Podcast Transcript

Online Professional Development for Mental Health Practitioners

mhpn Mental Health Professionals' Network

In Conversation With…Dr Ruth Vine, Dr Sarah Cavanagh and Priseena Radha

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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 Ruth Vine (00:18):

Hello, and welcome to this episode of MHPN Presents: In Conversation With. My name is Ruth Vine. I'm a psychiatrist by trade, I'm based in Melbourne, but I'm currently working with the Commonwealth Department of Health in the role of Deputy Chief Medical Officer. That sort of means that I get to have a bit to do with workforce, and a bit to do with policy and quality, and we'll touch on some of those things today. Today, I'm joined by Sarah Cavanagh, clinical psychologist and Priseena Radha, mental health nurse. Hi Sarah, thanks for joining me.

Dr Sarah Cavanagh (00:50):

Hi Ruth. It's great to be here.

Dr Ruth Vine (00:52):

And Priseena, welcome.

Priseena Radha (00:53):

Hi Ruth. Thank you. I'm looking forward to the conversation.

Dr Ruth Vine (00:56):

And indeed, so am I, so thanks, Priseena. Today's episode, what I'm hoping to do, is to explore some of the merits, some of the challenges, some of the opportunities of working in the mental health sector. Each of us here with you today currently work in the sector. But I have to say, we've got different roles and very different career paths, and we're going to explore that a bit. We'll spend a bit of time describing our roles, and why we've chosen them, or how we came to them, and then try and think a bit more perhaps from a patient journey perspective, of how someone might enter the mental health system, different places that they might receive treatment and care, and some of the areas that we think the system could improve in. And look, I promise this will be a warts and all. I'm expecting both Priseena and Sarah to be absolutely honest with their career history and their current roles, so that our listeners take home a real understanding of the sorts of work that we do.

(01:49):

And of course we're only going to touch on a bit, because only three of us, but a bit of an understanding of what can be achieved in public mental health, but also in other parts of mental health. And you never know, our paths may cross. So, Sarah, I might start with you. You told me the other day that you'd been wanting to be a psychologist since you were 15. If you could perhaps just talk a little bit about how you got to be where you are, and whether it's what you thought you did want, if you look back to that 15-year-old self.

Dr Sarah Cavanagh (02:18):

Yeah, happy to talk about that, Ruth. I was really lucky in year 11 and 12 to do psychology as part of my college degree, our college certificate in Canberra, and had a really great teacher who was just wonderful in terms of introducing, I guess, the topic of psychology. And I just found it really fascinating, and I think to this day I still find people, and the way our brains work, and the way our emotions interact with our behaviours, still find it very fascinating, and it's kind of what keeps me interested in psychology. It has been a long journey to become a clinical psychologist. So, I did my undergraduate degree, and then worked for a while, and then decided I wanted to go back and do my fourth year in psychology, which I did part-time while working. Then after that, a doctorate in clinical psychology, which I also did part-time while working.

(03:08):

Luckily, working in the Department of Health, and eventually finding my way to a policy position in mental health. It was sort of why I joined the Department of Health in the first place, but it was to work in mental health, but worked in lots of different areas, and actually think it is been really rewarding to work in the Commonwealth Department of Health, and in the sort of policy programe project areas of health and mental health in particular. So, I feel really lucky to be able to do clinical work and work with individuals, but also to work at system level and in reform, which is, I find, really exciting as well.

Dr Ruth Vine (03:47):

I mean look, certainly one of the reasons that I got into mental health, I think, is that it sort of gives you a bit of a licence to be curious, doesn't it? A licence to be curious about other people, about their lives, not in a voyeuristic way, but in a way that you hope will be able to bring therapeutic benefit. And Sarah, we'll come back later, because you just touched on about four different, completely different systems. Be it government work, clinical work, or as you said now, policy. And I know now you're at the absolute cutting edge of some of the digital bits and pieces, so we'll come back to that. But Priseena, you also took a rather winding path to get into mental health, and when we were talking the other day, you explained that you'd been a nurse for quite a long time, but a mental health nurse not for so long. Why did you jump ship from general nursing, and go into mental health nursing?

Priseena Radha (04:37):

It's very interesting. When I look back in my career, I can see that it was a big journey and a very big transition that I had taken, a very important decision in my life, in my career life. And I did my general medical nursing for a couple of years, maybe more than seven years to eight years in medical and surgical acute department, I did, and I started my career with Royal Melbourne Hospital in 2019, and by keeping kindness in friend and a patient and dedicated approach, I started working in different departments of medical and surgical, including cardiology and neurology, which was my background. I wanted to know, what is really happening in these patients who have mental illness. I used to look at them like, they have mental issues, but what was really happening? How this alcohol and the drug work in them, and how can we improve these conditions?

(05:39):

So, I really wanted to get into that. I never thought that I would take mental health nursing as my career. Then, I have joined with the John Cade department in Royal Melbourne Hospital, which is one of the most wide area of nursing skills, and most of the clinicians, and they all have given such a huge support for the medical nurses like me. I entered there and I have seen this different conditions, from eating disorder through several mental illness comorbidities with alcohol and drug issues. We started looking into the policies and the procedures, implementing evidence-based interventions. I started learning about more about the CBT/DBT motivation interview, how to improve the patient with the least restrictive practices, how can we improve a patient's mental status without medication by having a proper communication with them, and by developing that trust. And I found that, something incredible, some job satisfaction and I wanted to learn more. I'm still learning. I am doing my master's. I wanted to do some research in the future, and this is one of the best experience I have had until now.

Dr Ruth Vine (06:53):

And Priseena, so you're in a very acute unit, and as I said before, we'll try and take a bit of a patient journey. But just before I leave you, I've worked in John Cade too and I know that there's a lot of pressure on throughput, and there's always more people coming than you want to go. What do you think is the most difficult thing about your current work? You've said some of the very positive things and the benefits you bring to those you work with, but what would you say were some of the hard parts?

Priseena Radha (07:25):

Some of the hard parts, since the Covid pandemic, we have seen that many nurses have been resigned from the job because of the pressure they are having, and the workforce. And we have an influx of medical nurses, increase of medical nurses into the mental health nursing, and we have given lots of training for them. We are giving them most of the patient care approach, how to approach these mental illness patients along with their physical illness. The most difficult part I found is some of the time we have a short staff, and we are encouraging most of the medical nurses, come to the mental health, but we are managing it in a way that most of the time our managers are on the floor, psychiatrists are on the floor, and they're helping us, a multidisciplinary team approach and that makes our days very good. So, I found that since COVID-19 pandemic hit was difficult with the workforce, nursing workforce, otherwise with the job satisfaction, I'm completely sure that we were fine.

Dr Ruth Vine (08:29):

One of the things you've just mentioned, and it's a really, again, it's probably one of the reasons that I stayed in the public system, but the notion of being part of a team, and particularly part of a multidisciplinary team. So, Sarah, if I could flip to you, psychologists are a pretty important part of that team. I think in your career you spent some time working in Headspace, you clearly also work as part of a team in the department as well. But if you were going to say to our audience, who I think will be a mixture of people who do work in mental health and those who don't, what does a psychologist, particularly a clinical psychologist, bring to the multidisciplinary team?

Dr Sarah Cavanagh (09:08):

I think that, well just wanted to say I think working in a multidisciplinary team is really fantastic when you can make it happen. And my clinical practice at the moment is in a private practice as an employee, only working clinically one day a week, with my colleagues in the practice who are also psychologists. But we have I guess built up our network of other disciplines, and other providers that we kind of connect our clients to. But I think in terms of psychology and what we bring, I think from the clinical perspective it is that, I guess additional training that we do around understanding mental health disorders in particular, and the clinical presentations that people come with. But I also think just broadly in psychology, it really is, and this is probably not a traditional answer, but I do think it is that curiosity that we bring to really kind of understanding what's happening for the person in front of us, and being able to think about their childhood experiences, and the experiences that they've had in their family of origin and growing up, as well as more recent experiences and how all of that has combined to find themselves in the position that they're in now, and to be able to work with people to identify the things that are really working well for them and they want to keep doing, and the things that are not working so well.

(10:31):

And so, that might be around unhelpful thinking that's happening. It might be about unhelpful patterns of behaviour that they're in, or relationships that they're in. And so, I think the lens of that psychosocial holistic view of the person, and trying to work with them, and acknowledging that they're the experts on their lives and what we're there to do is to really facilitate a process of helping and healing.

Dr Ruth Vine (10:57):

That's a lovely answer. And I mean, one of the things that I quite like about our current multidisciplinary group, the three of us here, is that we do all come from different clinical professional backgrounds. I'd have to say that I would have to think of myself as a very late career psychiatrist. And Sarah, I'm going to plunk you somewhere in the middle, and Priseena I'm going to say you are still what I would call an early career, early yes. Even though you clearly had a lot of experience in other areas. But Priseena, when you sort of think about that career progression, do you also think, oh, I'm going to need to get some experience in the community or oh, I need to sort of think about the other areas within mental health that nursing can bring a particular facet or particular skillset too?

Priseena Radha (11:43):

Yes. I had an aim to do some research when I moved to Australia, so PhD research in a particular area in nursing. And when I started my journey with the mental health nursing, I have got support and the training from the transition programe department from the Northwestern Mental Health, and from there the education department, they have given us more clinical supervision, one-to-one basis. And they trained us, given lots of in-service education. And when I am standing on my masters, and I'm looking forward to do some research in implementing more least-restrictive practices in mental health settings, because we have seen that by incorporating more psychotherapeutic intervention, these patients can get well, and they improved their wellbeing. So, to eliminate the restrictive practices, or to eliminate the seclusion episodes in mental health settings, something that we can do if we work together as mental health nurses.

(12:46):

So, that I have experienced personally, for example, we had acute patient, acutely ill patient, who were highly disorganised on one night shift, whole 10 hour shift. And, patient-centered care approach, we have worked with that particular patient on a one-to-one basis by giving the music therapy as a simple iPod we have given to the patient. The patient had been listening to that. So, that has shown that the music therapy as the least restrictive intervention has improved that wellbeing by the morning, even though the other patients are waking up. But we had done something, that patient-centered care approach and that given me a lots of satisfaction, and I found myself that yes, I want to do a research and this, I want to do a PhD research in the coming years to prove that we can eliminate this restrictive practices.

Dr Ruth Vine (13:38):

What you've just sort of highlighted I guess, is that within mental health, and of course this is only mental health, I'm sure within renal medicine or lots of other things, there are, but particularly I think within mental health, there is the capacity to work across community settings, bed based settings, research settings. Sarah's mentioned that she spends time in private practice. And the other thing you've just highlighted Priseena, and I might just elaborate on this a little bit, because you've mentioned your strong desire to reduce the use of restrictive interventions. And what we mean by that, is that for some people, when they are very, very unwell, when they have particularly, perhaps, a very severe mood disorder or a very severe psychotic illness, they are very disorganised. They can experience a lot of impulsivity and a lot of shifting of emotions and thoughts. And so sometimes, that is managed in a way that is by using a thing we call seclusion, which effectively is placing a person on their own, in a room from which they cannot exit.

(14:37):

And that can be very traumatising. Sometimes it's the only thing. But as Priseena, you've just highlighted, there are alternatives to try. And you've mentioned one, which is giving a person a distraction of music to listen to rather than perhaps the other things going on. But let me switch focus a little bit, because we've sort of mentioned the patient journey, Sarah, at the moment, I know that you are doing work on a really exciting development, which is about improving digital mental health, which is sort of in a way the front door. It's where someone who's a bit worried, or a bit worried about someone might go for information and also even do a bit of an assessment. Now I know it's very new, but do you want to just talk a little bit about what you think, on that patient journey, that first front door, that you think digital mental health might be able to offer?

Dr Sarah Cavanagh (15:24):

Yeah, I think you're right, Ruth. I am working on a new national mental health platform, that has been announced by the government in the last budget, to sort of take the current headtohealth.gov.au website and transform that into something that works better in the digital space, to be really able to get people to the right information and the right services that they might need for their mental health and wellbeing, as seamlessly and as quickly as possible. And so, I do think that some of the advantages from the digital space is that they can be accessed anywhere. It doesn't have to grapple with the workforce issues and geographic issues that we have in the country at the moment. And being able to provide digital mental health treatment programes, in particular, that have good strong evidence base and can be really effective, and which are really useful for people who may not need face-to-face clinical treatment, or who may not be able to access it in their local area.

(16:28):

So, I think that there's a lot that the digital space can do, but I think the other thing that we're working on in our new national platform trial site is also trying to integrate better between those digital online services, and face-to-face services, and how do we actually move people through the stepped care model to get them to the right treatment at the right time? Because some people definitely do need more intensive treatment, and do need some of that face-to-face or in-person assessment and treatment. But there's a large chunk that can really benefit from the online treatment, which also then helps us tackle those bigger issues. I think some of what Priseena was talking about is also about managing demand, and workforce issues. And I do think psychologists have a particular role to play in the mental health system in those sort of therapeutic approaches, and the alternatives to medication, and the kind of restrictive practices. But I do think we don't have enough psychologists in the country, and they aren't in all of the acute mental health settings, or all the community-based mental health settings, when I think there's a real role there. And so, it's how do we address that issue in terms of not having quite enough workforce to meet demand?

Dr Ruth Vine (17:44):

Well, that's a whole other issue. That's a whole other issue. And of course, some would say that we don't have enough, but we also are not very good at having the right distribution. And we're probably also not very good at making sure that people are working to their full sort of scope of practice, or their full sort of professional breadth all of the time. But Sarah, thank you for that. And I guess this is not a one directional thing, but I'm being a bit artificial here, but I guess the availability of digital platforms, as you said, should be easily accessible. It's very broadly accessible.

Dr Sarah Cavanagh (18:23):

Yes.

Dr Ruth Vine (18:23):

We're going to try and find ways of making it feel appropriate to people, whatever their age, whatever their cultural background, give people better links. And then you've also just touched on, that a lot of services happen in the community, particularly through psychology, both clinical and nonclinical psychologists, but also a whole range of other professionals.

(18:45):

But of course, some people either need more than that, or they have a type of mental illness. And Priseena, you mentioned before that there's a whole range of very, very different mental illnesses, an eating disorder is a very different thing from a bipolar effective disorder, which is a very different thing from an anxiety disorder, with very, very different treatment approaches needed. And also, I think Sarah, you also mentioned the importance of a person's childhood, and development, and their experience in their family, which sort of influences how a person might present. But Priseena, you're working currently in a state-funded acute unit. Would most of the people in your unit, I know you've talked about non-medication means, but would most of the patients need some sort of biological treatment, in your current unit?

Priseena Radha (19:33):

Yes. Most of our patients are dual diagnosed patients, and also with the first episode of psychosis and alcohol and drug disorders, like you said Ruth, like as Sarah said, borderline personality disorder, bipolar disorders and several type of illness, even depression and generalised anxiety disorders, and these all patients are having, we know that they're under psychotropics, first generation and second generation antipsychotics. So, when we look into that first generation, second generation antipsychotics, antidepressants and antipsychotics, we know that the effects, and the side effects of these medications are huge. So, in terms of caring them, we do them physical, we do look into their physical illness, as well as their mental illness. And in terms of the biological factors, we start with their general observations, and we find out if the patient's mental status, how the patient's mental status is, whether the patient is low in their mood, and in their general observations, whether their blood pressure, their pulse rate, if it is normal or not. And, for example, if the patient is on clozapine, we look at for, the simple example is, we look at the heart rate, we look at their bowel movements and we look at whether they have a good input and intake and output.

Dr Ruth Vine (21:05):

So, you're really highlighting there, I think, that as a person presents with a more, if you like, more severe or more acute illness, they're often going to need treatment of different kinds. One of those kinds might be the biological kind you're talking about, very much a medical model of monitoring medications, side effects, the physical illness. And alongside that, you're also of course talking about the need for observation.

Priseena Radha (21:30):

And for example recently, Ruth, we had a patient who is in intensive care area who had hyperemesis. And immediately, we nurses, we made a look at the patient's blood test results and we found that the potassium is low, and we register as a concern to the on-call registrar in charge, we immediately informed to the on-call registrar in the evening. They overlooked into the patient, we took the ECG, and we found there is a variation in their T-wave. That's it, here we go. We had to transfer the patient to the medical ward, potassium infusion, the patient came back to the mental health ward. Finally, the patient discharged with lots of satisfaction. This is what we are looking at.

Dr Ruth Vine (22:12):

Look, I think this is a really important part, because often the treatment is complicated, but I think it's really important that we emphasise just how effective those treatments can be. Now sometimes, people need to receive treatment for a long time, and that can be psychological. Sarah, you've probably got some people who you've been with for months or longer. One of the key aspects of what we would term recovery oriented care is making sure that we are quite appropriately conveying hope about improvement. Sarah, if you were to, I mean probably in your career you cared for people who did have a very significant episode of illness, and then subsequently recovered or needed further recovery. Can you talk a little bit about, if we're thinking about that journey, there's the front door, there's people who do become unwell and even need inpatient care, and then there's that sort of follow up or continual monitoring or support in the community. What's important about that?

Dr Sarah Cavanagh (23:09):

I think there's lots of things that are important about that. I think one of the things that we're thinking about from the digital perspective, but also as a practitioner in private practice, is also around meeting the client's preferences, and the client's needs for how they would like to access support for their mental health. And I do think that also sits within the kind of recommendations that we might make clinically around the kind of support and treatment that they should access. But also, I do think that it kind of comes back to that multidisciplinary approach, and multi-service approach, where we do need the ability for people to move through the different levels of care that we provide across community settings, in private practice, state mental health, and inpatient services depending on their need, and how they're travelling with their mental health. And so, I think they all have a really important role to play.

(24:09):

And definitely in private practice, I work a lot with speech pathologists and OTs who are available in the community to help support my clients, as well as making sure those that are, particularly around medication, that we're constantly liaising with the GP, and also psychiatrists where needed, and really all of that kind of, I guess coming together to support people through. And I do think your point about hope is really important, Ruth, the reason I'm still working in this space is because I have hope, and I often talk with clients who are feeling maybe a bit hopeless, that I have hope for them. And I know from the evidence, and the experience of working with clients, that there is hope for recovery and that things can be better, and I can hold that hope for them if they're not quite ready.

Dr Ruth Vine (24:58):

And indeed that's such an important word, the holding. Because, sometimes one of the most important things we can do in our work is offer that sense of containment. It's not a physical containment, it's an emotional containment, but around that it's okay, they can be safe. You've both touched on the importance of team, and working across with other professions, but I think one of the other things that I hope we are very aware of in this area of practice is the need for our own supports and supervision. So, I know I've been in a peer group forever and a day, and it's a place where you can talk about the things that haven't gone right, and you can offer support to people who are going through pretty difficult times. Priseena, within your work setting, what are the sorts of supports that are available to you? If you've had a bad shift, if you've got a difficult person, if someone has been involved in an aggressive incident, what are the sort of supports that are available, or you think should be available to you?

Priseena Radha (25:59):

Yeah, like Sarah and like you said Ruth, that we have a wide multidisciplinary team over there in our unit. And if we have a difficult shift, I can see that our managers, our clinical nurse consultant, even psychiatrists like Dr. Jennifer Deck, they all are on the floor and they all help us. And the social workers, the occupational therapist, they do the group therapy for the patients, sometimes weekly, twice.

Dr Ruth Vine (26:29):

But do you get someone to support you?

Priseena Radha (26:31):

Yes, we got the support, our clinical nurse educators are there, they all step into the floor and they all, sometimes if we need, especially during COVID-19, our ward was a hot zone, so we all take break like hourly basis. We needed to drink some water. So, at that time, the clinical nurse educators and managers, Kelly Thomas, they, and Ima, they all were on the floor, to help us to support us. And that was the biggest self help that I have found in our unit, that they all work as a team to support.

Dr Ruth Vine (27:06):

Yeah, no, thank you so much. And Sarah, I mean one of the things that's a requirement, often during training in psychology, is that you have pretty regular supervision and support, but do you think ongoing supervision is something that most mental health professionals, and I guess particularly people who work in the area of clinical psychology, would think was a necessary part of their career support?

Dr Sarah Cavanagh (27:28):

Yeah, I do. I think it's quite, the access to peer supervision and professional supervision is quite embedded within the psychology practice. It's also part of our requirement for registration as a psychologist, that we do a certain number of hours of peer supervision. So, we are regulated and have to do that. But, I also think it's just part of our practice culture. And so, for example, and for myself in private practice, we have regular peer supervision between us all who are working there. But, I also have at different times sought out particular supervisors for particular clients that I've been working with, where things have been complex. And particularly in my earlier career, I definitely made sure I had

external supervision from an experienced psychologist who was not part of my workplace, that I could bounce ideas around with, and problem solve with in terms of complex clients, but also who was there for me to be able to talk about my baggage, and the stuff I bring into client sessions, and why a particular session might've been upsetting for me, for example, which is not something you want to obviously bring to the session with the client.

(28:37):

But yeah, needing that space to take, and think about separate from that. So, I think it is a really well-established practice, and I think there's lots of benefit for any professional, I think, working in the mental health space, to be able to find that space for reflective practice.

Dr Ruth Vine (28:55):

No, reflection is important. Look, we are almost out of time, but maybe Priseena, I'll go back to you first, and then wrap up with Sarah. Here you are. You've just said you started in mental health nursing relief about three years ago. If you were to sort of think, where would I like to be in five years, or 10 years? What are the sort of ambitions that you hold for that long-term? You've mentioned some research and masters, but what about beyond that?

Priseena Radha (29:19):

I would like to become a clinical nurse educator, and a clinical nurse consultant, and I want to encourage more medical nurses to have a look into the mental health nurse. Even some of my friends, even now they're starting their career as mental health nursing. I did five years time, I think, I want to become a clinical nurse educator in acute settings like John Cade, which is a high busy unit where we practice recovery-oriented practice in Royal Melbourne Hospital, yes.

Dr Ruth Vine (29:49):

Thank you. I think one of the difficult things about workforce, and we've all touched a bit on workforce, is often people are reluctant to stay in the acute sector because it is very, a sort of dynamic, and quite highly high-pressured area. But as you've highlighted, also at times, very, very satisfying in seeing people get their lives back on track. Sarah, if you were to think, what would your sort of, you've experienced lots of different paths, parts of your career already, but have you got a particular ambition to do with where you might want to get to?

Dr Sarah Cavanagh (30:23):

I definitely want to keep doing individual clinical work, with individuals and children and families. And I do have a particular client base where I do do a lot of work with children, young people and parents, around parenting. But I also really love the bigger system, policy, and programe work that I'm doing. And so, I want to keep doing that as well. But I also, I guess in terms of what, it's a bit more about what I would like to see for the country, is some more work in the space of being able to, in particular for me, it's in the early years. I have a particular mission around supporting children in the early years, and parents, and families, to be able to create environments that are optimal for child development. So that ultimately, we have less mental illness in the community is the ultimate aim. So, working in that space is somewhere I really still hope to be. I think doing the clinical work is really what keeps me in touch with

what the real world clinical system is, and what's really happening on the ground in mental health. And so. I think they're both together, definitely places I still want to be working.

Dr Ruth Vine (31:38):

Thanks, Sarah. I mean, I don't know if I can believe it anymore, but there are some things that would completely change, not just our society, but around the world. For instance, if we did understand the cause of an illness like schizophrenia, or we had an absolute treatment that was curative as opposed to managing it, that would change the lives for so many people. But equally, I think you've highlighted, that if we better understood some of that early childhood development and particularly the interaction that goes on between parents and their children or going right back to infancy, then we would hopefully develop people with much greater ability to reflect, but also to deal with their own emotions and be able to contain themselves, I guess, without needing that external containment. But anyway, look, our time has run out and I hope we've covered not just the different disciplines that work within the area of mental health, but also some of the phases of care, and some of the phases of career.

(32:30):

So, we hope you've enjoyed this conversation as much as we have. I hope Priseena and Sarah, you've enjoyed it. If you want to learn more about either myself, or Sarah, or Priseena please go to the landing page of this episode and you can follow the hyperlinks. You can also find there a link to a feedback survey. It's always great for MHPN to get your feedback, and to let us know whether you found this episode helpful or informative, and any suggestions that you might have about what else we can do. Also, please do stay tuned in for further episodes in this series of In Conversation With, or go looking at the other MHPN podcasts. I absolutely thank you for your commitment to an engagement with and the provision of mental health care. So, it's goodbye.

Dr Sarah Cavanagh (33:12):

Goodbye from me.

Priseena Radha (33:13):

Goodbye from me, Priseena.

Dr Ruth Vine (33:15):

And indeed, goodbye from me. Thank you very much.

Host (33:18):

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