Academy of PHYSICAL MEDICINE

Transcript

Mental Health First Aid With Malcom Parnell & David Crepaz-Keay

Cast List

Steven Bruce	SB
Malcom Parnell	MP
David Crepaz-Keay	DCK

SB: This evening we're going to be talking about mental health and how mental health considerations affect us as chiropractors and as osteopaths, and I have two great guests to help us out with this. The first of those guests you may well recognize if you've done any of our standard first aid courses. That is Malcom Parnell. He is a former paramedic, a very experienced first aid trainer, and also one of the few licensed mental health first aid trainers in this country and Malcom, it's great to have you with us again.

MP: Good evening.

SB: I'm sure you are going to make a great contribution to this evening. My second guest is David Crepaz-Keay. Now David is the head of empowerments and social inclusion at the Mental Health Foundation. He's also on a temporary seculment through Public Health England where he's a technical advisor for their film, Every Mind Matters. He's run a number of organizations and charities with budgets ranging from 750,000 to 34 million

pounds. He's very experienced, over 30 years experience in the mental health arena. He is also a regular contributor to the collaborating centre for values based practice at St. Catherine's College Oxford, and his primary qualification for being here perhaps is the fact that he is bonkers. David, great to have you with us as well.

DCK: Lovely to be here.

SB: People will think I'm being facetious, but you have described yourself as bonkers on a video which I watched on YouTube. Why did you do that?

DCK: Absolutely. I spent my early years ... when I was growing up, I spent half my time training to be an economist and a statistician and half my time going in and out of psychiatric hospitals as a psychiatric patient, and what I now realize is that the time I spent as a psychiatric patient was just preparing me for the stigma attached to being introduced as an economist. So really, it's a having a lived experience of using mental health services, having the experience of being diagnosed, and labelled, and treated in a variety of ways by a range of people, and for me, what became important is really taking control of how I described my experience of good and bad mental health and mental ill health, and I've chosen really to describe myself as culturally mad, and I think it's not something that I would recommend as a style guide. I'm sure when you are training in mental health first aid, you wouldn't encourage people to be describing people they work with as mad.

MP: No, no. We don't tend to.

DCK: But it's important for people ... what I found is, is people are very reluctant to talk about mental health, and that's something that has changed. I think it's fantastic.

SB: May I ask, what was your label when you were a psychiatric inpatient?

DCK: I managed to collect six different psychiatric diagnoses, and that included depression, hypomania, manic depression, I think it was then bipolar disorder and schizophrenia.

SB: Right.

DCK: I think I probably skipped a few. So I honestly don't think anybody knew what to make of me.

SB: Yeah, and you're now in a very senior position and first in mental health terms in the UK. Has that helped you, that experience of psychiatric care?

DCK: Oh, absolutely, and I think one of the things that has changed hugely over the time that I've been involved in mental health is attitudes towards mental ill health and organizing the way we treat people who experience poor mental

health now has hugely improved. There's a long way to go, but it is a hugely different to the days where people would have spent ... if I had been a generation older with my diagnoses, I would have lived my life in a Victorian asylum and I would certainly never have had the chance to engage in the activities that I have been able to do now, and I think it's important, it's recognized as hugely valuable. I've been a technical advisor to the World Health Organization. They recognize the importance of lived experience in terms of communicating the importance of understanding mental health, and I know later we'll talk about the prevalence of mental ill health and the impact it has on the society and the broader economy, and for me, the number of people who experience poor mental health is so significant that we have to create a culture in which people are prepared to talk about it, and particularly amongst anyone who's in any form of medical practice, the chances are if someone has any kind of medical problem, they're likely to have psychological concerns that go along with it.

SB: We're going to come back to that rather more specifically a bit later on, because you actually get regular chiropractic care.

DCK: I do.

SB: And I'm very much hoping that Katie Chimes, your chiropractor will be watching this this evening and will contribute to our discussion, and it would be interesting to hear both of your perspectives on how mental health might affect our interaction with our patients and their experience of what we do as well, but I did want to just spend a bit more time on the use of language, because you said we struggle with terminology, but that must be from both sides, because a patient, if that's the right term, will have their own opinion on how they want to be described, whereas we practitioners may be pussyfooting around wondering what is a sensitive thing to say, and they won't all be as candid as you about their mental health background.

DCK: Yeah. The short answer is there is no simple consensus. There is no perfect language that will work with everybody. The most sensible way is to ask people how they would describe themselves and how they would describe their experiences, because how we relate to our mental health is a highly personal thing, and how we choose to describe that is important. I mean, for most of the people watching and listening to this, they won't be doing it in a psychiatric context. So it's more important for them to feel comfortable talking to the person in front of them in whatever language is appropriate and useful for them than making sure they get the psychiatric diagnoses or the psychiatric language right or wrong.

And we can talk a little bit more detail as we go along about that sort of the things that are particularly important, but broadly speaking, people will be used to maybe dealing with people who are in a state of distress, a state of discomfort, and the most important thing is to put people at their ease, and

one of the ways of doing that is just asking people how they would describe themselves and their circumstances. Not everyone will describe themselves as mad. Not everyone will describe themselves as crazy. I've chosen to do that because I want to encourage people to talk about mental health.

SB: You said earlier on, I think before we went on air, that there's a mad pride rally.

DCK: Oh, yeah. Absolutely. Yeah, there's a mad pride movement. So in the same way that people have reclaimed the language around homosexuality and around race, there are people who have ... there's a mad pride movement that actively wants to celebrate madness. So from our point of view, it's not something that you should be embarrassed about, and if people take away anything from today, it's about creating a culture in which it's okay to talk about your mental health, your madness, your however you want to frame it in the way that you're comfortable with them, and to not make that a barrier to just -

SB: But it might not be entirely facetious to say that we're all somewhere on that spectrum.

DCK: Oh, absolutely.

SB: And it's just a question of degree. Malcom, you do lots of first aid treatment, mental health first aid training. Who are the people who come on your courses? Are they sufferers or are they -

MP: Both.

SB: - employers?

MP: You don't know that they're sufferers when they come on the course. They come on as a student on the first aid course, physical first aid course, but what we tend to find is as we're going through the two day ... because the course is over two days, I'd be going through the two day sessions, people start opening up and people start talking about their own experiences. We don't make them. Obviously it's voluntary, but people start opening up and talking about things. I mean recently I did a course and people were talking about bereavement that they've gone through, family bereavements. One or two people have also said that they attempted to take their own life, which you know nothing about initially, but as the course develops and as long as they feel comfortable, then they can open up.

SB: But the mental first aid training, is it designed for a particular group of people? Is it for -

MP: No, not really. It's really designed ... I'm coming at this from pretty much the point of the lay person. I haven't got the expertise that David's got, but I first

got involved with this because, as you said when, I was with the ambulance service, we would go and visit various people with broken legs, heart attacks, strokes, whatever it was, car accidents, and I felt equipped to deal with that, but we were also sent to suicide attempts. Used to get quite a number of those on the night shift for various reasons, and I felt totally ill. I just hadn't got a clue. We were not really briefed in that area, and there were times when I felt completely inadequate. I felt completely out of my depth. There were times when I was frightened, and if we had to sort of section someone and get social workers in and the police and things, and this has sort of got me thinking that there's an area here that I need to know more about. Plus, I've also had mental health issues. I have suffered depression in the past, so I'm interested in this and so I'm coming at it from the point of view that we need to open up, we need to talk, this is your message too, isn't it?

DCK: Yeah.

MP: You know, it is about reducing stigma, getting rid of prejudice and actually people opening up, because people will talk about broken legs. They'll even get people to sign the plaster, but they don't talk about problems up here.

SB: Yeah. Can I ask ... I mean you just mentioned that you've suffered depression yourself. Did you feel reluctant to discuss that with anybody at the time?

MP: Yes.

SB: Did you feel there was a stigma attached to it?

MP: Very much so. Yeah.

SB: Yeah.

MP: Yeah, absolutely.

SB: Interesting. What we didn't say when I introduced you is actually you play the drums, don't you? And David's already said there's a close connection between drumming and madness, and I think he listed half a dozen bands where the drummer was completely bonkers.

MP: Absolutely right. Keith may have been the main one, of course.

SB: But having said that, I mean people would not ... I don't know that people would associate the word mad with depression, although of course both relate to a mental illness. Am I being unfair there?

DCK: Again, I think it's how people choose to frame their experience, and we know that depression is commonly used language, and I think that there is a difference between the ups and downs of day to day life and feeling sad and what people may say, "I feel a bit depressed," and that is not the same as the

experience of what you might think of as clinical depression or something that gets you a diagnosis.

MP: No. We all feel a bit blue at times.

DCK: Exactly. Right.

MP: Yeah.

DCK: Yeah, but again, what you say is so right. It's about creating a culture in which people can talk about it in the language that they're comfortable doing, and here we are, three men of a certain age, we are the worst group at talking about mental health.

MP: Absolutely.

DCK: And we know that the culture has changed enormously and it's almost impossible now to watch a television program without people talking about mental health issues, and that's fantastic, but it's still ... there's a hard core of people who find it really difficult to talk about, and men of a certain age are probably the hardest of that hard core of people.

MP: I do a lot of work in the physical aspects of first aid, in construction industry, and possibly sort of stereotyping slightly, but the guys that I tend to work with are not the sort that's going to open up on lunch break about their innermost feelings. They'll talk about football, they'll talk about rugby, cricket, whatever, but they're not going to ... it's still seen ... well we'd see it as a weakness.

DCK: Yeah. We've been doing some work with older Irish men in Northwest London, and they are one of the biggest suicide risk groups, and they're largely in a construction industry, often came over to the UK from Ireland and worked in construction industry. They're coming towards the end of that kind of career, really brought up in a time where you just didn't talk about that kind of thing.

MP: No, absolutely.

DCK: It wasn't seen as the kind of thing that men talked about.

MP: Stiff upper lip.

DCK: Exactly. It was a sign of weakness.

SB: I'll just put this slide up, because you mentioned that, and one of the bullets on this slide is that it’s men aged 40 to 49 who are most prone to suicide. Now, I'm not sure the source or the statistics. You might be able to

remember, Malcom. I'm not sure, but is that, do you think, broadly correct then, based on what you've just said?

DCK: Absolutely. I wouldn't like to say precisely where the limits are. What we know is that that age rate has grown up with a cohort. So it seems that there is a cohort of men of a particular age, and as they got older, I suspect it's slightly higher than that now, because it seems to have followed my age. I'm in my mid fifties and I'm kind of at the higher end of that peak.

SB: Any idea why that would be? Generationally, what happened 50 years ago?

DCK: I think that it is a group that weren't brought up to talk about feelings or emotions or mental health or anything like that. I think it's a group where the social roles have changed. So men would have been brought up with a particular social role to take on. They'd have been the breadwinners, they'd have been ... as you say, lots of them would have been in construction or heavy industry, miners, fisherman, and so on, and these are largely industries that have died. Those social roles have changed, and I think when we talk about gender, we often take that shorthand meaning we're talking about women. There are gender issues for all of us, and I think there's a cohort of men who kind of missed out on that dialogue and that change in societal attitudes, and I think some of it is around that, but it's a complicated question.

SB: It's an interesting set of statistics, though, isn't it? Because it would never have occurred to me that if this is true, 75% of these problems start before you're 18, and that 75% of people don't ever get treatment, 75% of sufferers don't get treatment for their mental health problems.

MP: It doesn't surprise me, the top one, regarding the age thing, because a lot of these problems start off in childhood, maybe placed there by others.

SB: Yes.

MP: Parents, teachers, people that you look up to, that's when a lot of the damage is done, I think.

SB: We had an interesting question come through. We got two interesting questions, but the first of these is from an anonymous viewer who says, "How would you recommend that one of us, an osteopath chiropractor, goes about broaching the question or the subject of mental health with someone who doesn't acknowledge it, to us at least?" I mean if one is in the least bit suspicious of their mental health, or -

MP: It is a difficult thing, particularly if someone doesn't acknowledge it themselves, and a lot of people don't. A lot of people don't even realize there is an issue. In the mental health first aid training that we do, we use a mnemonic ALGI, and the first, the letter A stands for approach. So how do

you approach someone? Which can be difficult, and as you were alluding to earlier on, David, people worry about the terminology, saying the right things and saying the wrong things. There are various way. I mean it depends on how well you know the person, first of all, of course. If you know the well, that might make it easier, but -

SB: Rarely the case for us with our patients, of course. We might've seen them several times, but we wouldn't really regard that as knowing them.

MP: Yeah, it would be ... just simply say, "I've noticed that you're not possibly feeling yourself," or there are different avenues. It's not an easy question to answer.

DCK: This is the kind of question, what would it be that kind of triggers that kind of feeling in you when you're facing someone? Is it the way they're holding themselves? Is it ... and the kind of maybe gateway language you can use, you can talk about tension or stress. I mean if you see someone holding themselves ... I always hold my stress in my shoulders -

SB: Funnily enough, a lot of our patients are holding themselves like that.

DCK: Exactly. So it's worth ... you can have a neutral conversation, which is, people hold themselves like this for a variety of reasons, and you can have a list that includes stress in that list, and the other kind of gateway conversation piece is sleep. So stress and sleep are things that we're now much more happy talking about, and they don't have necessarily the same kind of stigmatizing approach, so -

MP: No. Sleep, a lot of people are quite happy to talk about it.

DCK: Yeah.

MP: Absolutely, yeah.

DCK: And it may be that when you start talking about those things, if somebody wants to talk about something that is causing them to have problems sleeping or causing them to have a physical stress response, then that may be the opportunity to talk about that, but you don't want to push people into it because -

MP: No. No, you can't.

DCK: - the more you kind ... kind of the draw drawbridge will go down, but giving examples and giving -

MP: Yeah, I mean in the workplace, if you're working with colleagues, it might be that their productivity's dropped or there's a lot of absentees suddenly and this sort of thing. So you could sort of approach it from that angle. "You've

been off for a little while, is there a problem?" That sort of thing. It's more difficult when you don't know the person in the chiropractic and osteopath.

SB: Yeah, and most of our practices are small, so the number of coworkers that we might have is very few.

MP: Yeah.

SB: But of course, if you notice that one of your fellow practitioners is not up to scratch, ore receptionist -

MP: That might be the way in.

SB: That may be a trigger for further question. I'll put this one up, because these statistics are quite worrying, aren't they? I mean one in four of the population suffer a mental health problem every year and one in six of working age adults have a mental health problem. It's very, very likely that some of these people will come through the doors of osteopaths and chiropractors -

DCK: And some of them will be osteopaths or chiropractors.

SB: Indeed, yeah, and maybe we should be making sure that we're aware of the signs that our colleagues might exhibit in order that we can spot that, and I should say that Bob Allen has sent in an observation here that he said he's attended a two day mental health first aid course, and I think they're all two days, aren't they?

MP: Yes. There are derivatives, but the two day one is the recommended.

SB: Is the licensed one.

MP: Yeah.

SB: And he considers himself relatively sane, he says with a question mark in brackets. He said it's an excellent course and he did it because he thinks it's very relevant to his work as an osteopath, and it was a fascinating course which made him realize that he didn't know anything like as much about mental health issues as he'd thought, and he says he'd recommend it to anyone that has to deal with real people, which is ... that's a really useful observation, isn't it? Because you don't know the mental history of anybody, at work or anywhere else.

MP: No.

SB: Two days does seem a long time. You must cover a lot in there.

MP: Yeah, we do. I think the important thing though, the course is based on recognition, and I think its purpose is to break down stigma, breakdown prejudice, and actually encourage people to talk, but it's not about offering therapies. It's not about diagnostics. We don't diagnose, as we don't diagnose in physical first aid. So it's not about suddenly becoming a counselor and offering advice. It's about recognition of a potential problem arising, how possibly to approach it, which may stop it developing. Signposting people into various avenues of help. So it's very basic in that respect. We talk about anxiety, we talk about depression, bipolar, psychosis in general, eating disorders, suicide, self-harm, at a level that ... I think also what it does it, it dispels some of the myths. When I did my training initially, the thoughts of the self harm section, particularly, was a bit of an eye opener for me because of why people do it, as opposed to why I thought people did it.

SB: You're going to let us in on the secret?

MP: Well they do it because it gives them a feeling of power. It gives them a feeling of control in many respects. A lot of people see it as attention seeking, but it isn't.

DCK: And this is where understanding that is really important. So historically, a lot of people I spent time in hospital with, particularly young women, would harm themselves, would go to an accident and emergency department, and would be told they were wasting people's time, and that lowered their self esteem. That made them feel worse about themselves, and actually it made them more likely to go home and harm themselves -

MP: Because it was self-inflicted.

DCK: Because it was self-inflicted, and colleagues of mine then developed the concept of safer self-harm, which on the face of it sounds odd, but actually it's about training people to understand exactly what you've articulated, and rather than effectively wag your finger at someone who self harmed and make them feel worse about themselves, it's actually working to build their self esteem and self confidence so that they can identify other ways of being more in control of their own lives that doesn't involve some of the more -

MP: That's right, and we have to adopt a degree of acceptance, and say "This is how they are. This is what they're going to do," and that may be that it's fine, actually.

SB: Can I ask though, either of you really, but when I think of self harm, I think of somebody who might present in a clinic and you can see scars across their forearm because they've been -

MP: And it often is.

SB: But there must be other things that people do which may be a little bit more subtle, a bit more difficult spot.

MP: Yes. Cutting is one of the most usual ways of doing it.

SB: And is it usually the arm or could it be something more discreet?

MP: It can be thigh. Again, I've not got huge experience in this, but one of the ladies on the ... there was a lady came in on the course who had been self-harming for 30 odd years and she's very candid about it and she was talking about it, and she did have masses of scars, and she says that the looks and the comments that she gets sometimes when she's out and about in the shops and things got quite awful really, but burning, pulling out hair, swallowing things, that's not an obvious one, of course.

DCK: Again, it's really complicated, because there are lots of behaviours that people engage in that are effectively self-harming and a lot of them just don't get termed in that way. So some people ... we tend to attach that diagnosis, particularly to young women, whereas a young man who gets tanked up and starts provoking fights, that is in effect self-harming.

MP: Smoking.

DCK: Yeah, smoking.

MP: There's actually quite a degree, isn't it?

DCK: Exactly, and so understanding motivation and understanding how to respond to that is really important, and again, you make such a good point about mental health first aid is not about turning out amateur psychiatrists or amateur counselors.

MP: Definitely not.

DCK: It really isn't, and much the same way that first aid isn't about turning out amateur surgeons. The last thing you want is someone who's done a two day first aid course who thinks they can do cardiac surgery.

SB: Well, I mean we regularly get asked by people in our one day course whether if someone was choking, they should do an emergency tracheotomy on them. Because everyone's read about it. But do you regard an eating disorder, let's say anorexia, as self harm, or do you distinguish and separate those two?

MP: It's difficult. I don't know if I've got the expertise to answer that.

DCK: You're into quite challenging territory there, and again, different people will take a different view. There are certainly issues about control and power and

self control and self power that can be exhibited in that way, but there are also a lot of external pressures on how people should look into -

MP: And their perception of themselves.

DCK: Exactly.

SB: We've had a question in about it, and I said the questions would all come in at the end and they're coming in in droves already. I don't know who asked the question, but whoever said it says, "Do you have any suggestions as to how you discuss the health issues caused by eating disorders when it's clear that a patient is suffering?" Because quite often it's a subject or topic or condition which people are very prone to deny, aren't they, a eating disorder?

MP: I don't know if discussing the health issues is, from my point of view, necessarily relevant, because I think the people who are willing to take these things possibly know it's not doing them any good. It's harmful, but that's not the reason they're doing it. It's like discussing the health issues with someone who's smoking, isn't it? Surely they know it's not good for them, but they will continue to do so. I don't think that's an argument that you can use to stop them doing it.

SB: So what would we be looking for then? Are we were looking for an opportunity to point them to the relevant health care support agency?

MP: Yeah. I mean the first point of call is usually to the GP, and that's not always the first point of call, but a lot of people don't want to go to the GP.

SB: How good are GPs, do we think, in dealing with ... mental health is a very complicated issue, isn't it? I mean are GPs, amongst all of their other hugely complicated things, are they good at it?

MP: Yeah. I must admit, I do sympathize with GPs in that respect. I don't think they're particularly well gifted in that in ... not gifted, but trained up in this particular area, and they all under pressure. There's time factors and all this sort of thing, and a lot of people won't go to the GP because they think, "Well, they're just going to put me on antidepressants," which in some cases probably could be the answer, but people have this aversion to drugs in some cases.

DCK: But also, certainly larger practices these days it's quite common for at least one or two people within a larger practice to have more of a special interest in mental health.

SB: Is it?

DCK: Yeah, because on a lot of estimates, you don't have a slide that says this, but about somewhere between 25 and 35% of GP's workload is mental health related, and so -

MP: So have that changed recently?

DCK: No, I think it's just become more recognized.

MP: Right.

DCK: And so a lots of things that may present as one thing may have a psychological underpinning, and certainly I've done some work with people who do a lot of GP training, large GPs who trained GPs, and constantly mental health is one of those things that GPs feel they need to be more prepared for and understand and are putting a lot more work into, and I think, as I say, it's much more common now for larger practices to have -

MP: Because of the greater awareness, probably.

DCK: Exactly. Exactly right, yeah.

SB: Sue has sent in a question which is apparently for you, David. She appreciates this is very specific, but says, "I've got two patients who are bipolar. Do you have any tips for how to work with them? For example, one goes on mega shopping sprees when hyper. She's also less able to take advice on osteopathic stuff when she's like that. Should she alert relatives? Should she ask the patient more? Should she butt out and accept that she's got no training in dealing with this?"

DCK: Bipolar is one of the areas where there's been really strong progress in self management and peer support. So there will be ... Bipolar UK is a really good organization that it's worth putting anyone in touch with. There are lots of people with a bipolar diagnosis who are really skilled at understanding and managing their own cycles and sharing those skills and techniques with others. So there is a ... I mean I don't know how well established self management practices are in osteopathy. They have their roots in chronic pain management and arthritis and some of the best models of self management developed by Stanford University in the States come from arthritis, diabetes, and chronic pain management. The bipolar world is really very strong in self management and peer support and I think people understanding those cycles and planning for them, there's been huge progress in, and I think probably the best thing you can do is signpost people to Bipolar UK and similar organizations.

Where people can talk to others, share those experiences and share those coping strategies.

MP: It is one of the most difficult ones to diagnose though, isn't it?

DCK: It is.

MP: Because of the differences between the mania at one end and the depression at the other and the gaps between the two.

DCK: Absolutely. But there's also been some really interesting work, you talk about spending habits. There's been some really interesting work with credit card companies and algorithms and actually identifying spending patterns. And there have been some really good examples of working with credit cards that will selectively stop particular spends without embarrassing you. So, they won't stop your supermarket spend, but if you try and buy the third ticket in a row to Acapulco, or as a friend of mine did, buy an ocean going yacht. Those kind of spending patterns can be-

SB: Do you know, I think my credit card would stop me buying an ocean going yacht without having to tell it to do it.

DCK: Yeah well, this friend of mine was very senior in PR. She had a phenomenal credit card limit.

SB: Right.

DCK: And yeah, but no use at all for ocean going yachts.

SB: Right, so this is something that a sufferer would have to actively seek out through their credit card company.

DCK: Oh yeah, absolutely. I don't know how widespread it is, but it is one of those things where there are likely to be... We talk about algorithms and artificial intelligence starting to contribute significantly to clinical practice in a wide variety of areas.

MP: That's interesting, I had not heard of that.

DCK: Yeah. It is one of those areas. Because in the general scheme of things, those spending patterns are quite simple to pick up. Because there is quite a disjoint between...

MP: I see.

DCK: Those rhythms of how your spending behavior is. And how they are -

SB: Is there a regular rhythm to bipolarity?

DCK: Most people will be aware of their peaks and troughs. And I wouldn't say you could set a stop watch by it, but they'll be aware of those... And one of the things that's made self-management so effective in bipolar is people learning

to recognize their own ups and downs and intervene and get support from others when they are at exactly the right point.

And again, friends of mine describe it a bit like surfing. Because as you get high you get very productive, you're getting hyper sensitive to a whole range of things. And there is a point where you have to switch between enjoying that buzz and not getting into that destructive phase, that destructive behaviour.

But that's a really personal thing that people can be trained to identify in themselves much more effectively. But it is very much about them sharing that information with people around you and so on.

SB: And all of this brings up actually a very complicated issue of consent in practice, doesn't it? Because on the one hand there is getting consent for treatment from people whose mental state may not be appropriate for giving informed consent.

But also, Sue raised this and Aiden raise this. She's just sent in an observation here as well. It's about, Sue said, "Should we talk to their relatives and friends, whatever and tell them what's going on?" Aiden says, "Well, what authority do we have to talk to GPs if we don't have the patient's consent to do so?"

And I'm assuming that if the patient is... If we suspect that they're suicidal, that we have a duty to prevent them from harming themselves. So we have to tell somebody. So do you have any idea where the boundaries are in this?

DCK: They are dynamic as always. I mean there isn't a simple straight forward answer. I mean and it is one of those challenges particularly within self-management and so on. Is people can make advanced decisions about when it is and isn't appropriate to have discussions with others around them. So it is a discussion that you would have.

So I absolutely completely trust my wife and there is nothing that I... If it happened that I was in a session with my chiropodist and I went mad, I would have absolutely no problem at all with instant contact with my wife because I absolutely trust her to do that. But it's much more complicated if you're a 20-year-old boy and it's your mother or your father you're talking about. Or a 20-year-old girl and it's your mother or father you're talking about.

So it is something where it is really useful to start having discussions about that. And people have historically had things like crisis cards. So like a diabetic may carry a card that says, "If I go into a diabetic hypo, please contact this person. Please take this action. Please don't take this action." There is a culture of crisis cards.

MP: And advise friends are aware of these so they can use them in the case of a...

DCK: And that's a really good tool to use because you're still, as an individual. What you don't want to do is disempower, take control away from people because you might make that worse. But what you also don't want to allow people to do themselves harm or damage, which is also a potential risk.

SB: And again, I mentioned this earlier, I mean osteopaths and chiropractors both have a duty of care to prevent patients from harming themselves. But all of them, particularly with any of the publicity that these things have had over recent months or perhaps years, will be very concerned that whenever anything is referred to the professional conduct committee at our general councils, the first thing they will look for is did you have consent for what you did with your patient? Whatever that might be. And they will be desperately worried that if they have called a GP and said, "I'm worried about David because I think he's bonkers." And you find out what you're going to say, "You had no right to talk to my GP or I didn't give you consent for that."

And particularly if I call someone who I believe you might trust, because I don't know that you trust your wife. She might not know any of these things and you could easily complain about that, couldn't you?

DCK: Yeah, yeah, yeah. But it is difficult. I think, again, having a discussion about this is useful. Presumably you will be having consent discussions.

SB: Of course.

DCK: For any kind of treatment. I don't know how you approach that on a call.

SB: It's very difficult.

DCK: So, I think it's something that you may want to build in. Presumably you'll have a list of preexisting conditions that you might want people to self-identify and talk about. And is there someone we should contact in the case of things going awry?

SB: Let me put it in a more personal context. Katie, your chiropractor told me that she would probably be traveling for the first half of the first half hour of this broadcast. So I'm hoping she's in front of her computer now and listening to this. Because I'm interested in when you first presented to Katie as a patient, at what stage did the issue of mental health arise?

DCK: Do you know? I have absolutely no idea. I suspect I was in such chronic pain, acute pain when I did it, it was the last thing on my mind.

SB: Right.

DCK: And I think it's probably more cropped up in the context of my work and what I do than my personal experience.

SB: So, have you given her the equivalent of a crisis card? Have you said it is okay if something happens to me?

DCK: You know, I don't think I have. I should walk the walk, shouldn't I?

SB: I actually think that right now you've probably given probably the best informed consent you probably count in front of several hundred osteopaths and chiropractors.

DCK: Yeah. Yeah. Do osteopaths count as reliable witnesses? I don't know really.

SB: Well I mean, I suppose the ones who are appealing to the....

DCK: Oh, those that aren't drummers.

SB: Yeah. I suppose the ones who have appeared in front of the professional conduct committee would argue that they're never treated as reliable witnesses. I'd be interested to hear Katie's observations on how the subject has arisen and what she might've taken on board from it if she's watching.

DCK: Yeah, I think that's fascinating. I think it's opportunities like this evening are a really good opportunity to start these conversations. Or to think about what kind of culture do I want to create in my family environment, in my organizational environment? As well as it's not just in a fact the patient coming through the door is probably only a small part of what we need to think about when we start discussions.

SB: It probably is though. I mean the first of you on the nemonic was approach, wasn't it? So we can't have any policy with a particular patient over this until the subject has actually raised its head. We can't ask for informed consent. We can't establish a policy for what I'll do when you come to my clinic if I don't know that there's a problem there. So recognizing the signs or hearing the symptoms of a first aid problem is an important part of our case history taking before we start cracking people's backs and getting out of chronic or acute pain.

DCK: Yeah, yeah, yeah, and I think being aware of sleep issues, of stress issues and of the kind of social context around it presumably is something that you're used to talking about. I mean, you're not talking about just a joint or a bone or a limb in isolation. I mean, they're always attached to a person who's attached to the world in some way, shape or form. So the opportunity to approach is there.

DCK: And you don't want to overthink it. I mean, the last thing we want to do is create a organizational paralysis in which you absolutely-

MP: Obviously the longer you have a patient on the treatment, then that would make it easy because you get to know them a little bit more. You may be able

to spot the signs. But it is important to say though regarding some of this that if you suspect a person is suicidal or a harm to themselves or possibly a harm to others, then you can break any confidences and that will need to be dealt with.

SB: Do you cover that on the mental health first aid course? How you would recognize suicidal tendencies?

MP: Yeah. The things to look for. One of the when the biggest myths attached to so the suicide risk is that the myth is that people who talk about suicide are not going to do it. But that's just incorrect. And it's looking for pointers, it's looking for behaviour, it's looking for people who are possibly getting things in order, saying goodbye to people. Behavioural differences, planning it, having the means. But then you are duty bound to report that if you suspect it.

SB: I've got an observation on that topic and you know me well Malcom. I'm in danger of using the bollocks word on this one because someone has sent in here. It's anonymous but it's about reporting distress and they said they were in a situation where I believe in clinic with a 20 year old girl who was self-harming. And he or she was concerned about this girl.

He contacted our trade organization for want of a better word, the Institute of Osteopathy, to ask what he could do in terms of reporting it and was told that without her consent he couldn't report the situation to anyone. And I have to say that I think that that is utter rubbish because if someone is self-harming, they're doing themselves harm. We have a duty to prevent that and for self-harm presumably could lead onto worse things. It could be a precursor to suicidal.

MP: It could be. It doesn't necessarily mean it will be.

SB: No.

MP: But obviously the risks are higher. Yeah. You have to take that into account.

SB: Yeah, and I really appreciate that question because it does raise an issue, which I think there are plenty of sources of bad advice around, often given with good intent. But if I had anyone in my clinic who I thought was in danger of harming themselves, I don't think I'd have any qualms about calling their GP. Even if I said to the GP, "I haven't got consent for this, but I'm really concerned."

Somebody sent in some interesting stuff. And it's Sally Matthews, sent in something. She says that there is recent evidence that eating disorders were genetic. Have you heard that?

MP: I haven't.

SB: I've certainly not seen that. Not always.

DCK: So the genetics of mental health, I know a little bit about the genetics of mental health and most things will have a genetic element, mental or physical. It's generally over estimated. If you ask people what the genetic element of pretty much anything is, it's generally overestimated.

I don't know off the top of my head what the genetic contribution to eating disorders is. It's not one that gets flagged as particularly high. So just for clarity, I sit on the International Society of Psychiatric Genetics Ethics Committee.

SB: I'm really sorry I didn't list all of the things you do when I introduced you. But it is really hard because you do so much.

DCK: It is one of those things that I have a particular interest in. I'm not a geneticist. I'm not genetically skilled in any way, shape or form, but I spend probably an unhealthy amount of time with people who are. It's not one that has come up as one of those where there is a strong genetic component, but there will be a genetic element to it. What does that tell you? It tells you that someone may be of elevated risk. So if you were going about it.

MP: That's what it says, that's all it says.

DCK: You'd sequence, their DNA, you'd get a polygenic risk score that says you are X percent more likely than average to develop this. It gives you some indication of risk, but it's actually probably not very useful.

I remember once at last year International Congress of Psychiatric Genetics, a very skilled geneticist said when they were talking about understanding genetic risks, "You are going to do your patient more good by making sure they get a good night's sleep than understanding their polygenic risk score." And of course it's important, but actually there are far more important things and particularly-

MP: Would you say that every single aspect of mentally poor health can be through the genes, can't they?

DCK: Absolutely.

MP: I mean it's just a high risk factor. It doesn't mean that it will follow, any more than a person who's got heart disease in the family will develop a heart attack.

DCK: Yeah.

SB: Let us come back to sleep in a minute.

DCK: Of course.

SB: The other thing that I wanted to mention there was that Sally had mentioned that in her area, Hampshire, they have a service called italk.co.uk/selfreferral, I think it is, which is a tool whereby patients can self-refer for mental health issues and I suspect there may be similar organizations in other counties.

DCK; The IAPT service, the Increased Access to Psychological Therapies, which is NHS run. Anyone anywhere should be able to self-refer to that. So if you go to the NHS website and you search for IAPT, I-A-P-T.

SB: We've just had a question come in, another observation come in mentioning this.

DCK: You can put your postcode in and there will be a self-referral system for any individual to do that.

SB: So that's IAPT?

DCK: IAPT.

SB: .co.uk?

DCK: I would go to the NHS website and search on IAPT.

MP: What would that get you through? To who? To what?

DCK: That will get you to a postcode database where you put your postcode in and you will get your local IAPT service, which is an NHS service. So it is a statutory-

MP: But what service would they offer at that point?

DCK: Well it would be a psychological therapy, but that will get you to the entry point. It won't guarantee that you get a psychological therapy, but you can refer yourself to that service.

MP: But a lot of people have said to me when they've gone down this route that it can take six months before they actually see anyone.

DCK: It absolutely can, that's absolutely true.

MP: I mean they may get a phone call initially.

DCK: Yeah. They will get triaged.

MP: But face-to-face can take...

DCK: Yeah, there is good evidence for remote... it's cognitive behaviour therapy-based. So it's CBT-based and there is good evidence for both telephone and web-based CBT as an intervention. So the evidence is not entirely clear that... It's probably not as effective as face-to-face but it is reasonable. But you make a good point. There is still a wait for it and it doesn't guarantee that you get it. But you can self-refer to your IAPT service.

MP: And you're on the system, aren't you?

DCK: And that is as effective as going to your GP and them referring because actually GPs will tell me that they refer people and it will take six months before they get something. It varies hugely around the country, but for some people it is a really good service and it makes a really positive difference.

And it's a start. It would be fantastic if people could get access to it more quickly and it's not a magic wand. It doesn't work for everybody.

MP: No, no.

DCK: But it would be lovely if it was more quickly accessible to more people.

MP: And that's down to funds and et cetera, I'm assuming.

DCK: Of course it is.

SB: Some observations here. Robin's commented that his understanding has always been that we should intervene if we felt there was a genuine safeguarding issue. In fact, he always highlights to new patients that it's the only time he would breach their confidence other than if they were asking him to be complicit in an illegality.

MP: I think that that's reasonable.

SB: And is that a fair statement? I think that's an absolutely fair statement.

MP: Yes, absolutely.

SB: And very, very good to highlight it to patients at the outset.

DCK: Bear in mind that I'm not a qualified lawyer, so it seems to me, but yes, it makes sense. It makes sense.

MP: If someone's a threat to themselves or others. Then duty of care says that that's got to be reported.

DCK: Absolutely right.

SB: Well Pippa Slack's asked again about consent. I knew consent would be an issue for this evening. She says any psychotherapist or counselor would have a consent form at the start of treatment in which it says should you indicate if you may harm yourself, they have a duty to inform your GP or other suitable authority. And I wish somebody would stop messing around with my questions. That's a hint to whoever is doing my questions at the moment.

Should we osteopaths have a similar statement on our patient consent forms to fill in? I guess that's individual choice as a practitioner, as a chiropractor or an osteopath, isn't it? Because you can have endless forms for consent. That probably is one of the few areas where a written consent form or a signature might carry some weight after the treatment. Because written consent for what I do to you in practice doesn't really carry any weight. It has to be at the time I do it not before we start.

So maybe that is a good idea. As long as we're not overwhelming patients with paperwork to start with. But actually I mean maybe... I'm sorry. You were about to say something, but maybe by putting it on the consent form it helps you raise the topic of mental health in the first place.

MP: Well, yes. There is that. There is that. Yeah.

SB: We had a couple on suicide here because we mentioned it a little while ago. Someone who hasn't given their name, asks whether we're qualified to decide whether somebody is suicidal.

MP: You can ask them.

SB: Ask them.

MP: No, it's perfectly acceptable to ask.

SB: I genuinely wouldn't have thought of that.

MP: Yes, no, you can. Again, it's another one of these myths that by asking someone... People worry about asking someone if they're thinking of taking their own life because they feel it's implanting the thought in there that wasn't there, which is not true. Exactly the-

SB: You nearly said bollocks there, didn't you?

MP: I nearly did. Yes. Very close.

DCK: The opposite is true. Asking that question, the evidence is that that makes suicide less likely, not more likely. So, the perception is asking the question.

MP: That's going back to the point I made earlier about people worrying about saying the wrong thing. But it's perfectly acceptable. If you believe someone is thinking of taking their own life, to actually ask the question.

DCK: Right.

SB: The other observation on that, if I may just insert.

DCK: Of course.

SB: Is could we clarify the advice to what to do if we think there's a high risk if a patient is suicidal with or without consent. And I think we all agree that if you think someone is suicidal, you alert at least the GP.

MP: You call 999, if you think it's imminent.

DCK: Yeah.

SB: Really?

MP: Yeah, yeah, yeah, yeah. Absolutely.

SB: Who would you ask for? You told us the paramedics are not equipped to deal with mental health problems. We are calling the police to help restrain them?

MP: I would call for both, personally because paramedics haven't got the power of restraint, police have. And then that will depend on what would occur at that point. But yeah, they will need to be taken to hospital, of course. And that's the paramedic's job.

SB: So if it's an urgent risk of suicide or an imminent risk of suicide, 999.

MP: Then you would call an emergency the same you would a heart attack.

SB: If you think it's just maybe a little bit less urgent, the GP would be the appropriate contact?

DCK: Yeah. But I mean there are some constructive things that anyone can do if they find themselves in that situation. Like asking the question and talking about it is one that is counterintuitive, but it's certainly the case that that is beneficial. Anything that gets people to think for the future. So yeah, booking another appointment in two weeks time, signposting people to something that might help, discussing what it is that might be making people feel like that. Those are the kinds of things that are genuinely helpful.

So if it's a debt issue, signposting someone to something that will help you with debt. If it's a relationship issue, signposting towards people who will help with relationship counseling. Those are the kinds of constructive things

that are again, it's not your job as an osteopath to do that, but it's always useful to have in your back pocket places where you can refer on. Like you might have with bipolar UK. You mentioned the work that I've been doing with Public Health England, the Every Mind Matters campaign. There's a lot of resources of that therapy [crosstalk]

MP: In the first aid course that I run there's a manual that goes with it and there's a huge section at the back.

SB: Very good manual.

MP: It is a very good manual, I will say that. It's fantastic. Yeah. And there's a huge section at the back on where to refer to people and help and all sorts of things.

SB: Okay. Let me try and run through a few more of these questions. We have an astonishing number of questions this evening and the problem is that they keep flashing onto my list and bumps some of the ones I'm asking off. Anna Scullard has a sensitive one about consent. Following on from contacting family or friends. How many osteopaths or chiropractors have a next of kin sheet for their patients? So who would they know to contact them? That's possibly a good one, maybe we should do that.

Pippa has said that on their forms, I think they have a GP consent box on those, so that they consent to report being sent to their GPs if necessary. Should they be more specific in the consent to contact in case of a risk to self? I think that's probably unnecessary because we have a duty to report if someone's going to harm themselves. But then I come back to what I said earlier on that actually, if it enables you to raise that question, maybe it's a useful thing to just flag in the mind of a patient.

DCK: I would have thought it's not unreasonable to say, "Who would you like me to contact in case of an emergency?" And you don't need to call it a mental health thing. If someone bumped their head and concussed themselves on the way out of the surgery, who would you contact? So I think, yeah, in case of emergency, who would you like to contact? That seems to be a perfectly reasonable interpretation of that would be, "I'm really worried about this person. I think this is an emergency. They've asked me. They put on their form."

MP: And I have no experience of osteopathy or being a chiropractor, but I would have thought that would be the question that would be just standard.

SB: You'd think, wouldn't you?

MP: Well, obviously.

DCK: Perfectly reasonable.

SB: It's a perfectly reasonable and a very good idea and maybe that's something we should all take on board. I'd be interested in the feedback from the people who are watching. Sam Craigwood asks about mental health crisis teams. What about them? Can we refer them for urgent cases? I'm not sure what access we have to them.

DCK: Usually it's via GP. I mean, I don't think you could just as effectively a member of the public, which is what you would be in mental health terms, refer to a crisis team. It might go through an A&E department. I think police might have access to it and GPs would. I'm not aware of that being something that would just be publicly assessable. And again, I think that may be a judgment too far in terms of expecting someone to make that kind of... Because I think that's a clinical judgment that I would feel uncomfortable making.

SB: Yeah. Perhaps I could also refer anyone who's watching to the broadcast we did some time ago about mental health. It wasn't as specific as this one, but we talked about mental health crisis teams on that particular broadcast. So maybe worth looking back to that one for more information.

I've got an observation here from a, again, anonymous viewer, which is a comment about starting questions on mental health. They tell us that they use the analogy of a bucket for how much we are able to compensate for. And once your bucket's full or overflowing you experience symptoms. Things that fill your buckets include physical stress but also everything else it faces stress, sleep-

MP: It's called a stress container.

SB: A stress container? There we go, we've got a proper name for it now. And it usually gets conversations started about mental health. And that's I suppose most of us probably do that because we are now a well versed in the bio-psycho-social model of health. It's not all about whether this joint or this muscle is in trouble. It's about what else is going on in your life. So yeah, thank you for the observation whoever sent that one in. And Oh God, this is a long one. It was a long one. Let's see what this one is. Again, it's anonymous, so let's just put it somewhere where I can read it.

It's about patient management's advice. This person says that they have a patient who initially presented with MSK problem, with musculoskeletal problems, but also some non-Orthodox visualizations and interpretation of their pain. Structurally, this practitioner feels and they've explained that the musculoskeletal problem is significantly better. The patient agrees, but there's always a but attached to the patient's comments leading to the need for further treatment. That need is in inverted commas here.

"I feel that the patient could be very easily become dependent upon treatment and I don't want that to happen. I have when the patient's been in a receptive state, discussed the musculoskeletal situation and also their previous consultations with psychiatrist, but the patient feels that the psychiatrist and their GP don't understand the problem."

So the patient believes that the problem is of musculoskeletal origin, but the practitioner thinks that there are mental health issues involved. Now for all of that, have you any advice about how to proceed without wishing to distress the patient. And right at the end it says, Steven, the question sender has acknowledged this is a very complicated question. Hard enough to read, let alone answer.

DCK: Yeah, right, right.

SB: I mean it's a good question though.

DCK: It is very good. So there are several things that that prompts in my mind and I'm hoping that that will lead us to at least a plausible working answer. Firstly people whose primary experience is through psychiatric practitioners often have their broader physical health need under-met.

So we know that if you have a psychiatric diagnosis and you go in and talk about musculoskeletal pains, they're more likely to put it down to your psychiatric condition than actually a genuine musculoskeletal issue. And this then, there are plenty of studies that have told us that the broader physical health needs of people with a psychiatric diagnosis are less well-matched than the general population. So, it is firstly, it's a really good thing that someone who has clearly had a psychiatric diagnosis is getting good...

SB: Musculoskeletal care.

DCK: Musculoskeletal care. So that's a really good thing. And that is to be applauded and whoever's doing that is doing a really good job to do that because a lot of people will go that side, neglect it. It may be that their patient has had experience of their musculoskeletal stuff not being taken seriously or being branded as psychosomatic. So it may be that they have had a track record of not having had that bit taken seriously.

So they are therefore overcompensating because they found that the service they're getting from your colleague so good that they're really thinking, "Okay, I don't want to lose that and go back to my genuine interpretation of my pain being seen as psychological."

But at the same time, you don't want to replace one dependency perhaps with another. Maybe there are perhaps voluntary sector mental health support mechanisms that would fall short of being seen as being bounced

back into psychiatry, but may help support self help groups or other people, or groups.

SB: So how do we find those, then? What if this particular person-

DCK: Do we know where this person is geographically?

SB: No-

DCK: So they're either via the Mental Health Foundation, or via mind, or your colleague via local health services should be able to find local self-help groups, local support groups, certainly via the GP surgery they should-

SB: So the Mental Health Foundation, where you are, as we said earlier, the Head of Empowerment and Social Inclusion, is a very elevated organization. But they will take approaches from a practitioner or whatever and-?

DCK: All the time we get contacted, visits to websites, social media, is largely by people who want to find out what they can do, either to respond to, or to prevent escalation of everything from just improving your general mental health to how to manage more complicated conditions.

My role is to encourage people's understanding of their mental health, so that they can ask questions and make better choices, make more informed consent about a whole range of things. And I think we are now much better at understanding the relationship between mental and physical health. And in fact, when people ask me "What is good for your mental health?" The easiest way to answer that is to just remove the word "mental" from the question, because if something is good for your health, it's probably good for your mental health.

SB: Which will bring us back again to sleep in a minute.

DCK: Sleep, exercise, diet. Generally, if you strive towards living a more healthy life, you will live a more mentally healthy life.

MP: The two go hand in hand, don't they?

DCK: Absolutely.

SB: I just want a slight digression, because right at the beginning of the broadcast, you confessed to being a statistician, which means, of course, by definition you're also a fibber.

DCK: Indeed. Lies, damn lies, and statistics.

SB: What I wanted to say was that you're giving us lots of information about how to recognize, deal with, refer on for mental health, but this is not wooly,

ethereal stuff, this is based on good evidence. And your scientific background is that you recognize good evidence when you see it. So people can rely on the stuff you're giving us. And I say that, because we live in a world of evidence-based medicine, and I don't want people to think that you guys are making up opinions on the fly, they come from good sources.

People like asking questions about suicide, Siobhan just sent in another one. And that raises an interesting point. "Do you think if someone is suiciding, it might be better to approach them on a personal level rather than raising their stress levels by calling 999, or another-?"

MP: Personal level first, I would suggest. Well, the first thing to do is to make sure that you're safe. That's always the first thing. As in, physical first aid, the person's safety is paramount.

SB: Is that likely to be a problem with the suicidal people?

MP: It's not necessarily likely to be a problem, but obviously you'd just need to ensure.

DCK: It could be.

MP: So your safety's first. So assuming you think it's safe to approach them, then yes, by all means, a personal approach. I wouldn't necessarily immediately call 999, I'd try to talk to them first.

SB: I suppose the dilemma we have is that, we need to be very sure that they are safe when they leave us, because otherwise we haven't executed our duty to keep them from harm. If we're approaching at a personal level-

MP: Well, that's a very difficult thing because you don't know what they're thinking. So I think if the doubt is still there, then you are within rights to-

SB: And it might not be 999, it might be the GP, perhaps.

DCK: This is what I think the emergency contact is a really good thing to have as part of your conversation in any case. If you are genuinely, really concerned about that person walking out of your surgery, and you think that's an emergency, you have an emergency contact, that's a really perfectly reasonable thing to do. That is one way of discharging your duty of care is to say, "Okay, I think this is an emergency. I have an emergency contact. I've made contact with this person. I've expressed my concerns. They probably know the person way, way better than I do. They will have a better sense of perspective, they'll have a better sense of whether that presentation is..."

Supposing someone is bipolar, and that is a particular pattern, it may be very familiar to their emergency contact, who will probably say, "Well, thank you very much for letting me know. Don't worry about it. I'm going to meet them.

I'm going to see them in 20 minutes. But thank you very much for alerting me." And the chances are, if it were me leaving that, and it was my chiropractor making that call, I'd be delighted that they'd cared that much to do it. I might not be delighted in the instant.

MP: Yeah, in retrospect.

DCK: But this is one of the things that we hear a lot of the time. We hear so many stories about that person that made a difference to somebody's life X months ago.

MP: Just by listening.

DCK: Exactly.

SB: Well, that's the other side of it. I would bet on every first aid course that you and I have run, I distinctly remember, you will always say, "Never underestimate the importance of a kind word," and also perhaps, "A kind ear."

MP: Definitely. Kind ear, even more so.

SB: And there's somewhere in my questions, somebody asked about the importance of listening. Is that something that you discuss on the first aid training institute?

MP: I think it's the most essential thing. I'll say, the best gift you can give someone is your ears. Because it's an art, it's a skill, and most people don't know how to do it. We don't listen. We hear the words, but we don't listen. You have your own frame of reference. So if somebody is talking to you on a particular topic, it may be a topic that's touched your life in the past, so you immediately go to that and, and you refer to it from your own point of view. That's not listening, that's hearing what they're saying, but it's not listening to them. There's no empathy there.

And this is the biggest thing, I think. It's something that we do listing exercises on the course, because there's an element of practical on this. And it's the most interesting thing because it's very difficult to listen. One of the things on the ALGI nemonic is, listen non-judgmentally. That's a very difficult thing to do sometimes, because it may be, what they are saying to you is frightening. It may be what they're saying to you actually makes you angry. But you've got to put that to one side, and there aren't many people who can do that with any great degree of effect. And it's an art that needs to be practiced. And I don't think that people actually understand how important it is.

Whenever I've spoken to someone and they've listened to me, and I know they have, I feel buoyed, I feel good. It makes me feel good, just for the fact

that they've actually acknowledged the fact that they've listened to me, and they've fed keywords back, and so I understand that they've taken onboard what I've said. It makes a huge difference. It can make all the difference.

DCK: And that's where, having something to signpost people to, is really useful, because if someone has talked about the thing that's really worrying them is their relationship, or their housing situation, or something like that. If you've really listened and you've got that, you're thinking about, "Okay, so what can we do to address that?" Rather than, "I need the police, I need the doctor," actually, what this person really needs is relate-

MP: This is bigger picture.

DCK: ... Or shelter, or citizens advice bureau, or whatever. As an osteopath, as a chiropractor, being part of your local community, having those contacts in those broader community networks, and having that relationship with those other parts of the community. So that you can then say, "Well actually, I know Joe works at CAB. Go and talk to Joe." And that's-

SB: We've had a number of questions about getting help with dealing with these problems for our patients. And Seonaid has sent in when asking if there's a retrax's help for mental health problems in Scotland, because if you look at the NHS or IAPT, it only refers to England.

DCK: Yeah, that's true. Off the top of my head, I don't know. There will be mechanisms for both Scotland and for Wales, and indeed for Northern Ireland. Iapt is definitely England only. That's certainly the case. Wales has an equivalent, I can't remember what it is off the top of my head. And Scotland had something before England had IAPT, so there are services similar routes, which I'm sure...

SB: Well, if I can ask one of the team, somewhere in the background or the distance, if they make a note of this, we will find out those routes for you and we'll publish them.

DCK: We have a Scottish office who I can ask that question.

SB: Wonderful! That's even better.

DCK: I used to lead our work in Wales many moons ago, and I know my colleagues in Wales will be able to tell us what the up to date details is. So we can make sure that you get that.

SB: Brilliant. Thank you. I've been trying to ask this question or this observation for some time, because this is a slightly off-the-wall one, because it's not necessarily related to mental health. But Salome Olivia says she finds it difficult to ask questions of a minor when the parents are present, particularly if she suspects the parent is the source of the problem. So I guess

my question is not really how do we deal with the parents being there, but could it commonly be the case that the parents are the cause of a mental health problem in the child?

MP: Yes, they could be.

SB: Let's start with that, then. It could be, obviously. But statistically, are you aware that it is commonly the case, or?

MP: I don't know. I couldn't give you stats. But I mean, it simply could be, and it doesn't necessarily follow, but you couldn't rule it out.

DCK: But you don't want to assume it either.

SB: No.

DCK: So it's interesting and challenging territory. And I think one of the things that's changed with mental health legislation from, when I was a boy, the nearest relative was strictly defined in the mental health act and there was a hierarchy of who your nearest relative was.

SB: Whether you liked it or not.

DCK: Yeah, exactly. And that was set out in law. Now, you can choose who you want your advocate to be, and the assumption isn't in law that your nearest relative is the best person to talk on your behalf. It may be that that is the best person to talk on your behalf, but you can't assume that, and you shouldn't assume that. And again, I'm definitely not qualified to talk around the law or best practice with children and young people.

SB: No. And I think it is actually a topic for probably a different program on this. But one thing that I've discovered that many practitioners are unaware of, is that there is no cut-off age for giving informed consent. The only requirement is that the person giving informed consent is capable of doing so. So they could be eight years old. You don't have to cut-off at 16, and say you have to have patient parents with you until you're 16. But I suspect that even if you think that this 13 year old is capable of giving you informed consent, you can't ask the parents to leave the room. That will be very difficult.

MP: It would, very difficult.

SB: So it's a thorny subject, Salome Olivia, and I'm sorry that we perhaps haven't given you a simple answer on that.

DCK: While we're on that, I think it's really important to make it absolutely clear, just because someone has a psychiatric diagnosis, it doesn't mean that they're not capable of giving consent. And I think it is easy to equate

psychiatric diagnosis with mental capacity, and they are different concepts and they're tested in different ways in the law. You have different legislation, so for a young person you'll have Children's Act, you'll have Mental Health Act, and you have Mental Capacity Act. And they won't necessarily tell you the same thing.

SB: We've had an observation from Kerri, I think it is, who's talking about a case that was mentioned earlier, the 20 year old who she had concerns about. She had her mother's contact details, but the patient had specifically told her not to contact her parents. And that puts us in a very difficult position, because on the one hand, we cannot breach the confidentiality, unless we think there is a serious threat to the patient's wellbeing. And the osteopathic practice standards, and the chiropractic code don't specify it has to be a threat of suicide. It says, health for the patient, wellbeing of the patient with that effect.

DCK: I deliberately changed my GP when I was 18, because I did not want my GP talking to my parents about my mental health. In that circumstance, in these days, the conversation I would be having after that very explicit and clear statement is, "Okay, who should I contact then?" And I think that is a good opportunity to say, "Well, it's important for me as your practitioner to have an emergency contact. I get what you're saying. That's not the right person, can you give me someone who is?" Because you still need that. You still have that true to care. Someone who's 20-

MP: It doesn't have to be a family member, does it?

DCK: It absolutely doesn't. Someone who is 20, clearly, their parent has no right.

SB: And Kerri has said that, I'm sorry I'm reading on subsequent questions and observations. She says that further and further, the 20 year old did eventually give her consent to talk to the GP about the problem. But it must've been a lengthy or involved conversation to get that. But she doesn't know what she would have done, had she not given that consent. Kerri, again, if we record emergency contact details, does that constitute implied consent that you can you use them, or do they have to give signed consent to use as emergency contact details? And again, that's a difficult question.

DCK: You need a lawyer.

SB: I reassure you that we are going to get a very, very, very highly qualified lawyer on this show, to talk about informed consent issues.

DCK: Can I listen in on that one?

SB: You'd be more than welcome, you can come and join in. But we were getting it in to talk about what it is that gets people into trouble at the professional conduct committee. So we'll be looking at it from the legal point of view, not

from the esoteric academic perspective, which we've had in the past as well. We have ways of nuancing consent forms and so on. So thanks Kerri It's a difficult one for us to answer, and maybe we have to wait until we get the lawyer in here.

SB: I think we might have dealt with this, but Jess has asked, are there any other left field helplines, support groups, or whatever that you can recommend for people, for borderline personality disorder patients in particular? Because it can really affect relationships, especially in primary care. So it's important for us as chiropractors and osteopaths to know.

DCK: Again, I will follow that up. And there is... I just can't remember off the top of my head. I think it may be emerge, but I need to go and double check. There is a good organization that deals specifically with borderline personality disorder, run at least in part by people with that diagnosis. I can get the details to you on that along with-

MP: I can recommend one for self harm, because I believe it's the only one of its type in the country. There's a group, it's a self help, it's a drop in center. I'm not sure where it's in Leeds or Bradford, but it's called Battle Scars. And they have a website, and it's for people who obviously indulge in self harm, but it's also for family and friends can go in and discuss openly about issues and stuff. And the lady who actually run it came into talk to us about it. And very, very interesting stuff. But I don't think there's anywhere else specifically, that deals with self harming, but this one, Battle Scars, just Google that and they should come up.

SB: Okay. I promised we'd come back to sleep. And somebody, an anonymous viewer, has said that they would never have thought of asking questions about sleep in order to open the door to find out more about mental health problems. It's a really good idea they say. David, you were talking about sleep earlier on. Is it just straight forward to get good sleep, or is there more to it than that?

DCK: There is more to it than that. Sleep is one of the topics we chose at Public Health England as one of our four core subjects to talk about in our mental health campaign, so is sleep, anxiety, low mood and stress. And sleep has proven to be one of the most popular. The Mental Health Foundation will be talking a lot about sleep in mental health awareness week this year, which is in May. It's absolutely, fundamental, I would say, if I'm going to talk slightly tongue in cheek, I would say there are three really good ways to drive people mad, send them war, send them to prison, deprive them of sleep.

SB: Did you say send them to Britain?

DCK: Prison. Send them to war, send them to prison, deprive them of sleep. Those are the best ways of generating mental health-.

SB: As a former soldier, we're well versed in training as to what might happen to us. The first thing you do is deprive people of sleep, if you want to get questions answered, because it's the quickest way to affect psychology, much better than pain, and other methods.

DCK: Absolutely. So good sleep is really important. It's quite common for people to not get it. There are a whole range of reasons why they might not get it. And of course, there's a-

MP: One of their symptoms are depression, isn't it?

DCK: Exactly, right. And there's a symbiotic relationship between sleep and poor mental health, and of course there are also plenty of medications that will disrupt your sleep, and there are plenty of chronic pain conditions that would disrupt your sleep. So if you've got a physical problem that's causing a sleep problem, that is likely to cause a psychological problem.

MP: And it is not only just getting to sleep, it's staying asleep.

DCK: Absolutely.

SB: And perhaps I should say, we've had a very interesting broadcast in the past with Neil Stanley about getting good quality sleep and the factors that affect it. And we've got Neil Stanley coming back in the future. And I don't know the date off the top of my head, so we talking some more about sleep then. So if you're interested in how that affects people's mental health, he'll be the man to ask on that.

DCK: We found it was a really... People aren't embarrassed about talking about sleep.

MP: No. Not the fact that they quite relish it.

DCK: Yeah, absolutely. And it is part of the British condition, what's about sleep and the weather. But it's a very good starting point. Even if someone just looks tired, those kinds of observations, are you sleeping okay? That can lead you to important places.

SB: Sam Craigwood has asked, "How much power GPs have to get for someone who is refusing to see them? So a person who is bipolar and so manic that they're defined, do they have to be at the point of suicide before they can force them to get help or force help upon them?"

DCK: Well, there is mental health legislation that clearly sets out when that can and can't be done. Someone who is presenting a serious risk to themselves or others to their health, or other people's health, that is sufficient, it doesn't have to be imminent risk of death. So, no. If they're in a public place, then the police have the section 136, the power to detain someone. Nurses have

holding powers if someone's in a hospital setting... The law is relatively clear on what circumstances-

SB: And that they can do so without reference to a court in the initial staging-

DCK: Absolutely.

SB: ... Because they've got a genuine medical concern.

DCK: Absolutely. And in the case of specific professions like the police. The police aren't clinicians at all, they're making a judgment call, but they have the legislation that allows them to detain someone for up to 72 hours under section 136.

SB: Which is purely concerned their safety, or for the safety of others.

DCK: That is when someone is in a public place. Now, I don't know whether, for example, an osteopath's waiting room would be seen as a public place under the law. You have to check, but if it's somewhere where you feel you could call the police too, in the case of a disorder, then-

SB: There's a different act then isn't it? An anonymous observation. As osteopath says, this person, we have a duty of trust with our patients, and as we spend often half an hour or so with them, they find that they were prepared to discuss their issues with them. What this person finds difficult, is when their patients are asking for answers that the practitioner doesn't feel qualified to give, and I can empathize with that. Because, you want to lend that listening ear that you talked about Malcolm, but when you're asked, "What should I do?" We aren't qualified for that, are we?

MP: No, no, no, no, no, no.

SB: What's your advice on the course, or something like this? Again, just look at those signposts, and go speak to, if nothing else the samaritans, or they-

MP: We're not qualified to give advice or to diagnose any more than we would have with physical problem.

SB: Do you suggest-

MP: And I'll- this slightly different, but-

SB: Do you suggest referring to the samaritans, or-

MP: It may be. If it's necessarily in their field, it could be. As David was alluding, it could be a number of things. It could be, what's the underlying cause? Is it that, is it this, is it this? So we can look at these avenues. Depends on what

the problem is. But I would not give advice on specific or actually say, "This is what's wrong with you." No, I'm not qualified to do that.

SB: Another anonymous person says, "Good evening." That's nice. "How would you encourage a young student, who is very anxious and depressed to get help? And where should they go for that help as the GP doesn't take the problem seriously and she doesn't want to take pills?"

MP: The GP didn't take the problem seriously, obviously, from that then she's this person who has already seen the GP.

DCK: Did you say student?

SB: A student, yes.

DCK: Most academic organizations now will have a student welfare service, and they are getting way better at dealing with mental health problems. Students mental health is being taken much more seriously. I mean, actually my university... Again, apologies for my language. I went mad when I was a student at University College Cardiff, as it then was. And the university was superb in supporting me. They were really, really good. Very, very supportive.

SB: And yet. Only recently, Oxbridge, in particular, have been accused of not looking after the mental health of their students. Because they put such pressure on them and don't really care of the side effects for that.

DCK: So the students union, and the Student Welfare Service should be taking these things seriously. If I were a student, I'd probably start there rather than my GP. It's a real shame if they don't feel they're getting a good service from their GP. I mean, it does happen in the same way that you can not get good service from any healthcare professional. But if you're a student welfare, it is definitely being taken much more seriously. The NUS, National Union of Students have lots of good advice around that. Again, Mental Health Foundation, I have colleagues who are working explicitly in student mental health. I can probably give us more details on-.

MP: It doesn't say on there, whether the person is getting any support from family or friends?

SB: No, it doesn't.

MP: So, family or friends could be a very good source of support. Self help groups. It doesn't have to be the GP if the feel uncomfortable with it.

SB: There's a wonderful comment here from Aiden, who sent in something earlier on. He says, as his mentor used to say, "Never miss a good opportunity to shut up."

MP: I like that.

SB: Because I think as practitioners, I mean, we're trained to tell people what to do to some extent. And I like to think that in osteopathy and chiropractic we have a longer with our patients than GPs, and maybe we have a longer opportunity to listen to them. But it's so tempting that the minute someone comes in, and you start telling them what you think is going wrong, and what they need to do and what you're going to do, and maybe you miss those opportunities to shut up. Thank you for that Aiden, I like that.

MP: I know a lot of people that are frightened to silence. It seems that there's a need to break it somewhere, where sometimes silence is what's required.

SB: Elly's pointed out that during case history taking, actually the medications that patients list might give you a clue to mental health conditions. And I imagine, I can't think of them off the top of my head, but there will be standard medications, amitriptyline, or-

MP: Sertraline, serotonin, that sort of thing.

SB: Which will give you an idea that there may be something going on. CBT, cognitive behavioral therapy. Bob Allen wants to know what both of your views are on that. He says he's spoken to a hypnotherapist colleagues, and they don't rate the approach very highly as it can be limited in scope and can retraumatize people with PTSD, for example. Is it better than no treatment at all?

MP: Against that on the individual.

SB: Individual practitioner, or patient?

MP: Both. Is not one size fits all. So CBT might be actually fantastic for one person, but absolutely useless to someone else. Sorry David. If it doesn't suit, what the problem often is, that a person will go for therapy and they'll try a particular type of therapy that's been recommended, and it doesn't work. So then they'll give up on therapy altogether, because they'll think, "Well, this doesn't work. So obviously therapy doesn't work." But there are so many different types. So CBT is one of them. There's the humanistic approach as well, which takes a different view. So there are different ways. So it will depend on the individual as to whether it's effective or not.

SB: Any way of predicting what will work with them without it?

MP: No, not without taste in it.

DCK: I mean, there is a reasonably good evidence base for CBT for quite a few conditions, including PTSD. But again, I mean, it's not a one size fits all, it's probably, if you're working with someone, the adverse effects of something

like CBT are far less damaging than the adverse effects of a biochemical intervention, if that isn't working for somebody. However, if it's not useful, it may cause you problems, it may cause you to lose hope, it may cause you to get very frustrated.

SB: I guess, I would like to think we can identify-

MP: You saw the quick fix. No, no, no, it's not the quick fix. It can take a long time before you actually see the benefits, because you're learning to change your habits, you're learning to show your thought processes.

SB: Well, we'd like to think that a good CBT therapist would recognize when their approach wasn't working. So, I guess we're out of time.

DCK: Oh.

SB: I'm really sorry about that. As I said, we've got loads of questions left. Would it be okay to put those questions to you offline, and try and get the information out to our viewers?

DCK: Of course, absolutely.

SB: It has been clearly a very popular broadcast. I mean, it's a massive amount of information that you've imparted. Malcom, you are running a Mental Health First Aid course in North London on the 30th and 31st of May-

MP: Correct.

SB: ... Which is a weekend. We're setting that up. The course is available online. This has not been a marketing exercise for that course, but there's clearly a lot of interest in it, which is why we set it up in the first place. And so if you are interested in learning more about mental health first aid, getting some practical skills in dealing with what you might perceive as a problem, that would be a very good place to start. The Mental Health First Aid England course is probably the best regarded in the country. Is that a fair thing to say?

MP: Yeah, I think it is.

SB: They're a very worthwhile organization.

MP: It's recognized by the department of health.

SB: So it's a good course. Thank you very much both for coming in here this evening and, and for sharing your own personal histories as well, because that's, I would imagine, not an easy thing to do. I'm not sure if we're allowed to do this, but thank you. Thank you for coming. You and I can do a fist bump.

DCK: I'm taking this absolutely fine. No exchanging of bodily fluids.