In Conversation With…Dr Ruth Vine and Dr Marianne Farkas

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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):

Welcome to this episode of the Mental Health Professionals' Network, or MHPN Presents: In Conversation With. My name is Ruth Vine, I'm a psychiatrist. I'm based in Melbourne, but I am currently employed by the Commonwealth Department of Health as Deputy Chief Medical Officer in Mental Health. Today, I'm thrilled to be joined by Marianne Farkas, a clinical psychologist working in Boston, United States of America. Hi, Marianne.

Dr Marianne Farkas (00:43):

Hello. Hi, Ruth. It's great to be here.

Dr Ruth Vine (00:47):

I'm looking forward to our conversation today. We're going to touch on some themes that I think we've both long encountered in our respective work histories, and particularly we'll look at the experience by the person, but also, I guess, by those who are involved in care and support and treatment, the nexus between mental illness, disability, rehabilitation, what rehabilitation might mean, and recovery. And I was fortunate enough, Marianne, to hear a bit of your talk about recovery colleges recently. And I should also confess that I'm on the Board of Mind in Victoria, Australia, and Mind started recovery colleges some years ago. So, a very exciting development for Mind. But perhaps, Marianne, I could start by saying in my work, I've almost predominantly worked in public psychiatry in Victoria, which means a fair chunk of the people we engage with have significant illnesses like schizophrenia or schizoaffective disorder. They often have problems with comorbid substance abuse, often with unstable housing. And I guess my take on disability in that area is, particularly in some of how people engage with life, and how they feel supported in life, so feel able to do the things that enable social connection, and interpret and relate to families, and engage with social services. And the supports that are needed are often around that sort of, understanding interpersonal relationships. I'd be just fascinated to get your take on what you think disability means in the context of severe mental illness.

Dr Marianne Farkas (02:32):

Well, the World Health Organisation put out a categorization system some time ago, and it used to be called impairment, disability, and handicap. And they changed it, I think in the last five years. And now it's called, the categories are, health, task performance, and participation. I may have gotten the second one wrong, but that I think is a good clue to what disability used to mean. And it's often defined as a barrier, or a challenge to role performance. So, being unable to perform a particular role, like that of a worker, or family member, or a tenant is the generic definition of disability that is true for any branch of rehabilitation, whether you're speaking about physical rehabilitation or psychiatric rehabilitation. So, we generally follow that particular definition. So, let me elaborate for a minute. You can have a lot of impairment, and a very small amount of disability. You can also have fairly significant disability, and a small amount of impairment as evidenced by the fact that two people with the same diagnosis can be more or less disabled than each other. One person with schizophrenia can be fully engaged, going to work, living at home on their own, maybe following some courses, having family, being a parent, et cetera. Whereas another person with schizophrenia may be unable to do any of those things. So, the impairment and the disability are two distinct categories that affect the person's capacity to participate.

Dr Ruth Vine (04:34):

I mean, I think that absolutely then impacts on the sort of skillset that the people providing support to those with disability and impairment need to bring. And I guess, particularly in illnesses like schizophrenia, some of those impairments that result in disability are things like struggling with motivation and struggling with concentration. So, I'm going to come to evidence base later, Marianne, but just for now, when you think of the skillset of the people you work with who bring that engagement in rehabilitation for those with mental illness, what sort of talents do you think are most important in those skill sets?

Dr Marianne Farkas (05:16):

I did some consultation with the World Health Organisation several years ago, and they asked me to come up with one sentence to train workers in China. If you can imagine, one sentence. I didn't succeed. I gave the sentence, but the person who was the head of the mental health division at the time, Norman Sartorius, was not happy, so I said that the main skill that you have to have as a provider is to see the person.

(05:51):

Not the disability or the illness, and to let the person know that they're seen. And it's very simplistic, but it was the best I could do in a one sentence synopsis. So, for me, the talent, if you like, of working with people with disabilities or psychiatric mental health conditions really has to do with being able to see the person as a whole person, with talent, and with strengths, and with interests, and not just as a set of deficits and a pathology. And of course, if you ask the average person these days, if they do see the whole person and if they interact with respect, et cetera, I mean, I don't know anyone who says no to that question. No, I'm not respectful. Nobody says that, or no, I don't see the person and their worth, and they don't say that either. But there are specific skill sets that allow you to hone in on those things, and to use people's talents and strengths and interests in the service of the larger goal. I don't know whether that actually answers your question.

Dr Ruth Vine (07:06):

No, it does. And of course, I agree with you. You wouldn't go to a health professional and say, hi, are you a disrespectful, impatient, critical, prejudiced sort of a person? We would all like to think that we, through our training and through our interest in our profession, that we bring a capacity for empathy, and a capacity for understanding. But, I also think that, if I think of some of the greats who I've worked with in the area of psychosocial rehabilitation, then some of the particular, I don't know whether it's a skillset or a talent, but anyway, some of the particular things they bring is a capacity to be patient, to stand back when they need to, and then step forward when they need to, and to have a finely honed ability to know when to step back, and when to step forward, in a way that is absolutely, as you say, respectful of the person, but absolutely appreciates that person's experience of themselves, and their life, and their world, so that the worker, if you like, is, I don't know, sort of a participant rather than conductor if you like.

Dr Marianne Farkas (08:23):

Ah, I'm glad you said that because my response earlier was to the part of your question that asked for a talent, but if you ask for a skillset, the skills of partnership are a very specific set of clinical tools that we can teach people, and we do teach people how to develop a partnership. In psychology, they talk about a working alliance, but we mean something much more than a working alliance. We mean, what are the skills you have to bring to the interaction to help stimulate that person's capacity to interact with you? So they're not sitting there as a passive recipient, which most mental health services train people to be. To be a good client, in most mental health services, you go along to get along, you do what you're told, you follow instructions.

Dr Ruth Vine (09:18):

Do you think that's still true?

Dr Marianne Farkas (09:20):

Yes, unfortunately it is. It's much more subtle, but it is still true, in the sense that when people don't follow the program, there is a treatment review, there is a discussion amongst the team of what's going on, what's the problem, as opposed to thinking about this notion of partnership, what do I bring as a clinician to this interaction? What are the skills? Empathy being the critical one, of course, but there are also skills of self-disclosure. How do I disclose myself as a person in this interaction to be in partnership, and what do I have to do to help the other person know that this is a relationship in which they need to be the actor? My role is to be a consultant or a coach, and to shift that so that it's not that, the traditional interaction is, if you give me good information, I, the expert, will give you the plan for what to do. So, your role becomes providing me with good information, and then following my instructions.

Dr Ruth Vine (10:36):

Yeah, okay. I mean, that also brings the question that, of how important it is then for who is participating. You just talked about if things aren't working right, then there's a clinical review or a team review. But would your normal sense be, that in any sort of review, participants had to include the individual and his or her family and supporters?

Dr Marianne Farkas (11:01):

Well, I'll say something about families separately from the individual, absolutely the individual. But I think first, before having a review about what's wrong, the process has to start earlier than that. You were talking before about motivation, and it used to be when I was trained, motivation, the lack of motivation, was an indicator of mental illness. It was one of the things we assessed in order to be able to identify categories of diagnoses. And what we know now is that yes, that may be true for some people, but there is also the question of, what do I have to be motivated for? Is there something for me to get up every day for, or are you just going to focus on the fact that I have withdrawn from life and I'm sleeping because I have no future. So, how much of our assessment and analysis has to do with that person's meaningful life?

(12:06):

What brings meaning to this person? What are the options for this person, as opposed to everything being seen through the lens of the pathology, or the illness? So, that's one thing. And then the second thing you asked, so therefore, yes, of course I would involve the person in that treatment review, but having thought through some of these other issues before I got to that point, and the involvement of the family is very tricky because, when I say it's tricky, most of the people, at least that we work with in our centre, are adults. They're not children, they're adults. And if you think about yourself having a condition, and going to see a professional for that condition, there are certain conditions that you would ask your family member to be involved in, and to participate in, because you want that support. And there are other conditions that you maybe wouldn't do that. So, and every family dynamic is different. If the person wants the family there, by all means the family needs to be there. If the person doesn't want the family member to be there, then there's a whole lot of work about why they don't want the family member to be there. What does that mean, blah, blah, blah. But it isn't a proforma kind of circumstance if the person's an adult of course, and hasn't been judged to be not competent, and has a surrogate, and all those other circumstances.

Dr Ruth Vine (13:40):

Yeah, I did a survey, some years back now, but I did a survey of carers of people with significant mental illness, and many of the people who answered my survey were quite elderly. So, maybe talking about another era and another philosophy, but certainly among that group, they were so concerned about their adult child, and so concerned about who would support their adult child when they were no longer able to. So, I think perhaps it's not for this conversation, Marianne, but that whole discussion about how you engage carers, and the information provided to them, and the extent to which they are aware of work happening is an important one. But, let me skip a bit, because one of the things we've both touched on is the importance of the relationship, and the dynamics of the relationship, and that is a very hard thing to measure. So, you've been working in academic circles as well as others. I'm always suspicious of the evidence base in some of these areas, and how well it can be generalised to many of our local situations. What do you think about the evidence base, and how we should be translating the evidence base in this area of psychiatric disability and rehabilitation?

Dr Marianne Farkas (15:12):

Wow, you ask very difficult questions, Ruth!

Dr Ruth Vine (15:14):

Well, why not, when I've got the opportunity?

Dr Marianne Farkas (15:18):

Let me first ask you back, Ruth, you were saying that you were suspicious of evidence base, of the evidence base. Could you tell me more about that?

Dr Ruth Vine (15:30):

Yeah, well, what I mean is very often when people are doing research studies, they are very particular about who is part of that research. Firstly, people have to want to be part of it. People have to stay the course. Often, they have to exclude things like whether you can or cannot speak English, or whether you have comorbid drug and alcohol abuse. It immediately becomes a rather artificial cohort. And probably, most often, it's a cohort that is selected to do better. And by better, I don't mean, I'm not making that as a sort of judgmental term, but in terms of the outcomes, in terms of rating scales improving, or employment being sustained, or not going back to prison, the sort of outcomes. So, I then worry that whatever the intervention might be, whether it's cognitive behavioural treatment, or interpersonal therapy, or family cognitive therapy, whatever the intervention might be, is being given to a selected group. And that the evidence that it is terrific is then hard to generalise to people who don't speak English, and who do go back to jail, and who do suffer drug and alcohol abuse. So that's what I meant.

Dr Marianne Farkas (16:48):

I understand. So, you're basically saying that life is a lot messier than a research study allows for?

Dr Ruth Vine (16:55):

Well, I am, and particularly when what we're trying to measure, when often the intervention is not a sort of thing. The intervention includes the relationship. It includes a very subjective and dynamic part, and I think that's hard to measure. And the danger then, of course, is that, well, we say, well, if I get along with you, I'm doing well. But that's not good enough either.

Dr Marianne Farkas (17:20):

Well, the reason I was sighing before is that it's a very deep topic because, it goes to, there was a book by a man named Thomas Kuhn, I think his name was Thomas Kuhn in 1976, it might've been. 1972, '76, a long time ago, who wrote about the nature of scientific revolution. And basically, why I referenced that book, is that he made it very clear that science is a way of knowing. And we in the western universe have attached our way of knowing to a particular methodology. And we have said, okay, if you want to know something, here are the rules you have to follow. Because we believe that if you follow those rules, you can isolate the noise and the mess, and see what the action, the mechanism of action actually is. Of course, that's a very limited way of knowing. There's experiential knowledge, there's observational knowledge, there's a lot of different kinds of knowledge.

(18:29):

But, if you think of evidence-based practise more as one strand in a repertoire of bits of knowledge that we're accumulating in this field, then you've given evidence-based practise it's proper due. It is a significant contribution to what we know, when we know that if we follow the rules, if we follow the manualized intervention, if we follow these particular structures, something happens, there's an impact. We can count on that impact. It does not say we should then make that particular outcome policy for a country, or a state, or a province. And that's unfortunately what happens. So, the problem with evidence-based practise is not the evidence base at all. It's, the problem is, how that evidence gets used, because there is room for a scientific form of inquiry, but part of using scientific information is that you use it parsimoniously, you use it for the purpose that it was created to be used, and it was used to add something to our knowledge base.

(19:53):

If you then take that piece of evidence that has been strictly controlled, and conducted under very strict circumstances, and then try to create policy based on that one piece of evidence that affects an entire geographic area in which there are many different kinds of providers, and many different levels of education, and many different kinds of clients with different conditions, et cetera. You nullify the knowledge that was created in the study, and it was never intended to become policy, it was intended to add to our base of general knowledge about what to do. Politicians often can't wait that long, so they jump.

Dr Ruth Vine (20:46):

You are a very wise woman. And look, my reason for pointing to evidence base is in Australia, we have various kinds of mental health provision. Some of those are government subsidised through a thing we call the Medicare Benefits Schedule, or MBS, and some are state provided. And so, some are block funded and some are activity funded. But one of the things that people are very keen about at the moment is measuring outcomes, not just outputs, not how many times did I see you, but what was the impact of me seeing you? What was the impact of my care? Because governments want to pay for what works.

Dr Marianne Farkas (21:29):

So do people receiving services!

Dr Ruth Vine (21:31):

That's right, people receiving services. So, there is a relationship, I think, between what we see in, if you like, evidence-based practise, and then how we record or measure outcomes. And sometimes that's subjective, and sometimes it's rather more objective. Have you sort of explored that as well?

Dr Marianne Farkas (21:53):

As you know, from conversation we had before, I've been working in the area of recovery, mental health recovery for decades at this point. And if you look at evidence and outcomes from a recovery lens, then the outcome that we're interested in is a meaningful life for the individual. Whatever you have to do, whether you're doing recovery-oriented treatment, psycho pharm prescription, or you're doing psychosocial rehabilitation or wellness services, all of that should contribute to the person achieving a meaningful life. And a meaningful life is usually defined individually. The elements of a meaningful life are pretty universal: a decent place to live, people who love you, meaningful work, and if you like, education.

(23:00):

So, if you take those elements, you can operationalize those elements. So, we did a five-year study in which we asked people every six months to tell us about their recovery, not tell us about their mental illness, but tell us about their recovery. And then we asked them, how did they know? If they were telling us about, I feel like I'm doing better in my recovery, I'm doing worse. We asked them, how do they know? And they were very clear about it. Well, in the last six months, I've been able to go out to a movie with my girlfriend, and I couldn't do that before. So, I know that I'm on the road to recovery because gee, really what I'd like to do is live in an apartment downtown with my girlfriend, which I've never been able to do, and get a job, even a part-time job that I can do and feel good about myself. So, when you ask people, the outcomes they identify are not points on a BPRS scale, but very concrete things. Either I can live in a decent home, decent housing, or I don't. And either I do that more than I did last time, or I don't. And I believe that if we focused our evaluation on those outcomes that matter to the people we serve, the question of what is and is not an outcome would be less mysterious.

Dr Ruth Vine (24:36):

Yeah. No, thank you. Thank you. And Marianne, I know our time is a bit limited, but I think we've got time to explore one more area, if you're up for it? This is the Mental Health Professionals' Network. So, we have people who are clinical psychologists like yourself, psychiatrists like me, but also social workers, OTs. When you think, what is the best way of those professionals working together in this area of psychosocial recovery, again, what are the necessary ingredients that you come up for the best working relationship?

Dr Marianne Farkas (25:09):

Well, let me just say the thing I said a minute ago, you do not ask light questions. This is deep. This is deep for the end of a working day, oh my God. It's hard to give anything but motherhood and apple-pie type of answers. But it's also true. I mean, you cannot work with a team of people that you do not respect, and who do not respect you. So, basic respect is really important. The other thing is that an important key ingredient of recovery that we know from past research, et cetera, et cetera, et cetera, is hope. The ability to hold hope for people, even when they don't hold hope for themselves. And hopefulness is not a common, always a common ingredient. So if you asked me what are some of the characteristics of a good, well-functioning team working with folks in this field, their belief in people's aspirations, their belief in the potential of people to reach those aspirations ,is perhaps the key ingredient. To me that's more important than what credential they have, and what perspective they come from. If I'm fighting against that helplessness, oh, people have schizophrenia, it's a chronic illness, it's severe and persistent, and all they're going to do is live on the margins of life and then finally die, then really, that's not going to be very helpful.

Dr Ruth Vine (26:47):

No, you're right. And I think the things that governments or service providers can bring to that, of course, they can try and establish cultures that promote respect and opportunity, but they can also bring systems that don't drive frustration. So, information systems that don't drive frustration, or amenities and places to be that feel loved and welcoming and cared for, because it's sort of symbolic of how we engage with people, that we want them to be in a place that respects them.

Dr Marianne Farkas (27:24):

If you wouldn't send your mother to your service, you're in the wrong service.

Dr Ruth Vine (27:29):

You're in the wrong service.

Dr Marianne Farkas (27:31):

If your mother could, if you wouldn't trust this group to work with your mother, or somebody that you love in your personal life, then it's probably not welcoming. It's probably not hope inspiring, and it's probably not focused on recovery.

Dr Ruth Vine (27:51):

Marianne, I reckon that's a fantastic place in which to leave this conversation. So, I would say to our listeners, we hope you've enjoyed this conversation as much as Marianne and I have. If you want to learn more about us, or access anything that we may have mentioned, please go to the landing page on this episode and follow the hyperlinks. And you'll also find a link there for a survey for feedback, and the Professionals' Network very much values your feedback. So, let us know whether you both enjoyed, but also found this episode helpful. And please provide any comments and suggestions about MHPN can better meet your needs. So, do stay tuned for further episodes in the series In Conversation With, and I thank you, absolutely thank you for your commitment to and engagement with interdisciplinary, person-centered mental health care. So, thank you very much. Goodbye from me, Ruth Vine and...

Dr Marianne Farkas (28:45):

Goodbye from me from the other side of the world and thank you for the opportunity to have the conversation. It was fun.

Dr Ruth Vine (28:51):

It was fun, Marianne. Bye-bye.

Host (28:54):

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