need to receive a referral for." Or they may say, "At this stage, okay, thank you for letting us know, but we don't feel that there's a concern at this stage, but if you have any concerns again in the future, come back to us."

SB: Is there a typical sort of person? Clearly you have a particular type of person, I imagine who comes to you as a client, but would you be able to spot someone who is likely to be at risk? Is there a typical person who would be at risk that we should be looking out for? I'm thinking small, female and probably with an area of vulnerability.

JN: In theory, anybody can be at risk. So stereotypically we may think of children being at risk. We may think of people with mental health conditions, people that are physically disabled. There are some stereotypes that we often associate with safeguarding, but actually anyone could be at risk. Anyone could be that person at risk. And the risk part is are they at risk of being taken advantage of or exploited, abused? It could apply to anyone.

SB: Right. You've given us one example there. Any other examples that spring to your mind on how safeguarding issues might emerge? Bruises, we're going to see lots of bruises in our physical therapy professions, because we treat sportsmen and other people who come with spinal injuries or whatever else. What about other clues that we might be looking for?

JN: Within your profession, obviously bruises are part and parcel, so those alone, and if you think back to the example I gave, it's the conversation that goes with that. It's what people say, and sometimes what people don't say. If I have a client and I notice a bruise on them and when we're talking, if I ask them about the bruise and maybe their body language changes, they become defensive, they look uncomfortable. It's the little cues that we pick up on that

may say to us, okay, I may need to explore this a little bit further. You might have a client that comes along with a child, and maybe the child is present when they turn up, and again, it's how the child is, what the child says, how they behave with the person they're with. So sometimes it's not the obvious things. It's not what we hear, it's what we pick up on.

SB: What's your approach then as a communications specialist, if someone appears reticent about a particular type of injury? How do you go about pursuing that? You can't deal with this in a military manner and poke a finger and say, "You will tell me." Can you?

JN: You could try but it probably wouldn't get you very far.

SB: It'd probably get you onto the end of the professional conduct committee hearing somewhere.

JN: Quite possibly. I think some of it depends on how well you know the individual. If it's the first time you've met them and you have concerns, you may not feel comfortable to start asking them direct questions. If it's somebody that you've built up a bit of a relationship with, probably over several sessions, you may feel more comfortable to ask them. We do have to consider that we don't want to potentially re-traumatize them by asking them lots of questions. But we're showing some concern initially, polite concern, which anyone can show to somebody. And it's about giving them the opportunity, if they want to, to then talk to us.

SB: Yeah. What about instances where, very often all of our patients are allowed to bring a chaperone with them if they wanted to? I mean I have in mind that if a person is in an abusive relationship, that the abuser in the relationship will probably want to accompany them everywhere to make sure that they don't do anything that brings to light that abuse. Is that always the case?

JN: It's not always the case, but it certainly can be applicable. I work with clients sometimes that have gambling addictions. And sometimes those people may be vulnerable themselves and they can sometimes come alone... They may be living in sheltered accommodation, and they could be adults and they would still maybe come with a chaperone as well. And sometimes the chaperone is trying to answer the questions for the person. So what we're trying to do is we're trying to say, "Okay. That's great, you're helping me, but I really need to let this person answer themselves." And we watch out for that. If the person keeps jumping in and trying to answer the questions, why are they doing that? Why are they not letting the person?

SB: Not always easy to isolate a patient, in your case a client?

JN: No, it isn't. But again, it's picking up on all the little things and if there's enough little things together to spark a concern. It's about, okay, what is the concern? And what can we do next to alleviate that concern?

SB: Slightly off the subject. Have you read Adam Kay's book, This is Going to Hurt?

JN: No, I don't believe so.

SB: He was a consultant, obstetrician gynecologist. An interesting book from a mental health perspective apart from anything else but in one of his hospitals, they had a system whereby in the ladies' loo there was a sign saying, if you have anything that you wish to discuss about abuse at home, then put one of these red stickers on your notes. So it's a way of them subtly letting the practitioners know that they let the doctors and the nurses know that they're being abused. And they had one woman he said in his book that came out and had loads of these stickers all over her notes, and they kept trying to get her away from her husband. And eventually it turned out that she'd gone to the loo with a four year old daughter who just thought this was a art project and sticking red stickers all over the notes. But I'm not suggesting we can do that in our clinics. A useful approach to getting an honest feedback from someone who might be under somebody's thumb, as it were.

JN: Within my profession, we often refer to the right intervention at the right time. And that approach may work with someone. It's about understanding that person and how we can try and reach out. And sometimes it's just about giving somebody the opportunity, so they know if they do want to say something, they know that they can. We often talk within psychotherapy about creating safe spaces. Those safe spaces are applicable I would say to your profession as well.

SB: What do you mean by safe space? How would you define that, regard that, describe that?

JN: So I think for me, a safe space is somewhere where somebody feels comfortable to actually express what they're feeling, what they're thinking. If they have a worry... we often as psychotherapists, we often see people that may not have many opportunities to talk to anyone about how they feel, for a variety of different reasons. But it's quite possible that you've also got people that are coming to see you that maybe don't have a range of people they can talk to where they feel comfortable. But when they build up a relationship with you, because they're seeing you regularly, they might suddenly say something one day. And if they feel safe to say it, that's when it could come out.

SB: It was, I'm sure it's mentioned in all the colleges, but in all of all of our collective training establishments, I'm sure that they all bring out the fact that you develop a particularly close relationship, potentially with people if you're touching them, which is of course what we do. And very often we're touching people who are partially undressed and so it becomes even more

intimate. And it's when people have become used to that relationship, I imagine it's more likely perhaps that they will open up to us.

JN: It is certainly a possibility. It is a very unique profession isn't it? In that regards because you have got that physical contact. But again, that physical contact could be seen as a way to actually strengthen the relationship. But I guess also that could present some of its own challenges as well, in terms of safeguarding. If you have a potentially a client who may be classed as vulnerable, maybe they have a learning difficulty and they've got an injury and they've come in to see you. Do they understand the process if they don't have the chaperone? And how much time do we spend explaining that to them?

SB: Yeah, well of course that raises a completely separate avenue of discussion, which is the issue of consent, isn't it? Which is is it valid consent? And in one of the definitions of that, according to virtually everything that is written, there's a lot written about it in our professions, is that the person must be capable of understanding what you've said to them. And although we work on a rough guideline of age 16 where you can get consent from a patient without their parent being present. Actually the rules don't say that, you can get consent from any age or patient, provided they are capable of understanding what you've said to them and analyzing the risks as you have explained them.

There's also, I suppose an issue which could raise its head in bigger clinics, in that the relationship that we enter into offers the opportunity for practitioners themselves to abuse their position, and therefore for other practitioners to recognize signs perhaps in that, that needs to be considered. Have you ever done any training, have any experience with that sort of thing? Looking at other practitioners?

JN: Probably not in those terms. I've been involved with safeguarding training before. I think when it comes to having concerns about colleagues that we're working with, the way they practice, maybe things that we've heard them say, a particular stance that they have on a particular client group. If we see them maybe and there is what we might consider inappropriate contact touching, if we have concerns, then I would imagine within your own profession there would be policies and procedures in relation to where you work in relation to that.

SB: Well, I think the policies are fairly general. That we have a responsibility to be professional in our conduct and to report unprofessional conduct in any colleagues where we notice it. But again, there's probably a degree of trust. We assume that all of our colleagues have the same ethical standards as we do ourselves. And it may be difficult to recognize when they are stepping inappropriately over the boundaries and maybe sometimes they are doing it without realizing and it's just the... so it's a relationship which is going a bit

too far with the patient. And of course that in everybody's mind that brings up the idea of a sexual relationship. But there has been a case not that long ago where a practitioner's been struck off in my profession for inappropriately pursuing a relationship with a patient, I think some 20 or 30 years ago. So that doesn't seem to be any time limits on these cases either.

JN: No, I don't believe there is. And I mean what we're talking about there really is kind of an ethical framework to work within. And safeguarding forms part of the ethical framework. If we look at an ethical framework for the PACP that I'm involved with, we can clearly see links and parallels between safeguarding policies that go back to the Care Act 2014, and the principles set aside within the ethical framework by the PACP. But if I have concerns about a colleague, one of the first things that I would be inclined to do would be to speak to that colleague. That comes down to how comfortable we are as individuals to challenge. And that comes back to safeguarding is everyone's responsibility.

SB: Yes. Do you have a picture of a typical abuser?

JN: No.

SB: So it could be the least likely person?

JN: It's the same when we ask the question of what does a typical or vulnerable person look like? It's the person on the street. It's a family member. It's someone we know. It's somebody we talk to in the shops. It's somebody we queue up behind in the bank. And it could be the same thing as terms of the perpetrator.

SB: But one gets the impression, particularly from high profile cases and I'm thinking, let's see, Jimmy Savile, let's take that for an example. The man was so arrogant and so confident that people just accepted his story even though there were, it would seem in retrospect, plenty of concerns about his behavior. Is that the case with a typical abuser? Or again, is there a spread in that aspect of their character?

JN: I like to think things have moved on significantly in terms of safeguarding since that sort of came to light. Do we do enough? Can we still do more? We can probably still do more in terms of improving communication between agencies. Improving the way that maybe give people more confidence to actually question and to increase the availability of information like the Multi Agency Safeguarding Hubs and the phone lines.

SB: It's the first time I've heard of it.

JN: Knowledge is obviously a wonderful thing. If you give people the knowledge and you give them the confidence to use that knowledge.

SB: So if we Google Multi Agency Safeguarding Hub, are we likely to come up with the nearest one to us? So it doesn't matter how near it is, because it's telephone call anyway.

JN: Yeah. I mean certainly in Northamptonshire, where we are now, you've got the Multi Agency Safeguarding Hub. Some areas might variation on the names of them, but if you were to Google, I would imagine you'd get a hit. I've not actually tried it.

SB: Right. I'm sure you would. We got some questions and then we'll come back to telephones. Somebody sent in a question quite some time ago saying, are these phone lines anonymous?

JN: Yes. So they are. They will ask you your name. So if I phone up and say I want to speak to someone to ask some advice about a safeguarding concern, or a concern that maybe safeguarding related, they would ask my name. And if I was reluctant to give my name, they might wonder why that was. Because actually I'm just phoning up to ask information. I would ask maybe why we're reluctant to give our name?

SB: I suppose practitioners might be very concerned. I mean given the constraints we have on sharing patient data, I can imagine practitioners being concerned about giving away things that might be you at the other end of the phone to know who it is I'm talking about. And to intervene where perhaps that might not in my opinion, be appropriate and maybe my opinion needs to be shaped when I make this phone call.

JN: So I mean in answer to that, I could phone up to ask for some advice or guidance. I could use my name to tell them who I am, but I could keep the details of the person I'm concerned about anonymous. That would be the approach I would take. I'd be quite happy to use my name. And I've used the MASH before and I have given my name, but I've kept the details of the person I'm concerned about anonymous. And they're happy to do that.

SB: Right. Will that always be your first point of call if you have concerns, MASH or the equivalent in different areas?

JN: They are the professionals to speak to, and they would be able to give you current up-to-date advice. And with their experience of dealing with safeguarding issues. One of the things when we make a safeguarding referral is, they're not always accepted. Somebody assesses the safeguarding referral and they decide whether or not it matches the criteria and whether or not it will be accepted and then followed up on. So sometimes I could submit one, but if I've not had the discussion first, it may not get accepted.

SB: Would you make that submission to the same people? So you've had your phone call with MASH, is it to them that you send this submission and say-

JN: Yes.

SB: Okay, all right and then they will take whatever legal or other action is necessary involving you or not?

JN: They would do any follow up investigation. It may not ever come back. When we make the referral, we put our details on. So the person making the referral has to put in their details. How much follow up there is, I've made referrals before and I've had very little follow up, other than to confirm the information that I've submitted.

SB: Are you required to have the patient's consent to make that referral?

JN: No.

SB: Interesting. That might come as a bit of a surprise to some sufferer, some victims, I imagine.

JN: Again, where we talk about safeguarding being everyone's responsibility. If I have a concern for someone, I might talk to them depending on their situation, or I might decide actually talking to them isn't appropriate. The concerns are serious and I'm just going to go straight into referral. But we don't need their consent to say that we're concerned about them.

SB: Now I'm going to ask a very clever question now. I'm going to say it's very clever, because you raised it when we had a preliminary discussion some weeks back. Is that do all sufferers, do all people at risk realize that they're at risk?

JN: That's an interesting question.

SB: Well yeah it was your question-

JN: I know

SB: I thought it was very interesting too.

JN: I mean, we don't know what we don't know. Someone could be at risk. Maybe a good way to answer is, I used to be involved with Relate and I used to run what was called the change program, which was working with perpetrators of domestic violence. It was a great program. And the groups would be up to 10 or 14 men. And because the groups were men, there was change program for women, but they tended to be one to one. But the men, because it was larger numbers, would be done in group.

SB: The idea of change being changing the behavior-

JN: Change in the behavior. And it was a rolling course. The course was six months long, and people would join it at different stages. So on an average evening, I might have five people that are within a few weeks of finishing, I might have five people that are within a few weeks of joining, and then those people in the middle. So you've got different levels of understanding and awareness.

And sometimes the people there, they weren't actually aware that what they was doing was abusive. It's not justifying their behavior, but they wasn't aware of it. But some of these people were also vulnerable within their own right, and they didn't recognize that either. So not everyone will recognize themselves as being vulnerable.

SB: How sensitive is the reaction of people who respond to a safeguarding concern? Do they go in police cars, either side of the house, all lights blazing, S.W.A.T teams at the ready? Or an easy to gentle cautious approach? Or do they get calculated, gage it according to the level of potential harm to the sufferer?

JN: I would like to think that the response is proportionate to the concern. So if they felt that there was an immediate risk or a threat, they might well be flashing their lights. But as long as the response is proportionate to what their concern is. And there's a justification for that response.

SB: You've used the term, you'd like to think on a number of occasions. That suggest that you're not confident. That you worry that they might not get it right. And I know everyone's entitled to make a mistake, but-

JN: We're all individuals.

SB: Yeah. And in your experience generally do they get it right?

JN: I think that overall they get it right, more than they get it wrong. But again, the media will often pick up on the times they get it wrong and use that, because that sells more papers than the times they get it right.

SB: It is just a horrible way of doing business, really. Some of the questions, this one slightly different, slightly off topic, really perhaps. Do we have a duty of care for a potentially self-harming patient? For example, a female, teenage patient or even an older patient who for example you might see signs of self harming, would that fall into your safeguarding category?

JN: I work with self-harm quite a lot. And we often think about self harm as something that's fairly new. We often link it to the internet and social media. I've recently finished working with somebody who's 72 and had been self-harming his entire life without his family knowing about it. And that suddenly made me realize actually self-harm is not new. It's always been there. We've

just become more aware of it now maybe because of social media and the internet.

SB: What was the form of the self harm? Because obviously it must've been concealable, whatever it was.

JN: It was a particular type of self harm and because it's very particular, I won't mention it. I will say that there is. I get young people that come and see me as clients for counseling and I will often talk to them about self harm if they are self harmers. And I will often talk to them about how they can continue to self harm safely and cleanly, because one of the things is a risk to do.

If someone's coping strategy is through self-harm, and if we suddenly remove that, what are they then going to do? So we want to minimize their use of self-harm, but why we're minimizing it, why we're trying to get them to actually change their strategy, is its important that they understand if they're going to continue to do it, they're doing it safely and cleanly. That's not encouraging them, that's about asking them what they do, how they do it, and getting them to identify the risks themselves.

SB: This is outside the area of our expertise generally as osteopaths, chiropractors, physiotherapists and so on. So again, if we have someone self-harming, is that something we should report to one of the hubs that you talked about?

JN: I believe that actually self-harm, wouldn't necessarily be accepted as a referral for safeguarding. If you felt comfortable to talk to the person about the marks, if they disclosed it was self-harm, there potentially is an abusive situation, because maybe they're self-harming as a way of coping with some abuse that they're experiencing. But self-harm itself without any background, probably wouldn't be accepted. Again, we could come back to using the consultation line to explore that, and get the professionals on the other end to give us their advice.

SB: Yeah. I must stay, I'd be really interested to hear what the experience is of the people watching this evening, because if you've had a patient in your clinic where you have had suspicions of some sort of either abuse, or self-harm, or anything like that, what your immediate reaction was. Because I know on... I've had a couple of occasions in the past, and I'm slightly embarrassed to say, not necessarily that distant past, where someone has revealed something of that nature, and I haven't known what to say, and therefore I have quickly steered the conversation away from it. And I'm thinking in particular a patient who had self-harmed, and I think it was historic, but I didn't actually ask the questions to find out whether it was historic. There weren't any bleeding wounds on this patient, but perhaps I should've known better, I should've been better prepared for that eventuality.

And I suspect that a lot of people in my profession don't expect that sort of thing to come through the door, and therefore they're used to the warm, friendly relationships that we have with our patients, and don't quite know how to take charge of the situation.

JN: One of the things I've learned in my role, is to be open to expecting anything, because we're dealing with people. And people by their very nature, human nature, is unpredictable, and we never know what somebody's going to say, or what they're going to do, no matter how well we think we know them. So the more knowledge we have, the more understanding we have. The communication skills... You spoke about communication skills, the better we are at our communication skills, the more comfortable we feel to talk about things.

SB: Yeah. Without doing an MSC in Psychotherapy, how do people improve their communication skills, because we all come with an ingrained set of, or an inbuilt set of communication techniques, don't we?

JN: It's about looking at ourselves, it's about looking at, "How do I communicate with my clients? Am I comfortable with the way that I communicate? Is there anything that I would feel uncomfortable talking about?" And if so, I look at why is it I'm uncomfortable about that. How could I change that? Take some-

SB: Is that something you think you can pursue successfully on your own, or does that... Excuse me, would that require not necessarily a professional like yourself to intervene, but just sit around the table with a group of colleagues saying, "This is something I'm not easy with?"

JN: Having discussions with colleagues concerning CPD events around communication skills, I recently finished a contract with the Department of Work and Pensions, and a large of that contract was about improving communication skills with frontline staff. So it is possible to do, but first of all we have to think about what our communication skills are, and whether there's any areas where we can improve on, and what are those areas, how would we like to improve. We need time to understand ourselves, to understand what we can improve if we want to.

SB: Well, you told me off for crossing my legs earlier on, are these courses all about body language?

JN: Well, body language isn't exact science, and some people dispute completely about body language. From the military, I learned a great deal about body language, and the use of body language, and I use it quite a lot as a therapist watching my clients when I'm asking them questions. But yes, certainly, body language is part of communication. Sometimes what we don't say, is as important as what we do say.

SB: I imagine in your role, you probably leave quite a lot of pauses in conversation, which we tend not to do, is that the case?

JN: I certainly do. I think silence is very, very powerful.

SB: It's not good TV, don't do it now.

JN: Okay. We can have a quick demonstration. Silence can be very powerful, and if you were chatting away to a client, and there was a pause and maybe it's filled an unnatural pause, maybe they don't usually pause to answer, that may be an indication of something.

SB: Yeah. Okay, let's go back to some questions that have come in. If we've established that there is an abuse issue, but the patient has asked us not to report it, what do we do? Are we breaching their confidentiality? Now, I think we've sort of answered that earlier on. Are there limits perhaps in things we are allowed to do without their consent?

JN: If we have a concern for somebody, we can make the report without their consent. Maybe one of the things... Within my client work, very early on, the first session, we talk about limits of confidentiality. We talk about disclosures that they may make, and if I have concerns for them or someone else that they refer to, at that stage I may break confidentiality. And that has been in place for psychotherapy and counseling professions for some time, and we refer to as the limits of confidentiality.

SB: Does that affect what they might tell you? If you've admitted to the fact that, "If you tell me something where I learn that you're being abused, then I'm going to tell someone else," might you never learn about that abuse?

JN: We don't know what we don't know. So it's possible that person has been put off telling me something, but I know from the clients I've worked with, I've often had disclosures made to me, and I've had to then talk to them and say, "This is one of the times when you've said something to me, that I have concern for you, and I now have to talk to you about breaking confidentiality." Personally what I always try to do, is I try to get the individual to break the confidentiality. I will explain my concern, I will explain why I'm concerned, and I would support them to actually tell someone. Because then-

SB: Who would you tell them to tell?

JN: Well, again, it depends on the nature of the concern, that individual could actually still use for instance, the MASH. They could do the referral themselves, and there's something which is quite empowering about somebody that's in a position where maybe they're being abused, and they take action, because someone's not taking the power away from them to

take action, they're taking it themselves. And there's something quite empowering about that.

SB: So it's actually well worth all of our members, all practitioners of my sort, having written down somewhere what their local MASH or the equivalent number is, because you never know when you might need it? And that's probably not the time to scramble for the internet, and try and find out.

JN: I would say its good practice wherever people are working, we're allowing the country, we're allowing the world to know where their local point of contact is for further information in relation to safeguarding issues.

SB: Yeah, okay. I did have a patient, where I had a serious safeguarding issue. An elderly patient, elderly partner, likely had generative mental health illness and was become physically abusive to her. In that case I had contacted social services with her written and signed consent to refer her case to them. Would it have been better to contact MASH, or whatever the equivalent was, rather than social services direct?

JN: I think the fact that there was action taken, was very positive. What action was chosen as the best option at the time, would've been based on their knowledge again, and their understanding. Maybe the question to ask back to that person is, now that they know about the MASH, if they didn't before, what option would they take tomorrow if the same thing happened again?

SB: This is a bit like dialing 999 though. Everyone thinks if you dial 999, you get an ambulance. Actually, you get someone on the end of the phone who can help you, and the same pertains with the MASH, doesn't it? So the outcome might have been the same here, but you could talk to somebody first of all, and say, "Well, am I thinking of doing the right things here? Is the right thing?" And you would get some reasonably well informed advice.

JN: Sometimes the advice that we get, can be very helpful. And I have a concern about somebody, and I'm not sure whether it is safeguarding, but I'm just concerned. I phone up and I speak to the consultation line, and I explain to them about my concerns and why I'm concerned, and they can talk me through. And they could maybe say to me, "Okay, well have you considered this?" They may not accept it straight away, they may say, "The next time you speak to the person, maybe talk to them about this." So there is a great value in using that advice line, but at the end of the day, they're the professionals, they're going to give us the knowledge and the insight based on all their experience that we don't necessarily have.

SB: I noticed that the GP hasn't figured in this chain of communication so far, so you're not suggesting that if we have concerns, what we should do is contact the GP immediately, and say, "I'm worried?"

JN: I wouldn't do that as part of the safeguarding procedure. If I have concerns, I would be going straight to the MASH or equivalent, and address it to them. Very often if we try to speak to GPs, I have reason to contact GPs with consent of my clients in relation to maybe medication they're being prescribed, and it can be very difficult to have those conversations with GPs, because people are very concerned about data protection, GDPR. So even with the consent, the GPs are still very wary of what they will and won't share. So if I have a concern, I would go for the referral of the consultation line.

SB: Well, GPs are not the only ones concerned, are they? Everybody in virtually every walk of life is concerned about it, particularly if they've got confidential records.

JN: Yes.

SB: Is this something that's bothered you? I mean, are you comfortable with data protection regulations?

JN: Personally, yes. I'm signed up as an individual. I'm a member of the ISO Information Commissions Office, and I abide by their best practice, and also with the BACP best practice in regards to data protection, how we store and use data. Mind actually volunteer our sign in register. We used to have a sign in book. People would come along, put their name, date and then they would come, but with GDPR we had to change that, because now somebody would come along, and they could see who'd signed in before them.

SB: Yes.

JN: Under GDPR we can't do that, so we now have a data entry system where you can't see anyone else has signed in.

SB: Well, interestingly, I was a private healthcare clinic a few days ago with a patient, I'd taken him along for an MRI, and I was fascinated. They have a sign in book, but the bit that you write on, you can't read what's been written on it.

JN: Yes.

SB: And clearly, that's for data protection, but I thought, "It makes it bloody difficult writing your own name sometimes when you can't see what you've written."

JN: It does, they're very popular in schools those books.

SB: Are they?

JN: Yes.

SB: Okay. And the same of course, as it relates to accident books. They used to be that people would use an exercise book in a cupboard, but now it has to be a torn off sheet of paper kept in a secure storage. And of course, we should all have accident books along with our first aid kits and so on. Sorry to come back to first aid again.

JN: No, that's fine.

SB: Let's have some more questions here. I had a patient who is obviously having problems with her eating, or lack thereof, and as soon as I broached the subject she seemed to be okay with discussing it, but never came back. I wish there was something else that I could've done, any suggestions? That comes from Jason.

JN: So, eating disorders, if that's maybe what it was, it sounds like maybe there was a difficult relationship of some sort with food, if it's the individual that's doing that, they may be doing it as a strategy because of something else, abuse, or it may be as part of a deterioration in mental health. Situations like that, I'd be inclined to be sign post into an organization like MIND, where they can maybe go in and speak to a mental health professional, maybe access counseling. It depends on... Again, it's about local services, what do I have, as I've been with my local Mind now for two and a half years. And one of the things I do, is try and make sure I stay up to date on who the local services are, so sometimes I can refer an individual to a local service.

SB: Could you elaborate just a little bit on Mind, because as you said, you've been volunteering with them for some time? But as I understand it, Mind is... effectively it's a franchise, isn't it? It can be set up anywhere, but it doesn't mean that it's actually nationwide.

JN: No. So we have... It works basically like a franchise. We have the central office in London, and then we have affiliations. So I'm a volunteer with Rushton Mind, and we're affiliated to National Mind. In terms of funding, we're self-funding, and all Mind branches are. So if you come along and you donate to National Mind, that money goes to the central office. If you want to donate money to Rushton Mind, you need to come to Rushton Mind and contact us to donate it. And this is often misunderstood, because people would often raise money for their local branch, but sometimes it will go to the national charity, and the local branch may not necessarily see any of that funding.

SB: But a practitioner in another part of the country, are they likely to have a nearby Mind that they can contact if they have concerns such as the one that we just raised?

JN: So there is a large number of Minds throughout the country. I think at the moment we're down to probably around about 150, 158 branches. So having

a look to see where your local branch is, is in your local area. What we're having now, is a lot of branches are consolidating and merging, because of the difficulties with funding and sustainability really, and improving services, and the changing need of services. So a lot of smaller branches are now merging into a larger branch to cover a countywide area, as opposed to having five or six across the county.

SB: Yeah. And for most of the people watching, this is probably a silly question, but some may be unclear on this, if we come across somebody who we think has any psychological problem, or challenge, we're probably best to call it a challenge these days aren't we, can we just point them in the direction of Mind and say, "Look, make contact," or should we be getting in touch with Mind, and telling the patient, "I'll ask them to contact you?"

JN: In terms of terminology, the problem is Central Mind, Mind refers to mental health problems. I actually don't always feel comfortable using that term myself, but that's the term that they do use. If you have concerns about someone you're working with, again, I would say maybe the first instance, maybe talk to them. And talk to them about maybe where they could go to get support, if they're not already receiving support. But maybe, initially, to their GP, and the GP may sign post them to a local service like Mind, briefing mental illness. There's a number of services throughout the country they may go to, but very often the GP may be the first point of call you may refer them to.

SB: Yeah, okay. This person has sent in an observation here. They think it might be helpful to talk about the different categories abuse people might be at risk of, and also other signs, for example, behavioral change, that might trigger a concern. This person says that they have training in safeguarding for another role, that they haven't found these points helpful. Also, an introduction of the idea of concepts in capacity. I'm not sure that was transcribed properly, but presumably capacity to understand what's being said, and what help they're being given.

JN: Well, you referred to capacity earlier on, and how do you determine whether or not they've got capacity when you ask them about the consent?

SB: I was hoping that was rhetorical. Well, personally, and I can't speak for anyone else who's watching this program, I think there's an awful lot of, what you called earlier on, other world experience. Not other world experience, previous life ex, in judging the nature of the person. If you disregard more obvious things such as intoxication, or the effects of drugs, and so on, I think you can easily form an opinion on whether a person has understood the sort of warnings or advice that we might be giving them. And we are asked, it is suggested in some of our training, that when we're seeking consent, we get them to repeat back the advice we've given to make sure they understand it. But I think I would only do that if I suspect that they haven't understood.

JN: Yeah. I've done the same thing when I meet someone for the first time, and we were talking them through what used to be called, a counseling contract. We now refer to it as a terms of service, and it covers a number of areas like confidentiality. But I often ask them whether they have any questions, and if I have any doubt, I will ask them if they can repeat back to me what their understanding of it was. But again, I only do that if I feel there's a requirement to do it.

SB: Yeah. And I suppose somebody will be wondering, well, how much of this do you actually record in your notes, "I didn't ask them to repeat it back, because I was happy." Or, do you just record, "I was happy that they gave valid consent," or whatever, which I think is what we would do if we believed we received valid consent.

JN: No keeping... It's quite a topical issue within psychotropic therapy and counseling. So in terms of that example, if I felt the need to ask someone to confirm they understood, I would record that, that I asked them to. If I didn't feel that there was a need to ask them to confirm it, I would just state that it was covered.

SB: Right, okay. I do remember from a previous speaker, and again, it's hot topic with physiotherapists, osteopaths, chiropractors, very hot topic about consent, but I remember being told some time ago that, if you're simply going to record, "I received consent," then you have to have a pretty standard procedure that you go through to reach that conclusion. If it's different every time, then it's not sufficient just to write, "I got valid consent," because you'll never be able to say in two years time when you come to be cross examined, "That's what I meant when I wrote that." Is that the same with you?

JN: Yes. Notes... We within counseling and psychotherapy, our notes are brief and they're factual. There's no, "I was thinking, I was feeling, I thought that." They're brief and factual notes, and that's-

SB: Mine are brief and illegible, which I find works well.

JN: Being able to read them back can certainly help.

SB: Yeah.

JN: I mean, part of that question, which maybe I didn't answer, was the categories of the abuse.

SB: Yes.

JN: So there's a number of different categories, and people can get more information if they search for these online. Looking at the Care Act 2014, is a good place to start. But the more common ones, are the ones we often think

about, are maybe the physical abuse, sexual abuse, psychological abuse, and those are probably the three main ones we often think about. But again, with something like this today, if everyone watching leaves with more questions than they came, I'll be very happy, because this is about generating questions. This is about getting people to look at their practice, and say, "Am I doing everything I can? Do I know as much as I feel comfortable with, and if I don't, where can I get more information?"

SB: There was a middle part to that question as well, which was about other signs of abuse, such as behavioral change. So you've talked about three main categories of abuse, according the Care Act, what would you be looking for to give you clues that you should be pursuing that line of inquiry?

JN: Behavioral change can be most effective if we've got a reputation... if we've got a relationship with somebody, because if I've never met you before, I don't know what your behavior is ordinarily.

SB: True.

JN: So as we get to know someone over a period of time, that's when we might start to notice behavioral change. And again, it comes down to how comfortable we are to actually ask about it. If I have a client that comes in that every time they see me has usually said, "Good morning, how are you," and they come in today and they don't, I will ask them, and I'll be watching for their response. But I can only do that if I've built up a relationship, so I know what their normal behavior is.

SB: Yeah. Oh I see. Oh the person who asked that question has just followed up by saying, that about that observation on capacity, they were referring to the Capacity Act.

JN: Okay.

SB: Clearly defined categories of abuse. Is there a Capacity Act?

JN: Mental Capacity Act.

SB: Right, okay. And that's an interesting thing to have a parliamentary act on. Is it simply there to define what constitutes mental capacity, or-

JN: Someone's ability, yeah, to determine capacity whether somebody has capacity.

SB: The problem with bringing up the Care Act and the Mental Capacity Act is, that I can pretty much guarantee that nobody watching this program is going to go out and download those acts and read them, because they are legal documents which will be very difficult to sit through without falling asleep. Are there useful summaries of these things somewhere, that you know of?

JN: There are, and the Capacity Act comes with the Mental Health Act. So you can go online, you can purchase from a number of different sources, condensed explanations of each part of the act. It depends on how much people want to know about how much they feel is relevant to them.

SB: Right.

JN: But again, having a general understanding can be beneficial. We don't need to be experts in this, because this isn't our field, but if we have an understanding about what the Mental Health Act is, the Mental Capacity Act, Deprivation of Liberty Standard, which I believe the name for that has now changed, if we have an understanding of what these are, they may give us more confidence to actually just ask people questions.

SB: Which was the one whose name has changed? I didn't catch that.

JN: It used to be called DOLS, Deprivation of Liberty Standards, I think that's-

SB: Right.

JN: ... recently had a name change.

SB: Okay. This is a interesting one. Is safeguarding really only for "registered vulnerable people" as you just said, or under 16-year-olds?

JN: If that's what they thought I said, no. Safeguarding is about anybody. Anybody can be that person at risk. They don't need to be a registered person, and they don't need to be a child. Safeguarding could apply to anyone, because the person at risk could be anyone.

SB: Don't you think almost all chiropractors and osteopaths work in private practice? Physios more often than us work in the ENHS. But because of the nature of our client base, we're really, really unlikely to come across any cases of abuse, aren't we?

JN: That's an interesting question. So statistically, they say one in four, one in five people has a mental health problem. So what are the statistics of people that are experiencing abuse? What are the statistics for how many people are there that fall into the category of persons at risk? And actually, we don't really know, because we don't know everyone whose at risk.

SB: Do you see people, do you have experience, or know of people from every bit of the socioeconomic spectrum that have had abuse problems, or safeguarding problems that people should be aware of?

JN: I think it covers a very broad spectrum, and it covers all walks of life, and every social element. And I think it would be... Again, stereotypically, we often think about people that may be more deprived, lower end of the social

spectrum, that may be more at risk. And again, maybe the media perpetuates that, but maybe there is an element of truth to it. But in actual fact, I would say that anyone could be that person at risk.

SB: I suppose that, turning that around, although one gets an impression that there are a large number of abusers at that lower end of the social spectrum, actually there are quite a few abusers at the higher end as well exploiting positions, or authority and power?

JN: Absolutely, and there's been some recent examples of that in the news, and that is quite topical again. It does, I believe, apply to all spectrums or walks of life.

SB: Is that something you think you would be ever likely to come across, is that rather than recognizing signs of abuse, you're recognizing someone... the possibility that they are an abuser? That must be much harder to spot?

JN: Well, it's-

SB: Again, we talked about it in terms of practitioners, but in terms of patients now or clients.

JN: So within the clients that I see, having somebody that maybe has been released from prison, that's been convicted of perpetuating sexual abuse, may as part of their release conditions may come into counseling, or they may choose to come into counseling. And that can be a challenging area to work with. And again, I go back to working with perpetrators of domestic abuse, it can be a challenging area to work with, and it gives us an opportunity to kind of reflect on our own values, and our own core beliefs, because we're working with quite unpleasant topics and subjects.

SB: Yeah. I don't whose asked this question, but they want to know whether you think a clinic needs a safeguarding policy document, written with all people working there made aware of it, and familiar with it, including third-party agencies, and so on.

JN: I think there would be benefits in terms of good practice, to having a standard safeguarding policy or procedure within a clinic. As Mind, again, as an affiliation, we have a safeguarding policy, and more and more organizations are. And very often when we talk about policies and procedures, we can start to imagine being bogged down with a real quagmire of paperwork, but it doesn't have to be too complicated. It could be one page of A4, it's just listing what our procedures would be, so if somebody had a concern, they would know what to do, what their own policy is.

SB: Yeah.

JN: And I'd say within good practice it would be a good thing to do.

SB: Nicely, if only it can be put so simply, because I'm always... Whenever someone asks a question like that, I'm always put in mind of those great big posters that used to adorn every factory wall, explaining the Health and Safety Act, which no-one ever looked at, but were all... But the factory owner was happy, because he'd made everybody aware of it, but actually nobody ever read it. The difficulty with all these things, is making sure that everybody knows about and complies with the policy, isn't it, especially if you've got a turnover of practitioners coming through your clinic? Not necessarily high, but you've got to remember to brief them on it.

JN: Well, as part of a standard induction, letting people know where the change rooms are, where the rest areas are, where the staffroom is, what your fire policy is, what your safeguarding policy is.

SB: Okay.

JN: I don't think it's particularly onerous. We can sometimes make it very onerous, but I don't think it needs to be onerous to ensure that people have an understanding.

SB: Yeah. Somebody sent a really interesting question here. There is a perception that psychotherapists and counselors, you're probably much more confident in dealing... in contacting and dealing with the social services than we would be, because we don't do it very often. What happens when you contact them? What's the procedure?

JN: I don't necessarily think that's true, that maybe psychotherapists and counselors are more confident. I think it comes down to individuals, and maybe if individuals working in professions where they have to deal with this more often, maybe the confidence grows. But I don't necessarily think as a general rule, I would agree with that.

So what happens? My experience of it is a consultation, telephone line, and talking to somebody about my concerns. They agreed that they felt that my concern was safeguarding. I then submitted an online safeguarding referral, which was accepted. They contacted me the following day to check the details. I was working with Young People's Residential Care Unit at the time, and I had concerns about an individual that was there. The safeguarding referral was picked up, I ended up having meetings with the MASH, the young person's Social Worker, and the Key Worker. But it was resolved. The safeguarding concern was picked up, and although it felt like it was quite drawn out, it took sometime. The initial response was very good, but the resolution actually felt like it took a long time. But it was resolved.

SB: You presumably have a greater chance of being part of that resolution, given that you are a psychotherapist and a counselor, whereas I imagine we would

probably not hear what happened after we'd made the referral in our own professions.

JN: Well, I wasn't actually a practicing psychotherapist at the time, I was still training on that occasion, and I was involved to the extent where I needed to be involved. There was lots of things that went on that I wasn't involved with, but it depends on whether they feel that there's a need for us to be involved. Again, we're back to proportionality. If we need to be involved, if it's appropriate for us to be involved, we may be.

SB: Yeah. I haven't heard from Daniele in Edinburgh for quite a while, but he sends in an observation here, he says about body language.

JN: Yes.

SB: Apparently, you'll know better than I do, even Freud said that "sometimes a cigar is just a cigar." So there must be some skill in interpreting body language.

JN: I think he's right, and that's why we say that body language isn't an exact science, it's more of an art form. There are statistics now, which is contested, in terms of communication and how much of communication is the words that we speak, how much of it is the way we speak it, and how much of it is body language.

SB: We should do a little poll actually, should ask everyone watching here. With our brand new website, we spent a lot of time deliberating over what the homepage should be. And on the front homepage, right in the middle, there's a picture of me in my white coat with my arms folded. Arms folded is a barrier, isn't it? So we all know that's a very nasty picture to put up there. But actually we came to the collusion that it looked quite nice. Very interested to hear what you feel, because if you think it looks horrible then we'll change it, but I think it looks very friendly. But then I'm probably biased in that.

More questions. "If the 'victim' in inverted commas, doesn't want to talk to me about getting help, should we get the authorities involved? May that make their situation worse?". I suppose we've talked about getting the authorities involved, but is there a possibility then that their situation could be made worse?

JN: You know there is always potentially a possibility that once we make a referral it's out of our hands. But we come back to safeguarding's everyone's business. It's everyone's responsibility. If we don't make the referral, the likelihood of it getting worse and continuing, is almost guaranteed. The likelihood of it getting worse for a while, if we make the referral, but ultimately getting resolved, is also increased.

SB: There's a very long question here. I don't know who this is from. "Hi guys," is what the person says. "Last week an associate saw a lady who's visited the clinic before but appears subsequently to have developed memory problems. She couldn't initially find her way to the clinic twice and she forgot she'd been in for an appointment the day afterwards when the associate gave her a follow-up call. She lives alone but otherwise appears to be functioning okay. What are your thoughts on safeguarding here? Is a letter to the GP to outline the position okay, without obtaining her consent? We're obviously worried this lady's mental health is deteriorating and nobody's spotting it.".

JN: So for me, in the first instance, I would be trying to talk to the lady and maybe saying, "I've noticed that it took longer to come in here today. You seemed a bit disorientated." And talking to her and maybe trying to get her to speak to her GP. Again, if we empower individuals to take responsibility, if they can, it can be beneficial for them, as opposed to us doing it for them.

SB: Yeah. There's a danger she'll forget to contact the GP perhaps, if she's forgotten that she's even been in to see you the day before.

JN: She might, or she may turn around and say, "That's a really good idea. I'd like to do that but at home I don't have a telephone. Would it be possible to use the phone in your reception?"

SB: Interesting. Yeah. "What if we have an adult patient who we suspect is in an abusive relationship but doesn't want to admit it? If they're at risk, do we have to treat them differently? Are we obliged to help if they're otherwise sane and physically normal, or do we have to respect their life choice, note concern and put to one side whilst treating them?"

So again, we talked a little bit earlier on didn't we, about adults who don't admit to being in an abusive... or don't admit to being at risk, or accept that they are in an abusive relationship. And can I say, comfortable with it?

JN: If we look at something like psychological abuse, not everyone will recognize psychological abuse. They may not recognize that they're in a psychologically abusive or controlling relationship. And again, I come back to having that safe space where you can give someone the time if they want to say something, if they have a concern. You can't force somebody to talk. If we have a genuine concern in the first instance, I would try talking to them. They might open up, they might not. And again, if we have still a concern, I would be looking at seeking additional advice about that.

SB: Okay. Sarah has asked a question. Sarah says, "How do we stop patients who are taking us into the depths of their problems? I know we need to be sympathetic, but it's not our area of expertise and it would be helpful to have a technique to bring the conversation to a close." Sarah admits to be drinking

rhubarb gin at the moment and thinks we all ought to know in case the questions are a bit too heavy.

JN: I've never tried rhubarb gin, but it sounds very nice.

SB: Sounds like an alcopop to me.

JN: I suppose we come back to communication skills. Developing ways where we can close down a conversation if we feel that it's going to an area there where we don't need to be involved. If we don't have a safeguarding concern, but someone is generally just talking to us about their life, we may want to close that down. And we can do that sometimes by referring people to other agencies. So, "It sounds like you've got quite a lot going on at the moment. I wonder whether you've ever thought about talking to somebody? Maybe go to your local Mind and speak to them." You're signposting them on, they've got the option, they can take responsibility if they want to go and explore that.

SB: All of this does make me wonder just how much training we ought to be doing in this. Is a conversation of 90 minutes between you and me, sufficient training for people in my position, or the position of the people watching this evening? Do they need to go on a course to learn about this, or have you given them enough sign posts yourself to recognize what they should be doing and their responsibilities under the law? You've got another 20 minutes so we haven't finished yet.

JN: Right. My aim really is to spark discussion, to spark conversations, for people to think about their own practice. And I'm not for one minute suggesting that anyone watching is not doing best practice, but if it gives people the opportunity to think, "Okay, can I do more? Do I know enough?" that alone is beneficial and they can then decide on the next step.

There is loads of organizations out there that provide training. I'm not here selling training, I am involved with safeguarding training but that's not what I'm here to do today. But there are lots of different organizations, very good organizations, where you can access good quality safeguarding training. I would say one of the best places to go to actually is to your local safeguarding board, your local social services, and talk to them and say, we would like to know more. Can you provide training or can you tell us where we could go to get some training? Because in some areas they do.

I recently was involved with the Department of Work and Pensions and they was looking at increasing their safeguarding training. And we liaise with different local authorities. And in different areas we got the different local authorities to come in and actually deliver the training because they're the best people really, because if we phone up the consultation lines, they're the people we're going to talk to. So let's get them to come in and talk to us.

SB: You're involved in training so are there different lengths of courses? Is there different levels of detail that you go into, or is safeguarding, safeguarding?

JN: There is different levels depending on what people's perceived need and understanding is. I would say that for my profession and maybe for your profession, having a general understanding about what safeguarding is, and more importantly, if I have concerns, what would I then do? We don't need to go maybe into the fine detail and you can obtain that information on a half day course.

SB: Right. Okay. Maybe we'll get some more details of courses like that so that people, if they want to take it further, they knew what they should be looking for, which we can post on the website afterwards.

JN: Yeah.

SB: Gosh, a long question. "Hi," says whoever asked this question. "I have a female patient who appeared to be a straightforward mechanical, low back pain patient, but as time has passed it's become apparent that her pain is a result of serious physical and sexual abuse by her brother from a very young age. She's contacted the police on my advice and encouragement, but the resulting investigation was badly run by the police and the net result was there was no case for the brother to answer, as the evidence had been eliminated, including her medical records. I still see this lady who is fairly suicidal in her outlook. She's adamant she will not authorize me to contact any other parties as she found the dealings with the police too much to bear."

: What options does this person have in dealing with this... Oh, my God, this very unfortunate lady?

JN: It sounds very traumatic and one of the things maybe to just quickly highlight is the concept of vicarious trauma.

So if I'm working with people that are in very difficult circumstances, mental health problems, it's possible for me to take on some of that trauma and for it start to impact on me. And that certainly jumps out of my mind as soon as you read that out, for the lady that posted the question. In terms of what we can do, talking to them about where they can seek support. They've had a very difficult experience with the police. There may have been other services involved, but if she has concerns in terms of her being suicidal and her ability to cope, again signposting her to an agency where she may be able to talk. Whether that's the Samaritans, whether it's the local Mind, Rethink Mental Illness, there's different organizations you could go to. It depends on what's around your local area.

SB: Again, would you contact one of the MASH hubs over this… ask their advice or...

JN: I mean one of the things that jumps out, is she still living with the brother? Is she living independently? Is she safe where she's living? Is the risk to her herself in feeling suicidal, suicidal thoughts, ideation? That's what I would want to know, but I wouldn't necessarily do a safeguarding referral unless I was to believe-

SB: There was still a risk.

JN: There was still a risk. Yeah.

SB: Right. Okay. Very useful. What a horrible situation to be in. This was one of the first questions that came in actually is, "If a patient suggests their life is not worth living, what do you do? What do you say?" It's a general counseling question this one, isn't it?

JN: It can be. I do hear this question from time to time. You know, when someone turns around and says that they don't feel their life is worth living, there's very often far more to it than just that very broad statement. That may be a point that they've got to where they're starting to feel that way. I often feel it's very positive when people are exploring how they're feeling, because if someone's going to tell me that they're feeling that way, then there is maybe things that can be done to prevent them from actually carrying out what they're feeling.

SB: So is that in itself a useful thing to say to the person concerned? It's very positive that you're admitting that.

JN: If a client says to me that they feel suicidal, I would acknowledge what they've said and I would say to them, "You know, the fact that you've said that suggests that you're reaching out for some help and some support, otherwise you wouldn't have told me. So there's part of you, no matter how low, maybe how desperate you're feeling, no matter how strong these feelings are, part of you wants support because you've told me about this. And that is positive. We can work with that small part, no matter how small it is. And let's talk to that small part of you that wants that support."

SB: Yeah. So the key with this particular lady would have been, or this particular person, hypothetical person we've used, to make sure she gets somebody appropriate to talk to. Interesting. It's again, suspicions about consent I think coming out here. I don't know who's asked it, but someone says, "What would happen if we contacted one of the MASH organizations and the patient then complained about us contacting MASH?"

JN: Okay. So we are able to make safeguarding referrals without somebody's consent if we have concern, if we can demonstrate what our concern was. So if I had a concern for a client, I would be recording the concern in my client notes.

SB: Where is that right to do so made clear?

JN: It's made clear in legislation. So again, if you go onto the Care Act, I believe it's stipulated in there. We don't need consent to do a safeguarding concern. What we do need is we need a justification. So what was the justification? If I can't articulate to myself what the justification was, then maybe that's the time when I need to be phoning the consultation line.

SB: If memory serves me right, there is a specific subparagraph in the general data protection regulations which says that if you need to not have consent in order to save someone's health, or protect them from harm, then you're allowed to do it.

JN: Yeah.

SB: I'm getting the words jumbled up there, but-

JN: If we have somebody say that they are suicidal, and we tried to talk to them in the counseling environment and they say, "I'm leaving now, that's it, I'm going to go off," then because we aware of that, we have a duty of care. We can inform the police, we can get in touch with the crisis team, or the urgent care and assistance teams. We could get in touch with their GP without-

SB: Who are the crisis teams? What are they?

JN: So the crisis teams are part of NHS services, they're mental health teams. So they might respond if someone's having a mental health crisis and they don't feel safe, maybe they're a risk of suicide. They may not fit the criteria to be sectioned. The crisis team, generally they work in pairs and they would go out and visit somebody every day, and that can be for a week, two weeks, depending on how long they feel that the need was there. So they just offer support in somebody's home.

SB: Okay. I think this is Yvonne. I know she's referring to somebody called Yvonne. "I think maybe without training we're in danger of being taken in too deeply. Patients feel happy to talk to us and can use us as their counselor, which is not our field."

I suppose there is a risk of that isn't there? That people... I'm not sure there's a lesson to be learned from that. People will talk to us. We simply have to know what to do with that information and remember at the end of the day that we're there for the benefit of the patient, not just to have a conversation.

JN: I guess it comes down to our own moral obligations, our own core beliefs. My role is maybe more broad, in terms of this subject matter, than than your own profession, but it comes down to safeguarding is everyone's concern. If someone is chatting generally, but you don't have any concerns about

anything that they're saying, you might want to close that down. You might want to let them continue chatting, but when they're chatting, if they say anything that you have a concern about, that's the point where maybe if you have one, your safeguarding policy kicks in. There's a concern there and I now have a duty of care to do something with that concern.

SB: Sorry, I'm not laughing at what you said. I'm just laughing because Daniele, concerned that I'd said I hadn't heard from him for a while, has written me War and Peace. So bear with me while I run through this. Bear in mind I haven't seen it before.

JN: Okay.

SB: "This is not a question as such," says Daniele, "but merely my story or experience with a situation relevant to the discussion. Many years ago I had a patient, female with muscular dystrophy, or MND, or possibly even MS." He can't remember it was so long ago. "However, she was wheelchair bound. Her husband brought her in on one occasion. To this day. I vividly remember that he was obviously not very happy at all. As soon as he very abruptly and almost aggressively wheeled her in, he couldn't get away quick enough. There was obviously a palpable and very strong tension between him and his wife. The feeling I had was that it was all coming from his side and that he himself had also suffered by proxy from his wife's condition. Bottom line is I felt so sorry for her, even though she shrugged it all off, she being a strong woman."

But she came to Daniele for quite a while and became not quite friends as such, but very friendly with him. "She did open up a little through cryptic things that she'd say, but what could I do?" asks Daniele. "The problem was not one of physical abuse, but very much mental, psychological. She wasn't short of friends and that stood her in good stead when, if I remember correctly, her husband left her. Again. she was quite a strong and vivacious lady. I think the answer, or one of them is to be at least on the cusp of friendships to potential abusees and give them that avenue of amicability to, in their own time, feel comfortable enough in opening up." Thank you for that Daniele.

JN: So the last part really, so that for me in terms of the friendship, because I often think of myself as being friendly with my clients, but I'm not their friend. I have concern for them, but I'm not their friend, I'm not their family and we need to keep that professional boundary. Offering to be friendly is not the same as offering friendship and sometimes that...

SB: Yeah, it's very much that the relationship that we have to strike in physical therapy I think, but I suspect that sometimes it's easy to fall into the trap of becoming a friend isn't it?

JN: I think it can be easy for clients to start to see professionals, of any profession, as friends and it's about maintaining our own professional boundaries and sometimes reinforcing those boundaries. Because those boundaries can be really important in actually getting people to open up because they don't necessarily always open up because they start to see us as friends.

SB: How do you reinforce those boundaries? What do you do to reinforce the fact that you're not a friend without alienating your clients?

JN: Sometimes it can be very straightforward and actually reminding someone that I'm here to listen to you, or you're coming to see me, you're paying me to listen to you and I have your best interest at heart. Do no harm to my client. I'm interested in you and what's good for you and how you are, but I'm not your friend. One of the things we talk about in the first session is, if we meet outside of this environment, because if we meet, if I'm in the supermarket and the client comes along, I won't say hello to them unless they speak to me first, but during the first session I always say to them, if that does happen, and you speak to me first, I'll say hello If you say hello first. But what we're not going to do is we're not going to start discussing the previous session stood in the frozen pea aisle. It will be "Hello," and then move on, and I make that very clear from the beginning. And again we're about reinforcing those boundaries. I'm a professional, I do care, but I'm not your friend.

SB: Yeah. Okay. "If we see bruising on a child and we are suspicious, are there questions that we can ask that might help us find out more without upsetting the parent?" And whoever asked this question says they have had this happen once.

JN: I think again, we come back to the way the question is asked. If the parent is there and we see a bruise and we have concern, I suppose within your role maybe it's easier to justify why you're asking, than it is for me.

SB: Yes.

JN: It can be more obvious that I've got a concern if I ask. I don't work with very young children. I tend to work with age eight upwards. But if I had a concern, the parent was there, and sometimes they are sat in on the sessions, I would ask them. I think for yourself it may be easier to justify why you're asking, in terms of you've noticed a bruise.

SB: Okay. Regarding self-harm, taking us back to that topic, this viewer says, "I've had a few patients with self-harming scars and I found it difficult to know how and whether I should talk to the patient about them." Which I guess is actually what I was describing, how I felt earlier on as well. "In all cases I've

not felt that the patient was at serious risk however. At what point does that become a duty of care issue?"

Picking up the last point, when might it be appropriate to discuss this with the patient's family; e.g. if it's a young teenager or...

JN: People self-harm for lots of different reasons. So again, it's having maybe the dialogue with somebody and picking up on what they say about their self-harm, if they're willing to talk about it. If somebody openly says that they self-harm as a way of coping with life, I would ask them what is it about life that's causing them the problem that they feel they need to do that. They may then say, "I'm living with somebody that I find abusive." They may not say that. It may not be that clear cut, but self-harm scars on their own don't necessarily automatically lead to a safeguarding referral. Again, it's about asking them about their scars, if they're willing to talk about it. Some people are very open about talking about their self-harm and other people are less…

SB: Do people who self-harm typically always self-harm through the same method? The reason I ask the question is, if I see long healed scars on somebody's arm and think, "Oh, those were probably self-harming scars, but they're clearly history," can I make an assumption, if there are no other obvious scars, that they haven't resorted to some other method of self-harm? And I don't know what other methods there might be. I can probably think of some of them.

JN: You can make the assumption, but it won't necessarily be right. People do tend to, once they establish a ritual of self harm, a preferred method, they do tend to stick to it. Very early on people may try a number of different methods, but once they've found one that works for them... And people use self-harm for different reasons. Some people like the physical sensation of the pain. Some people like to see the physical mark. So it depends on what method they start to adopt, but once they adopt one they tend to stick to it.

SB: Trevor has sent this in. "There's a refuge service for abused women, which is a place they can stay. The address is kept secret for the woman's protection. Do you know any more about this?" That sounds a very suspicious question but I know I'm sure that's not how Trevor means it.

JN: So a lot women's refuges, the addresses are not available on Google for obvious reasons, but the same can be for men's services as well. I know of a women's and men's service not very far from here. And again, the address is withheld for obvious reasons.

SB: But if we pointed somebody to social services, or it went through one of the MASH hubs, they would know how to get people into the right pathways to find those things?

JN: Absolutely. Yeah. And there's other agencies as well. I mean again, Mind, other organizations like Northampton Rape Crisis, they would have access to refuges as well.

SB: Bob Allen says: "Safeguarding is a fascinating subject." I think everyone can agree with that on the basis of this evening. "It's a really good topic and very appropriate for osteopaths and therefore for chiropractors as well. For anyone that wants to know more on the mental health side of things, I'd highly recommend that they attend a mental health first aid course." Now, that'd be interesting. "I went on one earlier this year and it covered a lot of the areas that have been discussed tonight."

What do you think of mental health first aid training itself, not the organization?

JN: So, I've done the training myself and the training covers a lot of areas. There is a lot of information there and the information is very good. It's like any training really. It comes down to who the trainers are that are delivering it as to the content and the quality, but yes it is very good training and it's worthwhile attending if people have got that interest.

SB: Okay. Now you might not be surprised to learn that actually we have plans probably to set up a mental health first aid training course within the next six to nine months. We need to sound out whether that would be something which would appeal to our members and others, but we have a very good instructor. But the reason I said let's not talk about the organization, because Mental Health First Aid is actually the name of at least one of the central bodies for first aid training, isn't it?

JN: It is. It's a body that's actually leading the way and I've come across some since I first done the training in about 2007 or eight. I've come across them a number of times in different guises and they're involved with lots of different organization, public sector and private sector.

SB: Is safeguarding covered on their course?

JN: It wasn't... It was touched on when I done the course. I don't know whether it's a bigger part of the course now. It is predominantly mental health, but I would imagine there are elements where they do touch on safeguarding. Still, how much detail they go into, I don't know.

SB: Well if you've only got one email in you, or one message in you, don't worry about telling me whether you like the picture on the website. I'd be more interested to know if you're interested in attending a mental health first aid training course. I've been quite intrigued by them and the fellow I would have to run it is a chap called Malcolm Parnell who, if you've been on one of my first aid courses, you will know as being a fantastic instructor and I'm sure he

delivers a very, very good course. But that's up to the amount of response that we get.

Oh some observations here. Somebody says, "I say hi to all my patients outside. Is that unprofessional?"

JN: I don't think it's unprofessional if you're happy to do that. As a rule for myself, and quite common among psychotherapists and counselors, we will only usually say hi if somebody says hello to us first. But we've got different types of client groups haven't we?

SB: Yes.

JN: Somebody coming to me to talk about their mental health problem, they may not want whoever they're with at the time, for me to say "Hi," because then they're going to say, "Hey, how do you know that person?" So there's different types of client groups.

SB: We can't make assumptions of course, but I mean I should imagine that there is a much higher percentage of people who would be reluctant to let people know that they had been for counseling or psychotherapy, than would simply say I have been for physical therapy for a sprained ankle, or back pain, or whatever.

JN: I think that's probably right. I think a lot of it comes down to what it is they're having counseling for. That may determine whether or not they're happy to share why they're going into counseling.

SB: Yeah, interesting question. It's a very serious issue to cover, but two viewers have lightened the tone by asking quite independently how people can self harm cleanly. By which, if that makes sense to you, I take it meaning that there are no outward signs of self harm. She suggests holding an ice cube or hurting themselves with soap.

JN: So some different methods. Elastic bands on the wrist. So we put an elastic band on the wrist and whenever we feel the urge to self harm, we can ping it. Depending on the type of elastic band, depends on the sensation, depends on where we put it. Ice cubes: we can hold ice cubes in the hand, we can put them in the mouth and crunch on them. That can be quite painful and it can take away the need to maybe want to cut or burn. So there's a number of different techniques. Again, it's about understanding why somebody wants to self-harm and what their preferred method is and how we can actually replace that.

One of the methods I use quite a lot is what we call the 15 minute window. So if somebody feels the urge to self-harm, I will say to them, okay, so we try to wait 15 minutes. The first time they do that, they usually get to 30 seconds, a minute, a minute and a half. The next time they do it, maybe

they'll get to three minutes. But eventually over a period of weeks we'll get them to 15 minutes. And the reason 15 minutes is, is because if we can get them to 15 minutes, that urge to self-harm has very often gone away.

SB: Blimey, Jack, I mean I've got half a dozen questions I haven't had time to ask you, but we are at the end of our scheduled 90 minutes and I'm very conscious that you've got to go back to work now to finish notes that you didn't have time to do earlier on.

I'm so grateful for you coming in. I think it's been really useful for everybody. I think it'll have put people's minds at rest. Would I be... Would it be unfair of me to summarize by saying that actually, what you have said tonight is enough to let people know the sort of things they should be concerned about, the pathways that they should be aware of to push people down if they have concerns. And remind them or reassure them that, you know, issues of consent are not necessarily unbreakable. There are times when you can refer people without their consent, and that the law covers us in that regard. Anything else that you'd like to say as a throwaway comment before we go?

JN: We don't need to be safeguarding professionals, but we do need to have a working knowledge and understanding of safeguarding policies and procedures so we can actually act if we become aware of a concern.

SB: Brilliant. Thank you so much.

JN: Thank you.

SB: You're very kind.