Podcast Transcript

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mhpn Mental Health Professionals' Network

Book Club: What's the Risk? A Critical Response to 'Reformulating Suicide Risk Formulation'

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Presenters:	Dr Mary Emeleus, GP and Psychiatry Trainee Associate Professor Chris Ryan, Psychiatrist

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Host (00:01):

Hi there. Welcome to Mental Health Professionals' Network podcast series. MHPN's aim is to promote and celebrate interdisciplinary, collaborative mental health care.

Dr Mary Emeleus (00:18):

Hello and welcome to the Book Club. My name is Dr. Mary Emeleus, I'm a psychiatry registrar. I have a background as a general practitioner and psychotherapist, and I'm currently working in Queensland. Today we're going to be talking about an article called Reformulating Suicide Risk Formulation: From Prediction to Prevention. It was published in Academic Psychiatry in 2015, and it's written by a fellow called Anthony, or Tony, Pisani and his colleagues. He's from the University of Rochester in New York State. And I'm going to be talking about this article with Dr. Chris Ryan. I think I'm just going to ask you to introduce yourself, rather than me describing you in ways which are inaccurate.

Assoc Prof Chris Ryan (01:03):

That seems very sensible. So, I'm Chris Ryan. I'm a psychiatrist at Westmead Hospital in Sydney, and I also work for the University of Sydney, and I'm a consultation liaison psychiatrist. So, issues of risk and suicide are a pretty big part of my work. I've also done quite a lot of academic stuff around risk, suicide risk, and essentially its utility or lack thereof.

Dr Mary Emeleus (01:38):

Great. And I'm really looking forward to having this discussion with you, Chris, because I've read quite a few of your articles and found them really helpful. So, particularly as a GP, there was an editorial, I think in the Medical Journal of Australia in about 2010 that was really helpful. And then I'm aware that you've been involved in a big meta analysis of the data in about 2016.

Assoc Prof Chris Ryan (02:02):

I've done a few of those, but yes.

Dr Mary Emeleus (02:04):

Yeah, so I think it'll be a really good conversation about this particular article. So, it's obviously a topic that's clearly on the agenda nationally and in each state. And I guess in the state that I work in, there is a framework called zero suicide, which I think we might chat about a bit later as well. But I think this is a really important topic that a lot of people, understandably, care about and have an interest in. And as mental health professionals, I think we all would probably like to be able to think about this in more nuanced ways, I suspect. So, Chris, I met you through an MHPN webinar on the topic of suicide prevention some years ago.

Assoc Prof Chris Ryan (02:47):

Yes. Yes, we did. I thought it was a great webinar. There was a bunch of people, and we were chatting about, I think suicide prevention and also what to do after suicides, so not unrelated in many ways to the article.

Dr Mary Emeleus (03:04):

And I think at that time I hadn't any concept that I might train in psychiatry myself, and so subsequently am on that pathway. So, we've kind of, probably a little bit closer as colleagues now, although I've never actually met you in person, only through MHPN. But I imagine you have registrars in your teams, where you work?

Assoc Prof Chris Ryan (03:27):

Oh, yes. No, well, we've got four registrars in our service, and of course they rotate every six months. So, I have a lot to do with the registrars, which I really enjoy actually. It's a huge part of my job, spending time with the registrars, so it's great.

Dr Mary Emeleus (03:44):

So, I guess maybe moving into the article, one of the things that Pisani says was the purpose of writing this article is actually because it was a formulation that could be readily taught. So, he's actually in the business of teaching psychiatric registrars, in the US they're called residents, finding a way that people can consistently be taught to do a more rich formulation. And I suppose one of the things he's saying,

and it's in the title, is that we're moving from prediction to prevention. So, it's recognising that we can't predict risk.

Assoc Prof Chris Ryan (04:19):

Yes. So, I mean, it's an interesting paper, Reformulating Suicide Risk Formulation: From Prediction to Prevention. And he is, spoiler alert, I'm, it's going to be quite a lot negative about this paper. But on a positive side, it is about teaching, and it is about teaching a sort of slightly weird version of formulation. Formulation is the big thing in psychiatry training, really. That's, once you've got formulation right, you've pretty much got the idea. And there's not that much written on how to formulate. I think, to be fair, it's quite a difficult thing to write about, and that's probably part of the reason for that. But good on Pisani and colleagues for at least trying to do that. So, I think that is at least a tick, that they recognise that formulation is an important thing, and they've tried to set out a relatively straightforward way of setting out a formulation, and with the aim that you could teach that.

Dr Mary Emeleus (05:32):

And I suppose, just for people who may not be familiar with the idea of a formulation, it's really a couple of paragraphs, the purpose of which is to describe why this person has come with this particular problem at this particular time. And there are different perspectives or different paradigms with which you can view that question, but the idea is that it's a kind of richest story rather than a thin description, just a diagnosis or something. It's to be much more rich and person centred, I guess. Is that a fair description?

Assoc Prof Chris Ryan (06:04):

Oh, no, I think that's an excellent description. It's a concise telling of the psychiatrist's understanding of how this person got to be in this predicament at this time, drawing on the history that they've taken, drawing on the mental state examination, and also pulling in all their knowledge of psychiatry from the profession more generally. What's known about, for example, risk factors, what's known about diagnosis, what's known about causation, everything, all tried to be packed into this concise statement about what's going on for the patient. It is very difficult to do. It's actually literally impossible to do perfectly. Not surprisingly, you can't reduce someone's life into a few paragraphs, but it's a way of at least trying to understand the person and also possibly trying to be able to communicate your understanding back to the patient. So, it's a very central part of psychiatry, I think.

Dr Mary Emeleus (07:18):

Formulation is also used in a lot of the different psychotherapies. So, CBT therapists would do a formulation, psychodynamic therapists would do a formulation. EMDR therapists would do what they call a case conceptualization. So, that what you've just described is the psychiatric formulation. So, I think Pisani is using language that psychiatrists are familiar with, and then trying to put it into something that is teachable. And I suppose just for the audience, I'll just briefly describe what he does propose. So, through collecting the same kind of information that we would usually do in a risk assessment, if that's what we have in mind, and he does have an emphasis on other things, like strengths and resources, and available supports and things like that. But what he comes up with in the formulation itself describes what he calls the risk status, which are perhaps the longitudinal things that we might consider elevate someone's risk.

(08:23):

And I guess this is where it goes into stratification, even though he sort of starts off saying he's not going to do that. Anyway, there's the longitudinal elements, and then there's the risk state, which is what's happening for this person right now. Then there is foreseeable changes. So, the kinds of things that might happen, which might create more stress for someone, or might create improvements for someone, and then the available resources. And then he's got a quite teachable diagram, which is kind of easy to understand, a good reminder if you're trying to write this kind of formulation. That's just my kind of overview of it.

Assoc Prof Chris Ryan (09:00):

I mean, I think that gives you a good understanding of the sort of article that we're talking about. I mean, I think you and I weren't necessarily going to spend forever on the article anyway, but it's a good jumping off point for a discussion. I suppose, I mean I did praise it briefly, but for me, the big problem with this article is that it's obsessed with risk, and there's two problems with that. First of all, I don't really care that much about risk. I much more care about people, and how they're going, and how I can help them. I mean, the sort of formulation we were talking about right at the beginning, what's going on with this person? How do they get to be in this position? And following on from that, how can I help them best to get to a better position?

(09:59):

And the second problem is that most of what he writes about risk is just wrong. There's just really no basis for it at all. He actually quotes some of our papers, or at least one of our papers, which says that it's wrong, but then he just passes over that and he more or less says, at the beginning as you said, he said, well, you can't do this categorical risk thing, and then literally spends most of the paper talking about doing a categorical risk thing. It's a very peculiar paper, and it's amazing to me that it apparently has some influence on people who think about these things.

Dr Mary Emeleus (10:47):

Well, I mean, I think it's become quite important in the Queensland approach to suicide prevention, which as I mentioned before, there's a sort of zero suicide approach. And I understand that there are services in New South Wales that are also using the Pisani formulation, and teaching it.

Assoc Prof Chris Ryan (11:08):

Extraordinary.

Dr Mary Emeleus (11:09):

Do you know, Chris, it's funny we haven't discussed this before, but it just occurred to me, it's a little bit like the debate about validity and utility in diagnosis.

Assoc Prof Chris Ryan (11:19):

Yes.

Dr Mary Emeleus (11:20):

So, I wonder if it's useful, while not necessarily being particularly scientifically valid. Is that a reasonable question?

Assoc Prof Chris Ryan (11:29):

No, no. It's a very reasonable question, but it turns out it's not useful at all. In fact, in the very first paragraph he says that there's little evidence for its validity, reliability, or utility. He's actually wrong. He's right that there's little evidence for the validity and utility, in fact, there's essentially no evidence for validity and utility. In fact, the reliability, which is how often you might be able to repeat it and get the same answer, is pretty good.

Dr Mary Emeleus (12:01):

So, he's talking there about the risk prediction has no reliability or validity, is that what you're meaning? Because I think I was meaning his model. Has his model got some usefulness, even if it is on a bit shaky foundations?

Assoc Prof Chris Ryan (12:18):

No, I don't think so. I mean, because his model's not on a bit shaky foundations, it's on sand. There's literally nothing there. I should probably explain this a little, because not everybody who's listening is going to know that much about suicide risk assessment. So, just to be clear, it is very clear, there's oodles of evidence about this. So, it's not like it's in any doubt really, that there is no useful way of dividing people who present in some sort of psychiatric crisis to an emergency department, or find themselves in an inpatient ward or an outpatient department. There's no useful way of dividing them into those that are at higher risk of future suicide compared to lower risk of future suicide. And to the extent that he's saying that, that's great. I mean that's true, but beyond that, he sort of admits that right at the beginning, but then he just goes off in weird ways. I don't want to spend too long on it, but we might just look at the risk status idea, unfortunately he calls one risk status and one, what's the other one? Risk state, almost exactly the same word.

Dr Mary Emeleus (13:51):

I must admit, I do find that really confusing. And I never did Latin, and so I know status has a particular meaning, and I feel every time I have to look it up, that is a bit confusing.

Assoc Prof Chris Ryan (14:02):

Yeah, I mean, I'm not sure it's the lack of Latin. I think they're very similar words in English, but just to take the example of risk status, he has this sort of way, in the article, he presents a case, it's a US case, and it's a gentleman who comes in, and he's told his GP that "anything could happen when you're cleaning your gun". And the GP has obviously taken this as, oh, that could be a significant thing to say. And he sent him in. And it turns out that this guy is in his fifties, and his wife was recently unfaithful, and he's pretty unhappy, and he goes out and gets drunk from time to time, and he does in fact have a gun.

(14:48):

And we're given this little snapshot of this guy at the beginning, but not nearly enough history or context to provide any sort of actual real formulation about how this gentleman, Mr. Colban is going. I mean, you couldn't possibly provide a real formulation. But then, when we're talking about risk status, which according to Pisani is the risk compared to others, there's this dialogue where the wise tutor says, could you indicate Mr. Colban's risk compared with the general population? So, this is a guy who's talking about blowing his head off. He gets drunk all the time, he's got a gun, and his wife has recently been unfaithful to him. And the trainee says, with respect to the risk compared to the general population, I would say higher. He's had some past suicide attempts and some ongoing depression. Yes, his risk of suicide, his likelihood of suicide into the future is higher than the general population.

(15:57):

I mean, no shit, Sherlock, what did you think it was going to be? And it just goes on, because then he wants to know what about the risk compared to general outpatients? And he says, well, it's about middle of the road. But we know that there's no way of usefully dividing people by their risk, by their likelihood of future suicide. So, it's not really middle of the road. The answer to that question is, well, in terms of the likelihood of future suicide, I don't know. I can't tell you. Yeah, it's definitely higher than the general population. That's true. And because the general population risk of suicide is so low, fortunately, even if you're much, much higher than the general population, your absolute risk, the chances of you actually killing yourself, are still very, very low. So, you can say both of those things with assurity. But none of that's actually now all that useful, about how we're going to assist Mr. Colban. I mean, what could that possibly help us with?

Dr Mary Emeleus (17:05):

He does sort of talk about that this kind of formulation can then inform a person centred individualised support plan, to help the person with whatever issues are going on for them. And as you pointed out, that can arise from any kind of formulation. But I mean, because in CL psychiatry, you must be having to make decisions about people that you're going to discharge or not discharge every day.

Assoc Prof Chris Ryan (17:30):

Yes. Yes, we do.

Dr Mary Emeleus (17:31):

So I wonder, how do you do that?

Assoc Prof Chris Ryan (17:35):

Nothing, literally nothing to do with risk. Risk does not come into it. We do not consider risk at all. The likelihood of future suicide is not something that even crosses my mind when I'm talking to a patient in the emergency department.

Dr Mary Emeleus (17:54):

And that's so interesting to me. It's kind of just a different way of talking about it, isn't it? Completely different to what we're used to.

Assoc Prof Chris Ryan (18:05):

Well, I mean, it's not completely different to what we're used to. I mean, admittedly, I didn't have such a clear idea on this until we did a lot of research on it. I sort of had a notion about it, but it was one thing to have a bit of a notion, it's another thing to have a whole bunch of empirical data to back it up. But the empirical data is pretty clear. You literally can't usefully separate people out by their likelihood of suicide. So, everybody in the emergency department that I'm seeing is at increased risk of suicide compared to the general population, and I can't tell between person A and person B sitting in the emergency department. I can't separate them out. So, you can see that, of course, risk is going to be a part of my thinking. I literally can't say anything useful about it, so I won't. I'm much more interested in finding out what it's like for this person, what's going on for them, what supports do they have? What diagnosis might be relevant to them? What treatment are they interested in taking? How can I get their family involved? All these sorts of things. They're the things that govern the decisions. Risk can't, because I can't say anything useful about it.

Dr Mary Emeleus (19:25):

The idea of risk does make you, as a practitioner, anxious.

Assoc Prof Chris Ryan (19:29):

Yes.

Dr Mary Emeleus (19:29):

I know that I can't think as clearly if I'm really worried about something, particularly in clinical decisions. So, I guess what you're saying is that you're then really able to just focus on the person, and their situation, and their experience, and working together on how to come up with a plan to be helpful.

Assoc Prof Chris Ryan (19:49):

That is literally what I'm saying. And I'm not anxious because, I mean, sometimes I'm anxious because I'm letting a person go home, and I think, this could go badly. But that's not a risk thing, that's just being a human. That's just normal human nature. But I'm focused on trying to understand this person, and trying to work with them about where can we go from here? What resources have you got? What can we pull in to make things better for you? I literally don't consider risk at all.

Dr Mary Emeleus (20:33):

So, can we, I would be really interested to hear from, what you think about this kind of concept of zero suicide. Because I have a kind of philosophical difficulty with it, and I know a lot of people do, but one of the sort of aspects of the zero suicide policy is that it's actually that clinicians need to believe that suicide is preventable, and that the leadership leads people into that belief, and we have to have that

belief in order to do our work. And I feel, I'm a bit conflicted about that, and I imagine you've thought about it.

Assoc Prof Chris Ryan (21:13):

Yes. So, zero suicide, for those who don't know, and it is a bit tricky because different people mean different things by zero suicide, but I think probably the most common view is the idea that once a person has touched a mental health service, so, typically people in favour of zero suicide recognise that if nobody came to see them, there's nothing they can do about it if a person suicides. But once a person has been seen by a mental health service, then the aim is, the strong aim is, and the achievable aim, I think that's an important part of it, is that there would be no suicides in that group. And so it's not that suicide is preventable, because yes, I mean, I have no problem with, we can do things to make suicide preventable in the sense that we can make it less likely to occur.

(22:17):

I mean, I'm not that interested in risk in terms of the assessment, but I'm keen to help people in various ways, and I would like to think that if I can do that properly, it's less likely they would kill themselves. I mean, to be honest, that's not really the main reason I'm doing it. I think hardly anybody kills themselves, fortunately, and I don't want people to kill themselves. So, it's good if people don't, but there's a lot of suffering that's associated with psychiatric illness that's not killing yourself. I want to make things better in that more holistic sense. And if we can cut down the number of suicides, well, that's all good. Nobody wants suicides. I think everyone agreed they're bad. The idea though, that you could literally meet, you could literally have people come into a psychiatric service. So, these people that are, we know are much more likely than the general population to suicide at some point, and literally turn the frequency of suicide to zero. No sane person could believe, I don't think that's ever going to be true. It's certainly not true now, and it won't matter what we do. That's not going to happen.

Dr Mary Emeleus (23:41):

I think that was really helpful, that you've just clarified that it's really about once people have had contact with a mental health service. Then that becomes the goal, that if we are able to provide the right kind of help, and the right kind of support, then people might be able to see other options again, rather than just the narrow option of suicide.

Assoc Prof Chris Ryan (24:02):

Well, completely. And I mean, I hope we can do all of that. I mean, I hope that's certainly the case, and I think that's what we're here for. Although again, I'm less focused on actual suicide than I am on actually helping people. But yes, that will be a byproduct of that. But the idea that it is possible to eliminate suicide in that population seems fanciful, I'm afraid. I mean, it'd be great if it was true. I mean, don't get me wrong. If it were possible, I'd love that. I mean, who wouldn't? But it ain't.

Dr Mary Emeleus (24:44):

And there's plenty of people, including the consumer rep that came to the webinar that we had a few years ago. I mean, he stated really clearly that if he was suicidal again, he wouldn't be going to a mental health service. There's lots of people who've had suicidal crises and have not found the response from

the mental health service helpful. So, I think what you are talking about, that our goal is actually to be helpful, and to assist people with what they need, whether that's treatment for illness, or psychotherapy, or solving problems, or advocacy, or the many different kinds of things that health systems can do. So, it's a kind of more holistic view, I guess, rather than just focusing on that goal of prevention of suicide. It's providing care.

Assoc Prof Chris Ryan (25:34):

I mean, completely. If people, and they are, and you're quite right, if people are saying to themselves, well, when I'm in a bad way, I'm not going to go back to see a mental health service, then that's failure, then that's clear. We've screwed up there somehow, because that's our job. And that's pretty much hanging from the door. Come and see us if you need some help. And if some people, I mean, fortunately, not everybody, but some people definitely do, have not found that then, well, we've failed there. We're not going to be able to help everybody, but we should definitely be striving to help everybody. I'd be much happier with that. Zero unhappy people. I mean, probably equally unachievable, but at least it sounds like it could be.

Dr Mary Emeleus (26:28):

I think unhappiness is a part of the human condition, as you know.

Assoc Prof Chris Ryan (26:32):

Yes. Perhaps zero unhappy customers might have been better.

Dr Mary Emeleus (26:34):

Dissatisfied.

Assoc Prof Chris Ryan (26:36):

Yes. I like to keep customers happy and give them largely what they want, sometimes what they need, and then try and make those two the same.

Dr Mary Emeleus (26:49):

Yeah, it's such tricky territory, but I'm finding this really helpful to kind of think through. It's actually the holistic care provision that we should always have been doing.

Assoc Prof Chris Ryan (27:06):

Yes. I mean, I can't see that there's, what else would we be doing? That's the whole game, isn't it? And there's this idea of zero suicide, which by the way, there's literally no evidence for, no one has ever done it. No one's even tried to do it, actually.

Dr Mary Emeleus (27:28):

Do you mean in a population in general, or within a health system?

Assoc Prof Chris Ryan (27:32):

Within a health system. No one has ever driven the suicide rate down to zero. Hardly anybody has tried, and it hasn't happened. I mean, in some ways that's boring, of course it hasn't happened. It's literally not going to be possible. But forget about it, don't worry about it. That wasn't the game anyway. It's a very strange idea to have. I think it's largely because zero has a Z in it, and it's sort of good for selling, or something. I don't know.

Dr Mary Emeleus (28:08):

I don't know either. I mean, I guess I come from a psychotherapeutic background and I have different ways of thinking about suicidal crises, and the Jungians would view suicide as a crisis of the soul. And the soul is not so much in a spiritual sense, but it's kind of your essence of who you are as a human being. So, I think this kind of military idea of elimination or extermination is just kind of shocking, if you're using that kind of language, because it should be about compassion and understanding and complexity rather than a simple solution, I think.

Assoc Prof Chris Ryan (28:52):

Yeah, I mean, it does. It's interesting you should say that. It does bring to mind the war on drugs, for example, which was more about a slogan, which actually did, look, a great deal of harm. I'm not necessarily saying that zero suicide is likely to do a great deal of harm, although I mean, I guess I might. So yeah, I think yes, I'm not a big fan.

Dr Mary Emeleus (29:21):

I can tell. So, I'm just thinking, I guess coming back to what, I've had that idea a few minutes ago about the idea of validity and utility. And so I suppose for me, the Pisani, the idea about asking someone about their life, and their history, and their resources, and their strengths, and seeing them as a whole person could be done within this model of formulation.

Assoc Prof Chris Ryan (29:50):

I mean, it could, but why would you? It's got risk all over the shop. Why would you have?

Dr Mary Emeleus (29:58):

Well, it's in the title.

Assoc Prof Chris Ryan (30:00):

If you literally took, well, it's in the title and it must appear, I don't know, probably a hundred times in the article. I mean, the article might be quite a lot better if he just deleted the word "risk". It wouldn't really make any sense then.

Dr Mary Emeleus (30:15):

Just a formulation.

Assoc Prof Chris Ryan (30:17):

And just, yeah, found some way of teaching formulation. This is not useful, in my view. It's actually distracting. It's baseless, and possibly harmful.

Dr Mary Emeleus (30:30):

I'm not sure whether people have responded to it in the literature, actually. I don't know.

Assoc Prof Chris Ryan (30:36):

It's been largely ignored, which is not surprising, it's a really poor article. But oddly, certain health departments in Australia have picked it up. I think Pisani has been invited out here, and it seems to fit very well with the zero suicide thing, which has also involved a sort of American chap coming out. There is a sort of cargo cult thing about it.

Dr Mary Emeleus (31:08):

And I must say, I did attend a training with Pisani, and he was really very compassionate and humanistic and pleasant, and I would've felt quite comfortable to talk to him if I was having a crisis. So, I do feel like I need to say that, he did seem like a really nice guy, and he was a good teacher. And the other thing was that he presented with a mental health consumer, and that was really helpful. But yes, he has come out to talk to different health services about this model and this approach.

Assoc Prof Chris Ryan (31:42):

Yes, I mean, look, I'm sure he is a nice guy. I mean, these people do tend to be also excellent presenters, often very, I haven't seen Pisani, but the zero suicide chap that's often sort of touted is a guy called Coffey, and he's larger than life. He literally has nothing to talk about except his experience in his HMO, which didn't actually show anything, but he's got all the moves.

Dr Mary Emeleus (32:18):

Chris, I knew this would be a lively conversation. Do you think there's anything else that people, that we can leave people with, or that people might be interested in about you know what, because I think we're helping professionals because we want to help people. So, I think what I'm hearing you say is, be present. Listen to the story, bring everything you've got, be creative, be collaborative, work with the person's family, make shared decisions. As we said earlier, the kind of things that hopefully we're doing anyway.

Assoc Prof Chris Ryan (33:04):

Yeah, and it's tricky, right? It's not the sort of thing that you can easily put into an article. As I said at the beginning, good on Pisani for trying, but unfortunately, he's failed. And that's just the way it goes. There's plenty of people, I mean, I've written a whole bunch of shitty articles myself, so I'm not having a go at him for that. But yes, that's the game. That's what it's about. It's about trying to understand people, and then trying to help them, and help them to help themselves, and help their family to help themselves. It's an incredible privilege that those of us who are in this game are given, and it's important

that we approach it with all the subtlety and nuance that it deserves. And trying to reduce it in some sort of way to some statement about the likelihood of future suicide is distasteful, really, leaving aside the fact that it's literally useless and has no basis in fact. I'm sure it's meant with the best intention, but I actually find it difficult to stomach.

Dr Mary Emeleus (34:27):

Yeah. It's made me think about the idea in narrative therapy of a thick description and a thin description, and I think a really rich, nuanced formulation is a thick description. And I guess I kind of thought that this has the potential for that, in a way. But what you're describing is kind of much richer again. And it also made me think about the different perspectives that different disciplines are going to bring to the conversation. And in fact, the day I went to the Pisani training, I was working in a health service where, there was, remote clinicians would ring in for advice. And I actually got phoned up for advice about a 13-year-old in a remote community. And the clinician had needed to see that person, and make some decisions. And she went with the Aboriginal health worker, and the Aboriginal health worker said to me, we need to talk to this girl about culture. Because, she wasn't Aboriginal, but one of her parents was from, not born in Australia. And there was a very significant cultural issue that I hadn't even noticed, which the Aboriginal health worker beautifully pointed out. And I just think the value of different people's training, and perspective, and experiences adds to that richness, and the ways in which we can be helpful. And I'm not sure that that always gets celebrated as much as it should be within our health systems.

Assoc Prof Chris Ryan (36:04):

No, I mean, I think that's right. And I said right at the beginning that in many ways, formulation, in the way that we described it at the beginning, is impossible. And it sort of is. It's always going to be imperfect, and I think it's important to have appropriate humility about that. And there's going to be plenty of times where somebody's going to open a door and shed a whole new understanding on things, which just sounds like what had happened to you, and that's great. That's great when that happens. It's like, oh, yeah, okay. I didn't even think of that. Which, by the way, I've been doing this for a long time, but that happens quite a lot, even with me. But that's also what makes the job so great.

Dr Mary Emeleus (36:53):

Yeah. Look, I agree. I think I also find it a great privilege to do this kind of work, and it is endlessly interesting.

Assoc Prof Chris Ryan (37:03):

Endlessly.

Dr Mary Emeleus (37:04):

People are so generous, I find. So, maybe that's a good note for us to finish. What do you think?

Assoc Prof Chris Ryan (37:11):

It sounds like an excellent note to finish on.

Dr Mary Emeleus (37:13):

Okay, well, we would really like to hear your thoughts on this particular episode, as well as any ideas for future content for other episodes. And there will be information next to the show notes about the article that you can find, and it is actually freely available online. You can just Google it and you'll find a PDF copy. And make sure that you listen to the next episode of Book Club. So, thanks for listening. It's goodbye from me, Dr. Mary Emeleus, and from...

Assoc Prof Chris Ryan (37:45):

Me, Chris Ryan.

Dr Mary Emeleus (37:47):

Bye everybody.

Assoc Prof Chris Ryan (37:48):

Bye.

Host (37:50):

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