416 – Mental Health

With Steven Bruce and **David** Crepaz-Keay

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Steven (00:03):

I have Dr. David Crepaz-Keay in the studio with me. David is the head of research and applied learning at the Mental Health Foundation.

(00:50):

He's responsible for putting together the multi-author handbook Mental health today and tomorrow. He's been an advisor to the WHO. He's appeared on the BBC. He makes cheese and he does a whole load of other things. But of course his greatest claim to fame is that he's actually been my guest on this show on two occasions in the past, but not **David** for over four years now. So why we haven't been able to get you back in for four years, because this is a constant topic of concern in the country, isn't it? But maybe we should start by just finding out a bit more about what the Mental Health Foundation is, because there are a number of mental health organisations in the uk, aren't there?

David (01:26):

So yeah, the Mental Health Foundation, it's a charity. It's been established for over 75 years. I've worked there for over 20. And we are wholly funded by public donations or charitable donations or charitable trusts. And our priority at the moment is keeping the public's mental health as good as it could, excuse me, keeping the public's mental health as good as it can possibly be. So preventing mental ill health and keeping people's mental health in tip top shape.

Steven (02:00):

Interestingly, before we came on air, you were saying that yes, you've got an office in London, you've got one in Scotland, one in Wales, you've got one in Belfast. But the law is different subtly and in some cases quite significantly in those different parts of the uk. That's bizarre.

David (02:17):

It is. And what makes it even more complicated is that there isn't an English government. So We have a UK government, which largely does England and Wales in law and mental health policy terms, but there are subtle and sometimes not subtle policy differences between England, Wales, Scotland, and Northern Ireland. And I think they were at their most complicated. You remember the pandemic, that little thing that happened a few months ago, seems like only yesterday, doesn't it? That happened since you and I last sat down and had a chat about mental health. And when that started, I was doing a two day a week

secondment with Public Health England working on a project called Every Mind Matters, which is a really nice piece of public mental health work. And I foolishly said to the foundation, okay, we're going to need to make sure everything we do follows government guidance during this brief interlude for the pandemic. And this was kind of in week one, week two, I think it was kind of March of the first year. And I said, okay, I'm pretty familiar with government policy on stuff. I'll look after it. And the pandemic went on a long time and within six months I had to read over 10,000 pieces of government guidance,

(03:45):

Most of which weren't to do with mental health, but they were incredibly complicated and there was increasing divergence between England, England and Wales, Scotland and Northern Ireland. And it just became very, very complicated. And even just looking after your mental health and doing the stuff that you needed to do was just very, very difficult. And it was very difficult to do within guidelines. And it was quite difficult for us as a UK charity to make sure that we were accurate in England, in Wales, in Scotland and in Northern Ireland.

Steven (04:19):

Because it's interesting, inevitably you were going to mention the pandemic because that must have had an impact. But one of the first questions that's come in already from Paul is have you seen a big increase in mental health problems since Covid? We're all being told that there has been. But is that the reality?

David (04:35):

I think two things have happened. One is that there was a really significant psychological impact of the pandemic, and we know from any natural disaster that that has a psychological impact that affects people's mental health during and for months and months and months and years to follow. And the pandemic was no different in that respect. So people died, so people grieved, so people lost people. A lot of people lost their jobs or had their employment affected by it. Things changed. A lot of people became socially isolated and lonely and those things are bad for your mental health. So all those things happened and they happened in a concentrated period of time. And secondly, not entirely a bad thing, it's the first time we've had an event like that where people actually talked about the psychological impact, talked about

(05:38):

Mental health as part of the pandemic and understanding that. So just before I mentioned Public Health England, and in the run up to the pandemic or the start of pandemic, I was in England's leading public health organisation two days a week. We just didn't know what to expect. You prepare for these things, but you really don't know what they're going to be like. But one thing that was very clear was that it wasn't just about a virus. The psychological, the mental health impact of the pandemic was as damaging and as significant in the short, medium and longer term as the physical health terms were. And I think it was dreadful, but it was immensely helpful that people saw it as both a mental and physical health event.

Steven (06:28):

And the figures that I've had made up before we came on air say that mental health problems cost the economy £300 billion a year. I'm not sure how anyone works that out. You're the head of research. You must know these things. And actually the nice thing about you being head of research is you understand how research is meant to be carried out and what sort of research is reliable and valuable, don't you? But how do we assess the effect the cost of mental health Problems?

David (06:53):

The other thing is that I trained as an economist all those hundreds of years ago before I worked in mental health. And my first proper job was as an economist and I worked at the treasury. So understanding the cost of things was what I was originally trained to do. And I guess there's several things. There's the direct cost of providing mental health services. There's the indirect cost of people not being as productive as they could be because of their mental health.

Steven (07:28):

So much of that's Hidden, isn't it? Until they've admitted that they've got a problem, they might be unproductive or they might be dissatisfied with whatever's going on in their lives. But we don't know that it's a mental health problem.

David (07:37):

No, and the best estimates, and again, the science is tricky, but the best estimates are for every day lost to sickness for a mental health problem, the seven or eight days of lost productivity for people who are still in work, what we call presenteeism, strongly associated with mental health. So the visible tip of the iceberg is that kind of those days of sickness that people take off, and the invisible bottom of the iceberg is those kind of seven or eight days, seven or eight times as much time lost for people still in work but experience such poor mental health that they're not productive.

Steven (08:23):

And to some extent for this particular show, for our particular audience today, we are interested in what our practitioners might see in their own clinics. So they're not going to see the absentees because they're probably being assessed by somebody and they're on a pathway of some sort. They possibly are seeing the presentees, the ones who aren't admitting to a mental health problem but have got associated problems. You were talking earlier on again before we came on air about the relationship between mental health illness and chronic pain.

David (08:55):

And it's really important that, and you'll know this and all your viewers will know this, there isn't this kind of straightforward divide between mind and body. You can't say this bits your mind and this bits your body. And particularly for pain, it is exactly that interaction between your mind and your body. And it can be anything from when I'm feeling stressed, I feel it in my shoulders, I start hunching up, I start curving, I start curving up, I start creating little tension points in my back. You'll know I have routinely seen chiropractors for that. And as soon as I,

Steven (09:37):

So last time you were on the show in the studio, your chiropractor actually emailed in to say, sit up straight, didn't she?

David (09:42):

So you claim, so you, and of course, what did I do? I sat up straight like a, well, we have, yes I did. But she could tell when I walked in the room what state my mental health was by how I was holding myself. And I think there is such a strong relationship between your body and your mind. And it may be that there is a direct physical cause of your pain that then has a knock on impact for your mental health. Or there may be that you start off with a psychological stressor that causes you to just behave badly in terms of how you hold your body, which is certainly the case, certainly the case with me, and I think they are so closely tied up. And then I suppose the third leg of that stool is sleep. And both your physical health and your mental health start to affect your sleep. And that can really start to have a kind of negative spiral. And if you start having poor sleep, then that will really have a knock on effect for

Steven (10:52):

Your physical health. I would like to think that most people watching this show will consider mental health when they're talking about chronic pain and so on. But of course, in the questioning that we have as the introductory questions to your first visit to a practitioner, they'll probably be asking how well you sleep and how long the pain's going on. It's difficult asking those questions though, isn't it, that relates to your mental health. What I didn't mention, which you did on the first show we did together is that actually you've got a fairly individual insight in this. You described yourself as mad on the first show, so you've been there with mental health problems yourself of some sort. Would it have bothered you back then if I started asking in what might be sort of in depth questions about your mental health?

David (11:39):

Oh, absolutely. Yeah. And I think, so I had this strange dual career, that classic south of England career back then. O levels, a levels degree, civil service career. That's what was expected of me. But that was interlaced with going in and out of psychiatric hospital sometimes as a detained patient. And what was really interesting for me and very, very frustrating was that if someone introduced me as an economist or a statistician or a civil servant, I got treated very well. Really? Yeah, I know hard though it is to believe these days, but that was seen as something of status. But if I was introduced as a psychiatric patient, then it was doors closed and end of conversation. And I think of course that has an impact on you. It has an impact on you as a kind of late teenager or early twenties. You just get to assume that being a civil servant is a good thing and being a psychiatric patient is a bad thing.

Steven (12:45):

You did mention that at some point you were a detained patient, which makes it sound as though you were a danger to the public.

David (12:52):

Yeah, well, the mental health law is a bit strange. So strictly under mental health legislation, you can be detained for your own or others health and or safety. So if an approved clinician takes the view that you may be a risk to yourself to other people or that you may have the potential to become a risk to yourself or other people, you can be detained. So I don't think I was particularly ever viewed as a huge risk to other people. I certainly was seen as a risk to myself. Frankly, there were times when it made me so cross, I probably was a bit of a risk to other people. But that's another matter entirely. But certainly the way you were treated back then really didn't encourage you to talk about your mental health, your experiences of course, and so on

Steven (13:52):

That Stigma is still there though, isn't it?

If someone says they have mental health illness, I suspect there is an immediate image conjured up in people's minds even though we're all on a mental health spectrum of some sort.

David (14:05):

I think it's easing. I mean, it's very different to how it was. You may find it, hard to imagine, but it's a little while since I've been a teenager, even further back than the pandemic. But the world has changed a lot since I was a teenager. So the group of people who seem to be least most reluctant to talk about their mental health are men of our age. We are about as bad as it gets in terms of talking about it. Newer generations are getting better and better at talking about their mental health, about, I think there's still a little bit of a gender difference, but broadly speaking, we are getting better as a UK society, we are getting better at about talking

Steven (14:51):

It seems to me that although one could argue that having people staring at their mobile devices all the time is a bad thing in some ways, most people, these, they seem to want to share everything they do, whether it's on a telephone call, in a railway carriage or on social media. They want to tell everybody that what's going on in their lives is that genuinely a thing that they want to share their mental health.

David (15:16):

It's really interesting. Wearing my research hat, I've been involved with a really nice piece of research led by University of Birmingham looking at where people get their mental health advice online and particularly through social media. And there are three big sources that people are

Steven (15:34):

Kardashians.

David (15:35):

Well, they're influencers, they're experts, and they're people with lived experience.

Steven (15:44):

Right, okay.

David (15:45):

And what we are doing with that research is we are looking at how safe and reliable is the information coming from each of those groups and how are people responding to that? So you're absolutely right, people are spending more time, younger people particularly are spending more time talking about their own mental health, talking about each other's mental health and trying to find out about it.

Steven (16:09):

Is That a double-edged sword?

David (16:10):

Oh, it certainly Is.

Steven (16:11):

If you talk about it enough, you can become convinced that you've got a problem or even talked into having one, I suppose.

David (16:18):

I think there are two problems with this. One is exactly that. So it is probably almost certainly the case that one of the reasons why we're seeing increased in reported mental health problems is that people are finding them in themselves or in others in a way that they wouldn't previously. Now some of that is definitely because they were there and previously we were just burying them because we weren't talking about them. And some of it is because there is a risk that we are pathologizing stuff that we wouldn't previously have thought.

Steven (16:54):

And everyone who's studied medicine in any form will say that during your training, you always think you've got what you just learned about because you always fit in those symptoms somewhere.

David (17:02):

And then I think the other thing which is more troubling and something that we definitely want to do some work around at the Mental Health Foundation is we all have, as you said at the start, we all have our mental health or needs. We all need to look after our mental health and we all need to keep it the right side of healthy rather than unhealthy or ill. But trying to work out what is reliable and safer device online is not easy. And that becomes more difficult when through things like social media, people get more money for every person that looks at their page, that responds to their page. Some of these pages are set up by people who have really quite good commercial deals with, for example, supplement.

(17:50):

And through this research I saw one piece of advice, which was from someone who was legally a registered pharmacist, not in this country, not in the uk, and I don't think they'd be allowed to if they were in the UK basically saying, stop taking the medication that your psychiatrist has prescribed you and take these supplements instead. And that is just dangerous. And I'm not going to sit here and say there aren't plenty of cases of overprescribing a psychiatric medication. It happens, but just stopping taking your medication and taking supplements instead is a really dangerous thing to do. So you've got these two things. You've got this absolute incentive for people to engage and talk about this really personal stuff and do it in a really very public way, which you and I were not brought up to do.

Speaker 3 (18:48):

Good lord. No.

David (18:49):

And on the subject, if there was anything that was going to make me a danger to other people, it would be listening to somebody's phone conversation about their mental health on a railway carriage. That might just turn me homicidal

Steven (19:00):

Interrupting you for a second that Aiden sent in a comment a few minutes ago saying, going back 25 to 30 years, Aiden actually felt it was a responsibility to talk about his mental health to raise awareness because presumably it was such a closeted Experience.

David (19:16):

Absolutely. And interestingly, when we looked at those three strands of people talking about mental health, one of the most reliable was people with lived experience. So actually the people talking about their own experience on the basis of the bits that I've seen, and this is not a total sum of the research, what they were saying actually probably was mostly useful. It probably was raising issues.

Steven (19:43):

So That's still the case.

David (19:44):

That's still the case that it is always, if you're worried about your mental health, it is always better to articulate those concerns. And I'm not saying on as part of your social media presence, but in your family, in your friends, in your consulting room, if you think there's a mental health conversation to be had, you are probably right. And it's probably best to have it. And certainly in the privacy of your friends and family, it's still a very positive thing to do it. Where I'm more concerned is if that's the primary purpose for your online business. And what we need to do is give people the skills to be able to navigate all that information, really,

really and critically appraise that information and to draw sensible conclusions from it. And that is part of what the foundation should do.

Steven (20:41):

The physical therapist watching today will obviously be concerned that there's an expertise dealing with mental health, which isn't part of our basic training, and they're required to stick within their remit when they're administering treatment. So to what extent, to what lengths can we go as physical therapists in terms of recognising and signposting people who we think might have a problem?

David (21:07):

I think what any sensible and certainly what any trained professional in that space should be doing is becoming familiar with reliable sources of information. So I talked a little bit earlier about every mind matters. Now Public Health England has gone, but the every mind matters resources sit with the NHS, and they are still the place I would go to When anyone asks me, what do you do to look after your mental health? I will point them at Every Mind Matters. I will point them at the NHS if they're in Scotland or Wales. There are NHS Scotland and Wales equivalents, Northern Ireland, likewise. But start with the NHS web materials

Steven (21:46):

Every Mind Matters is what? It's a simple printed resource or is it interactive?

David (21:51):

It is an online resource, evidence-based interventions that anyone can use to look after their own and each other's mental health. It's particularly good for low mood that is short of clinical depression anxiety that is not quite at that kind of clinical level of generalised anxiety disorder, but the kind of anxiety that could take you into that space. There's really good materials to help sleep. It's the kind of things that If you haven't got a diagnosed mental illness or you are worried about your mental health, that's the level it's pitched at. And that's where I would start because it is really good evidence-based stuff.

It is interactive, it is on the web. There's a tool that can help you develop your own tailored mind plan. So you answer four or five questions and it will give you some evidence-based recommendations of things that you should do. So that's where I would start.

And it's not an alternative for an actual mental health service. If you have a diagnosed mental illness, you really need to be talking to someone in that clinical space. But if it's just about keeping your mental health as good as it can be, and particularly we know there are things that will have an impact on your mental health. We've talked about chronic pain, physical pain, that's going to have an impact on your mental health regardless of the cause. Any kind of traumatic injury is going to have an impact on your mental health. So you should then be aware of your mental health. We talked about bereavement and loss that has an impact on your mental health. Even just things like housing insecurity, food poverty, all these sort of things that are a real issue for people day to day. They will have a mental health impact. And for people like that who don't have a mental illness, don't have a psychiatric diagnosis,

(23:51):

But clearly their mental health is at risk. Those are the kind of resources that are genuinely helpful.

Steven (23:56):

One of the things you've just said was that chronic pain will have an impact on mental health, which goes without saying I guess, but also mental health problems will have an impact on one's perception of pain. Any idea which way is the stronger influence?

David (24:15):

I think it's a genuinely good question. You'd need someone who's much better skilled in the biomechanics of our brain and nervous system. Maybe that's a really good question For your Wednesday session.

Steven (24:29):

Yeah. Well maybe actually, I'm just going to go back on some things that came in earlier on. Sarah said earlier on that she's very disappointed. Apparently you were wearing a purple suit when you came in last time. She's disappointed you're not wearing a purple suit today. For some reason.

Steven (24:44):

She's feeling quite depressed about it.

David (24:45):

Well, if you invite me back during the summer season, the purple suit will be, I've got quite a nice Lilac one now as well, but that's very much the summer Collection.

Steven (24:55):

So that's nothing to do with mental health. But I quite enjoyed the comment.

David (24:59):

I've got pink dots on my tie. I'd like to think that's contributing.

Steven (25:02):

And somebody who's known as Meerkat on this system says that it was really good to hear your acknowledgement of the connection between mind and body as it were, between mental health and physical health, which is good. Simon earlier asked for a clarification when you said you with a subject of a detained person - Is that the same he said as a deprivation of liberty order?

David (25:25):

No. So this is interesting. This was 1983 Mental Health Act. So in common parlance is “being sectioned”, which actually means being detained under a section of the Mental Health Act.

(25:40):

Deprivation of liberties is a slightly different thing, not my area of expertise. And I'm not a lawyer, so I'll tread carefully. But what's really interesting is that, there were some interesting cases on people being illegally detained, having their liberty deprived because of the diagnosis of dementia, not under the Mental Health Act, but under other legislation. And it was deemed to be illegal. And I think when Deprivation of Liberty legislation came in, DOLS came in, we actually saw an increase in use of the Mental Health Act on the kind of people who would previously have been subject to deprivation of liberties. So There are some people who hypothesise that the Mental Health Act is an easier way of detaining people now since DOLS has come in. But in my case, that was Pre DOLS. So yeah, 1983 Mental Health Act, sections two and three, possibly section 1 3 6 as well.

Steven (26:49):

You can't win with deprivation of Liberty though, can you? I mean, on the one hand people will complain that it might be done too readily as you implied just then, but equally we've missed a couple of opportunities recently where mental health issues might have saved people from attacks on public bodies.

David (27:05):

Yeah, it's interesting. My view, and this is my view, not the mental health foundation's view, is that mental health legislation is the wrong way to do that. And that the fact that we only allow people to be preventatively detained for mental health reasons, that's a flaw in our law. So if there is someone, for example, who is a serial abuser, a serial committer of domestic violence, a serial drink driver, and you are a police officer and with a reasonable degree of certainty that this person is within a matter of minutes going to commit a crime, and if they had a psychiatric diagnosis, you could detain them If you're a mental health professional. If you're a police officer, you can't because the law doesn't allow you to preventatively detain. Now, my view is that it is just discrimination to say you can only make that detention if someone has a psychiatric diagnosis, not if they're simply known to be violent or known to be predisposed to particular crimes. It shouldn't be about mental illness. It should be a risk assessment.

Steven (28:19):

Yes.

David (28:19):

And actually the best predictors of violent behaviour are history of violence, not psychiatric diagnosis. Psychiatric diagnosis is a really poor predictor of violent behaviour.

Steven (28:32):

It is one where you don't want to get the diagnosis or the projection wrong though, isn't it?

David (28:36):

Absolutely. And I think you can make a really good case for having an honest public discussion about preventative detention for people who are likely to commit crimes, but take mental health out of it because it's, it's discriminatory and it's spurious. And just to underline how we know, there are many reasons we know its spurious: firstly, the stats show you that people with a psychiatric diagnosis are no more likely to commit violent crimes than people without a psychiatric diagnosis. They are however more likely to be a victim of crime than those without a psychiatric diagnosis. That's another matter entirely. And we also know that for reasons that we genuinely don't understand, mental health legislation is way more likely to detain people who have a dark-coloured skin. And there's no epidemiological reason for that. And yet there is something intrinsically biassed in our use of mental health legislation that particularly detains young men for from particular racialized groups.

Steven (29:43):

Yeah, this is a slightly related question. It comes from Martin, and it is a really good question. We always get good questions from Martin. He says, when has there ever not been a mental health problem? Surely it's part of everyone, but his point is, is it possible to put too much emphasis on it? We talked about the 33% increase in mental health reported problems over the last two or three years. Is it possible that actually we are encouraging too many people to report mental health issues?

David (30:18):

I think recognising that it may be a part of what's going on for you is probably a good thing. It's how you then respond to that. And I'm not sure it's sufficient or necessary to just identify something as a mental health problem. If that helps you find the right solution, then it's a good thing. But if it distracts you from that, then it's a bad thing. And this is again, a conversation that you and I have had a few times Over the years.

(30:56):

If supposing you are working in an organisation with a bit of a rubbish culture and that culture includes bullying and other stuff, and that will have an impact on your mental health, there is no doubt at all that being exposed to a bullying environment in the workplace will have a negative impact on your mental health and for a significant number of people that will tip them over from being mentally healthy to mentally unhealthy or mentally ill. Now the question then is of course it is, right, that somebody gets support for their mental health in those situations, but is that job done or should you also then be looking at the causes, the underlying causes of that impact on your mental health, which is the workplace culture? And it's not just the workplace culture. It could be a culture in a school, for example.

(31:56):

And if you want me to get cross about something else, and I'm always happy to get cross about stuff, the idea that a school, and I've had this argument with a number of head teachers, they've asked me how can they best ensure the good mental health of the pupils in their school? And I would say, cut out bullying, deal with bullying in your school. And that is the one big thing that you can do to improve the mental health of your pupils. And actually your staff and a number of them have just said, well, there's no bullying in my school and

we've got a school counsellor. And I think that's the bit that worries me. This idea that you have the counsellor, you have the employee assistance programme, you have the mental health first aid practitioners, all good stuff. But if you think that's job done and you're not actually looking at the culture within your organisation that is creating those mental health problems or at least contributing to them, then you are applying sticking plasters. You're not dealing with preventing the problems in the first place. And that's the bit that does worry me. So I'm not against the solutions,

(33:10):

But I am against us thinking that that's done. Actually that's identifying symptoms and there's a root cause that needs dealing with. And sometimes that's in workplaces, sometimes that's in school, sometimes that needs politicians to get off their backside and do stuff. But so often it is your folk and mine that are picking up the pieces after the damage is done.

Steven (33:36):

So what's the role then of mental health first aid training, and I have an interest in this, as we're running a course in it later in the month. Does it have a beneficial role to play? I'm hoping you're going to say yes at this point,

David (33:50):

Absolutely it does. What we know it does, and the research is there, we know it encourages mental health first aid practitioners to feel confident that they can have good conversations about mental health, that they can signpost, that they can help people identify problems and concerns that they have and get them in the right direction to seek the help to do that.

Steven (34:18):

It's not about treatment, is it? It's about understanding what the natures of the different problems are, but then recognising them and being able to signpost.

David (34:26):

Absolutely. So again, I know plenty of people who are good compassionate people who've done mental health First Aid and who it has improved their confidence and their skills and their ability to have these really difficult conversations. Excellent, good. Where it worries me is if organisations have a borderline toxic culture, they train a lot of people in Mental Health First Aid, they have a really good employer assistance programme, but they don't address the toxic culture. That's the bit that troubles me. So mental health First aid is not a magic wand. It's a really good way of getting people to be skilled and confident in having those conversations. And that's a good thing,

Steven (35:14):

I suppose unlike clinic first aid, emergency first aid, at least you're not dealing necessarily with a problem once it's happened. You're addressing it preemptively almost by recognising the signs symptoms and be able to signpost people accordingly.

David (35:28):

You definitely hope so. You definitely hope so.

Steven (35:31):

The people watching today, I mean, of course they'll be thinking, well, how would it help me in a clinical situation? And I'm guessing from what you're saying that again, here we are standing back a little bit. We're not dealing with a friend or a member of the family, but we are then going to be able to recognise the things that indicate the various different types of mental health problem and give them the right signpost.

David (35:54):

Yeah, I think probably most of your people, and certainly the people who are watching this will be the kind of people that will have that kind of nagging doubt that there's something going on when they see someone in front of them that something doesn't feel right.

(36:07):

And anything you can do to kind of turn that instinct into something a little bit more concrete, something that will allow you to make those judgements with a little bit more confidence so that you can say the right thing, not say the wrong thing, make people feel comfortable to have those conversations, but also be clear about the boundaries. The other thing, one of the advantages of Mental Health First Aid is that it should stop people thinking they have to be psychiatrists, psychologists, or therapists. If someone comes out of a mental health first aid training course thinking they're now a psychologist, psychiatrist, or therapist, they probably weren't listening. So I think it should help reinforce those boundaries. It should help make sure that you know what you can and can't do.

Steven (37:00):

I do think sometimes it's a little bit of a problem for people like myself, like the people watching today because we have quite a long time with our patients generally, and it's very easy to feel that we are able to help by having the conversation we're having over that 30 minutes, 45 minutes, whatever it might be. And is there a possibility that we could be doing quite the opposite? We might be causing some harm by thinking we're helping but not having the skills to do it properly.

David (37:33):

I'm assuming that you're not going to be giving people instructions on what they should be doing with their own mental health. You're not going to be prescribing stuff to them for, you won't be doing that.

Speaker 3 (37:45):

Certainly

David (37:47):

You won't be telling them what you really need is a good strong drink. You won't be doing any, what you're doing is picking up potential indicators and some signposting. That's what

you should be doing. And if you're running a clinic, it's probably in your interest to just make sure you have in your back pocket or on your notice board or with your highly trained super receptionist, those kind of sources of additional help and support that will take that next step. So you might say to someone in the conversation, you've had that conversation, you realise they've got some pain, you've identified that there's a bit of a physical cause it's affecting their sleep, it may be affecting their work. It's certainly making them feel more stressed. All those things suggest that there are elevated mental health risk and therefore it is perfectly reasonable and within your professional remit to say, alongside the stuff that I can do for you, be aware that this may have an impact on your mental health. And these are good reliable sources that can help you with that. And that's your good professional behaviour.

Steven (38:58):

And a good resource would be every mind matters, which you Mentioned earlier

David (39:00):

Yeah, absolutely. The other thing that people have told us are good resources, and one of the places I would go to, community pharmacists are a good source of information. And again, one of the nice things about community pharmacists is that they're in your community and you don't have to go out of your way or do anything special to have a conversation with a pharmacist

Steven (39:23):

Except for the fact you've got to be brave enough to stand there in the crowd of other people and with all their assistants around and say that's what you're after, which I suspect is challenging for a lot of people with mental health Issues

David (39:32):

Yeah, it is a challenge, but from the feedback we get, it's less of a challenge than making that GP appointment,

Which Is a challenge anyway.

Steven (39:39):

Yes,

David (39:40):

Absolutely. So you are in the high street,

(39:46):

You are near the chemist. You are not going to get funny looks for going into a chemist particularly. In fact, the most embarrassing condition I've had recently is eczema. And I was working in Manchester and I went into a fantastic pharmacist in the Arndale Centre in Manchester and got really, really good advice. I have been putting off going to see my GP for far too long, and I was passing a pharmacist. I went and I got really good advice. And I know that's how a number of people that I've spoken to have talked about how they,

Steven (40:18):

So people should go to Manchester for their advice?

David (40:22):

We may need to edit that bit! I'm definitely not suggesting that. But there are good resources that are not in specialist settings where you will get that next level up of advice. So your crew here, they're well trained, they're professionals, they're good thinkers, but they know where their boundaries and limits are. One of those places where you can go to get a little bit more support

Apart From your GP might be your community pharmacist.

(40:55):

Likewise, I mean if other things come up in the conversation, again, not directly related to mental health, but we know these are things that might come up where again, you'd be signposting rather than making advice would be debt counsellors, systems advice, relationship counselling. These are things that we know are potentially mental health triggers. They're also triggers for stress that can lead to physical health problems. I don't understand the mechanisms for those, but I know that that's the case. So again, it would be really useful to have in your back pocket those kind of Citizens Advice Bureau and other kind of sources of help that are not directly about mental health, but are those other things that are going to have an impact on people's mental health.

Steven (41:43):

Well, Sally here has said that the Royal College of Chiropractor, I'm very jealous that the Royal College of Chiropractors has a royal title, I'm wondering how we manage to get the same thing for ourselves. It might be some distance away. She says they've got a pain faculty, which has a lot of stuff in the membership pathway about pain and mental health, which is really useful to chiropractors who are a member of the RCC obviously, but not to the rest of us sadly.

This is, and you may want to steer around this question - we may not address this at all, but Vince has asked a question about the relevance or importance of faith in handling coping with mental health problems.

David (42:19):

This is quite an interesting one and complicated.

Steven (42:22):

Yes.

David (42:26):

So broadly speaking, the evidence suggests that faith is protective for mental health. However, what's also interesting, I like to do interviews. I thoroughly enjoy it. One of the organisations I've done quite a few interviews for is a fantastic digital radio channel called

Voice of Islam, and they're a really great team there. I'm not from the Islamic community, but we like to work with them because they're really good. And what they tell me is that a lot of people in their community really don't like talking about mental health, but every time they do a feature on mental health, they get really positive feedback

Speaker 3 (43:18):

Really.

David (43:19):

So I definitely don't want to skirt around it. I think it's really important, but it's not a simple one. So there's a sense of belonging that comes with faith communities that is definitely positive for mental health. And that's not unique to faith communities, but it is definitely there within faith communities.

Steven (43:44):

Yes, it's possibly not the faith itself, which is helpful for mental health, is it? It's that community business, which is,

David (43:52):

That certainly seems to be the case. There is something about being part of a community, whether it's a faith community or other communities that is definitely helpful and constructive for your mental health. Different faiths definitely have different approaches to mental health, and there are definitely people who have felt excluded from their faith community because of a psychiatric diagnosis or mental health problems. And that can happen with a variety of faiths, and I've known it with a variety of faiths. And also I think faith communities, like any community, are not immune from mental health being a stigmatised topic to talk about. And that's certainly the interesting thing about the work I've done with voice of Islam is that there clearly is still that reluctance to talk about it in the Islamic community, but when we do, we get a really good positive response about it and people do see it as important and valuable thing to talk about. And I would say that, and I only pick that because a community I have done that particular work with, but I know those kind of push and pulls are similar with other Communities.

Steven (45:06):

Well, Vince very kindly said “great presentation” when he sent that question in a little while ago. So there's good feedback for you already from people watching today. Interesting comment came in from Pip earlier on. Pip was saying that if someone has anxiety, if she says that she suffers from anxiety herself, it helps that conversation flow. And again, maybe I can ask you, as someone who's admitted to mental health problems yourself, would that make a difference to you at any stage in your journey in talking to the person across the desk?

David (45:41):

I mean, given that my madness now a matter of public record, it makes very, there's very little, I mean I'll talk to anyone about anything, but I mean it is,

Steven (45:51):

But as a teenager,

David (45:53):

As a, yeah, it's difficult because times were so different back then and people wouldn't have said that. I mean, it's the key thing. Anxiety is really interesting and it's a slight tangent, but so many of these things, anxiety is not a bad thing in itself. Anxiety is an important human trait without which we would not live very long. Being anxious is not a bad thing in itself. Being stressed is not a bad thing in itself. Having your mood fluctuate is not a bad thing in itself. These are all human traits that, as you've said, we all have. It's when does it become disabling? When does it start having a detrimental effect on your day-to-day life? And particularly when does it start to have possibly a long-term or damaging effect. So anxiety is really, there are plenty of times when it's a good idea to be anxious us. If you are approaching a busy road, you should be a bit anxious. That's the bit of you that says there's something out there. There's risk and danger out there. Let's stop and look before we go too far into this dangerous dual carriage.

Steven (47:15):

Will I suspect that that threshold between anxiety and mental health disorder is different for different people, isn't it? Someone will be triggered much more easily than others,

David (47:22):

Perhaps,

Steven (47:23):

Or admit to it more readily

David (47:24):

At least? Yeah, it's really interesting. So if you look at, I've done some work with people in the armed forces. I used to be involved with forces in mine trust, and I'm pretty sure that people who actively, who are in the armed forces, their rates of suicide are no different if not slightly lower than general population, despite the fact they're exposed to all sorts of stuff that most of us fortunately don't get exposed to.

Steven (47:56):

We get shot before they can commit suicide. That's what I mean.

David (47:58):

But veterans are much higher risk.

(48:02):

So again, what we were saying about faith communities, when you are in that combat situation, when you are in the services, you've got all that support around you, you're part of

a very strong supportive community. When you're a veteran, that stuff's gone and that's when you are really, really high risk. So sometimes it's, it's not actually the level of threat or trauma or external stimulus that does the damage because you get that in spades when you're actually out doing combat. It's not having the support around you or not having the ability to cope or not having the protective characteristics as well. So it's always this balance of risk factors and protective factors. So you'll know from previous conversations, I have an interest in psychiatric genetics and for a long while I co-chaired the International Society of Psychiatric Genetics Ethics and Policy Committee. And we always just used to say, pick your parents carefully and your genes are this risk register. They're the lawrie card you are given. They're not determined, but they set your risk levels. So you and I will have slightly different risk levels for those triggers taking us into the wrong place.