Podcast Transcript

Online Professional Development for Mental Health Practitioners

In Conversation With… Dr Ruth Vine and Mary O'Hagan – Part 1

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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 presenting In Conversation With. My name's Ruth Vine, I'm a psychiatrist by background. I'm based in Melbourne, but I currently work with the Commonwealth Department of Health in the role of Deputy Chief Medical Officer for Mental Health, a role that was created in the context of Covid. But today I'm just ever so delighted to be joined by Mary O'Hagan, who is the inaugural, I think that's fair Mary, the inaugural Executive Director Lived Experience in the Mental Health and Wellbeing Division at the Department of Health in Victoria. Mary, thank you so much for joining me. This is the first, but I hope it's not the last of our meetings.

Mary O'Hagan (01:00):

Right, good to be here.

Dr Ruth Vine (01:01):

Mary, you and I are sort of, we both sit on executives and have sat on executives probably now for a number of years, we've been in those leadership roles, but we've sort of applied different lenses to help us understand the mental health system, and the ways in which consumers experience it. I come from a very clinical background. I've worked in forensic mental health and acute general mental health. You've clearly brought the lived experience, but also worked within New Zealand as another system. So, today what I'd like us to do, Mary, is explore a little bit about, I guess some of the new areas where lived experience is taking a really leadership role, some of the new service models, and if we're up to it, let's get into some of the challenges and tensions around some of those respective roles. So, Mary, maybe to start, I mean just because I don't know if everyone will be familiar with you, if you wouldn't mind, to give a brief introduction to yourself, and then maybe we might move straight into some of those new areas for innovation and development.

Mary O'Hagan (02:04):

Yeah, sounds good. My background is, I came into mental health as a user of services. I used services for, probably for about eight or nine years between about the ages of 18 and 27. And I was in and out of hospital, my life was a train wreck, and it was an incredibly formative experience. Life's been a walk in the park since then. And one of the things that was so difficult about it, it wasn't just the subjective experience, it was the way services, and society, and other people responded. That was incredibly difficult. And that's really the thing that has been my mission in life since then, in the various roles I've been in, is to try and bring about change in the way people respond to people who experience mental distress.

Dr Ruth Vine (03:03):

Yeah, thanks Mary. And I'm presuming that those years are now some years behind you.

Mary O'Hagan (03:10):

They are, yeah.

Dr Ruth Vine (03:11):

And that there will have been, and perhaps partly because of you, there will have been system changes, and societal changes since then.

Mary O'Hagan (03:22):

Well, I don't think there's been enough, Ruth.

Dr Ruth Vine (03:24):

No, no, not enough. Not enough. Not enough.

Mary O'Hagan (03:26):

In fact, in in some ways some things have got worse. One thing that has got worse is risk management in mental health. It's got worse. And you can tell, a sign of that is that the rate of compulsory treatment has risen since the days I used services.

Dr Ruth Vine (03:45):

So, Mary, I can feel that we're going to have this sort of explosion in areas, which is great. I don't have a problem with that. And I'm going to say it right now. Mary, will you be up to episodes two and three of this?

Mary O'Hagan (03:58):

Yes, certainly. Yeah.

Dr Ruth Vine (04:00):

Alright. In that case, we don't need to cover everything today. So, let's start though. And you've already raised, with some of the things that have gone not as we would've hoped, and I'd absolutely agree with you. And in fact, I think that's why Victoria ended up with a Royal Commission, and I lived and experienced that as a service director. So, let's park that for a minute and look at where you are now, in your new role, and developing new and innovative service models. And can you talk a little bit about what your job is now?

Mary O'Hagan (04:36):

Well, I mean when I was coming out of services and becoming an advocate, I wouldn't have imagined in my wildest dream that a job like this could exist. So, that's really, and in fact I wrote that in my letter of application. So, I think that this job is an unprecedented opportunity for someone in my position to have real influence. And the job I've got is, I lead within the Mental Health and Wellbeing Division, there are several branches, I lead the Lived Experience branch, which has about 20 FTEs in it. And most of those people have their own lived experience, either as a user of services, or as families or supporters. And our job at the Lived Experience branch is firstly, to stand up the Royal Commission recommendations that involve the development of lived experience agencies. I mean, one of them is a peer led crisis service. Another one is a series of family centres around Victoria, and there's a few others. But the other thing we do is we provide advice across the division to the other branches and particularly, when it comes to the initiatives, the reform initiatives that they're responsible for.

Dr Ruth Vine (06:06):

Wow. I'm glad you've got 20 FTEs. Part of me just doesn't know where to start really, but just thinking back to your team, your team of people with lived experience of mental illness and/or psychological distress, lived experience of caring for someone, do you as Director feel that those different perspectives can be combined to create a whole, the perspectives of carer and consumer? Or do you think there inevitably need to be different pathways for them?

Mary O'Hagan (06:39):

Not at all. When I started in this area, the families were incredibly conservative. In fact, we used to say they were more psychiatric than the psychiatrists. They loved the medication, they loved the biological explanation because I think they felt blamed, and it let them off the hook. They relished compulsory treatment because it was like a way to get their relative to jump the queue, or to services. I don't think they really liked the force about it. I think they just wanted their families to get into services. And they were really anti recovery, they had no hope. They thought we were spreading false hope when we talked about recovery. But most of those people have gone, I don't know where they've gone. Maybe they've got older, and met their end, I don't know. But I find the people from a family background in the department and the people I'm working with in the peaks, they don't think like that. In fact, our thinking is much more aligned. They're not in favour of a lot of the things that the old family movement people were in favour of. They're very much focused on social justice and human rights, which is where the consumer movement has always come from.

Dr Ruth Vine (08:01):

Yeah, no, thanks Mary. And so, you just talked about two particular models, I think, the sort of crisis respite model and the family centre model. Do you feel that both of those are within reach, so to speak, of being stood up? And as a secondary question, because you did just mention more like a psychiatrist than the psychiatrist, that their engagement with clinical services will be productive?

Mary O'Hagan (08:28):

Well, the peer led crisis service that is being procured at the moment, one of the requirements in the Royal Commission report, which is kind of being read like the Bible.

Dr Ruth Vine (08:46):

I agree.

Mary O'Hagan (08:46):

It's like the Protestant reading the Bible honestly. But anyway,

Dr Ruth Vine (08:51):

Let's not go there.

Mary O'Hagan (08:52):

And this is based on the New Zealand model. It states that the crisis service needs a relationship with an area mental health service. Now, there are tensions in that, most definitely. And they just have to be quite carefully navigated, I think. And that's been the case with peer led crisis services in New Zealand. But what they've found in New Zealand was that the clinicians were very sceptical about them, and very, sort of, were putting that risk lens on to them all the time. And they've often come round to the point of view that actually, these are really safe places, that we know that people have a much better time in them. The guests have a much better time, but also the staff do. And that there are incredibly few, what

we call critical incidents, or sentinel events, or whatever people call them, in these places. I think when the clinical people see how they work, they lose a lot of their scepticism, and they become supporters.

Dr Ruth Vine (10:01):

No, Mary, one of the things when I sort of saw this happening was, I sort of thought, oh no, this is ridiculous. I went to Canada in 2004, and I visited a peer led lived experience led crisis centre in Toronto that had really close links with, I think it was St. Michael's Health Service from memory. And it was well established, it was highly regarded, it was good. And that was 2004, which we have to sort of think is very close to 20 years ago. Do you get why Victoria has been so slow in this one?

Mary O'Hagan (10:38):

Well, everyone's been slow. Look, in New Zealand, these should be everywhere, these places. And they're not. Okay, Victoria's been a bit slower than others, but they're not around the rest of Australia. They're very rare in a lot of parts of the world. And my big concern about Victoria is that we don't just have one of these, that this is the beginning of a whole new model of crisis service delivery. And it's not just a little trophy.

Dr Ruth Vine (11:10):

Indeed. And again, if I went back in my history, when I was a fairly baby psychiatrist Mary, I became a psychiatrist in 1990. So, I did my registrar years during the eighties. And at that time, of course, Victoria was emerging from de-institutionalization. And in fact, there were CATT teams, and attached to every CATT team, from my memory, was a crisis respite sort of house. But it was clinically led, it wasn't lived experience led. But nonetheless, the idea was that if you were experiencing a crisis, there was somewhere you could go for a short period of time that was not the hospital ED, it was not an inpatient unit, and you would have quite intensive, I guess, it was a hybrid hospital in the home crisis respite centre. Do you see that these are akin to that, but peer led or lived experience led, rather than if you like, CATT or clinician led?

Mary O'Hagan (12:07):

Well, I mean in the sense that they're community based, they're intimate places, they don't have lots of beds in them. And yes, I think there are similarities. I think the philosophy might be quite different in some ways. I think in a peer led crisis service, we don't call people patients, we call them guests. So, there's quite a different sort of approach. But yes, at the basic level there are similarities.

Dr Ruth Vine (12:37):

Yeah. Mary, I want to shift us a little. You mentioned before that, in a way, the old guard had moved on, I don't know. And you said you'd not sure where they'd gone. We had a sort of brief pre-meeting, and I asked you a question about mental illness, and mental illnesses. There's lots of mental illnesses, in my view, because I'm a psychiatrist. But one of the ones that is, perhaps I guess, most challenging for families, and for the community, and for hospitals are people who experience psychosis, whether that be bipolar affective disorder or schizoaffective disorder or schizophrenia. Be that as it may, a sort of changed understanding of reality. And mostly, there's an acceptance that part of the response to that is biological treatment, alongside psychological and of course social. What's your take, particularly when

you're talking about these new models of how, people who are experiencing that absolutely altered sense of reality, who's talking to them, who's talking about them? What is safe and what is not safe? How do you think we should change our understanding of that, in these new models of service?

Mary O'Hagan (13:49):

I think one of the hugely corrosive concepts that we've had in mental health, one of them has been lack of insight. And of course often, we say this of people who have psychosis. And what it really means is, you don't agree you have an illness, and therefore you don't see a need for treatment. And I find that an incredibly discriminatory approach to people. It doesn't take into account the fullness of that subjective experience. It just invalidates it. And having experienced psychosis myself, it's an incredibly powerful human experience, and just sitting there struggling to make sense of it, and then you've got these people who feel they have a monopoly on the truth saying, well, you've got an illness. And in fact, I never thought of my psychotic experiences as an illness. They were a crisis of being, they were a real existential crisis. They didn't feel like an illness to me.

(15:01):

So, I think we've got to get rid of this idea of lack of insight. It's just an altered reality to me, and an incredibly powerful experience for people, and powerfully bad and powerfully wonderful at times too. See, what we get is, we get a system that receives people who are psychotic, and all they have in their toolkit is the Mental Health Act, drugs and locked wards. That's all they have. Quite honestly, they are the risk management tools of our system and we put an awful lot of resource into those tools. And what I would really love to see is a system that is much more responsive, much more flexible and prepared to stay engaged with people, and find out what it is that people really want. And if we had much more in the way of home and community-based crisis services, or safe houses where people who are feeling suicidal can go without having to be referred, or just sort of peer support, community connections, I mean housing, employment, all those things, we spend about two or 3% of our mental health money on those things that are very, very important to people at about 95% on the clinical system.

(16:30):

And we've got it all round the wrong way as far as I'm concerned. So, that's a rather rambling answer. But, I do think that we can't just keep on having these institutional responses. We need flexible responses. What happened to you, and how can we help, rather than go through that door because that's the only one we've got. And by the way, we'll put you under the Act as you go through it.

Dr Ruth Vine (16:55):

Mary, thank you. Of course. I'm going to pull you up on a couple of those things. First, I'm going to say housing and employment shouldn't come out of the health dollar. It should come out of the housing and employment dollar. But let's leave that for politicians. But I have to pull you up on the toolkit because, to me, and I think back to my, I confess I'm not a very good psychiatrist at the moment because I'm bureau, I'm basically a bureaucrat. But when I was a psychiatrist, and engaged with patients, I actually think the most potent tool in my toolkit was empathy and engagement, and forming a relationship that was supporting and containing, and perhaps not completely entering into a person's experience, but being able to understand what that experience was doing to their thinking, and to their sense of fear and safety. So, I would hate you to say that the toolkit is a drug and an Act and a locked ward, because it's not. It's the relationship. And to me, that's the central part of why on earth would I want to be a

psychiatrist, unless I wanted to be curious about people, engage with people, and use my most empathic skills to understand that person.

Mary O'Hagan (18:12):

At 2:00 AM, or when you've got a 15 minute appointment, and you've got an overcrowded ward, then they're your basic tools.

Dr Ruth Vine (18:25):

And I, I'm not disputing that. I'm just saying that those are the concrete constructs, but we should not lose sight of the relationship. And this is great, because this is where our different lenses happen, that I would say those things that you've talked about, legislation and an inpatient unit and drugs are, they're not the tools. Clearly we use them, we use them a lot. And you would say, we use them too much, but they should be used to enable the relationship that enables understanding, that enables a person's choices to be reasserted.

Mary O'Hagan (19:01):

Well, I've never known coercion to be a good relationship and trust forming way of doing things. Usually it's very bad for relationships.

Dr Ruth Vine (19:12):

Can I interrupt, because I was fortunate enough to work in forensic psychiatry where people are with us for years, decades, even. In forensic psychiatry, it's a little bit different, because the coercion is imposed by the correctional system, and the relation comes from the clinical system. But let's not get ourselves buried here, we might come back to this on another episode. One of the other areas, Mary, that I think you're very fortunate in being able to explore is that whole area of leadership, and lived experience leadership. And indeed, you are placed in a leadership role. There you are, you're heading up the team, it's your job. How do you see that collaboration? We talk a lot about collaboration and collegiality. How do you see that working across our various parts of the system?

Mary O'Hagan (20:05):

I think the Royal Commission report was actually almost marinated in lived experience leadership. I do hear from the clinical world that they're a bit worried about their place in the sun, which is a curious and interesting response. But of course, you do have to take that a bit seriously. If we want to have leadership in the system, we need to bring along other people with us or else we won't retain it, there'll be a backlash, and we'll just end up back where we were. And there are plenty of clinicians that, perhaps a more progressive end, who we can work in partnership with, and I think influence their practice. And there's a lot of clinicians who aren't happy with the way things are, who are very unhappy with what they do, and would like more in their toolkit. And I'm working with our chief clinical advisor to see how we can model a kind of partnership approach within the division, but also in the wider sector. So, I think it's really important that we bring those clinicians along who have some understanding, and who are at the more progressive end.

Dr Ruth Vine (21:26):

Thank you. I mean, you're absolutely right. I mean, again, speaking as a person who was working in what I think was the most underfunded service in Melbourne in terms of per capita spend, I know that the people I worked with, this is not what they went into mental health to do, to be so constrained. And the service had become so narrow, and so limited in its scope, so limited if you like in its toolkit, that heaven help us. We were looking back to halcyon days in the 1990s, which was crazy, but yet I can remember again, as a registrar, being in a place, Larundel it was called, but we had art therapy, we had recita house, we had community-based services. There was really, Toad Hall, we had exciting things happening in a miserable institution, but people were feeling very fulfilled in engaging in a different way, Mary, because it was 30 years ago. But I think that is a real dilemma, how to make those people who, if you were working in the system that was in decline, not through any fault of their own, how to make them not feel like the enemy. It's not their fault. It was the fault of, if you like, a decline of funding. And how do you think your role is going to sort of bring those people on board?

Mary O'Hagan (22:57):

I mean, there's a term called moral injury.

Dr Ruth Vine (23:00):

Yes, there is.

Mary O'Hagan (23:01):

And I think we need to understand that these systems are also hard on many of the people who work in them. I mean, they're hardest on the people who use them. And we just need to understand that there's a bit of recovery that has to happen among the current mental health workforce, actually. I'll never forget something I read about this by a psychiatrist called Sandra Bloom, who really talked about the way systems have a trauma response in the way they respond, a bit like the trauma response of the people who come into them. The whole system has a trauma response, and it's kind of numbing and hypervigilance. And of course, that is very bad for people, to be in that environment where they respond to these rather exaggerated ways to things. So, yeah, I think we do need to recognise that there has been a level of, for any decent person working in some of these places, having to put people into seclusion rooms, hold them down and inject them, be in a locked place with them. Well, if that was me, I'd be pretty upset, I wouldn't be feeling good about myself, or about the system, or about what I was doing.

Dr Ruth Vine (24:27):

So, do you think your role has a role in reassuring those clinicians that their intentions were good, but their system was bad? Or do you think that you're part of the rescue troop,?

Mary O'Hagan (24:41):

No, because I think there are a variety of people working in the system. Some of them are good people who've been expected to do what I'd call bad things. And some of them aren't such good people, so I'm

not there to rescue them. But I think if people have a level of discomfort about their role in the system, that's a good sign to me.

Dr Ruth Vine (25:05):

And Mary, again, I'm going to shift because as I said at the beginning, I'm hoping that I'm going to lure you back to further conversations, but you've now been in your role, is it three months already yet?

Mary O'Hagan (25:18):

Four months, yeah.

Dr Ruth Vine (25:20):

Four months, there you go. And do you feel in your role that you're, well, I guess that you're there, that you're an equal member of the executive, that you're part of the divisional plan to bring this reform forward, and that your voice is being heard?

Mary O'Hagan (25:40):

Yes, I do. I do. I've been reflecting in my earlier years, and I'd sit on committees with people, and you'd just think you knew where the power was in the room, and it wasn't with you. And look, I don't feel that in my current role, but it's quite interesting because some of the staff feel it quite a lot, which is an interesting thing. They feel that they're not being listened to, or that there isn't an equal power balance or whatever. So, in some ways, position itself protects you from some of those feelings. And in fact, you've got to be careful not to throw your power around as well. But I do think the department is not as tough a place to work, as a person with lived experience, as the clinical services are. I think they're really tough for those consumer consultants.

Dr Ruth Vine (26:47):

Yeah. Well, I sort of agree with you. And in fact, I think, again, I wouldn't say it's the fault of the other people in the place. I think they're tough places to work at the moment, and they're under a lot of pressure, and they're, change is not easy, and change is not easy when you're trying to develop a workforce. But look, the other area that I wanted to touch on, one of the things that I've been involved in, Mary, recently is a review of the Million Minds Mission Mental Research Future Fund. And so research, I think we all say that there should be more and better research into whole swathe of areas within mental illness and mental ill health. But one of those is, of course, is how should lived experience be engaged in research. And there's a whole, as you know, there's reams of evidence, be it longitudinal, or epidemiological, or clinical, or clinical trials. What's your take, if I might ask, on how lived experience people should be engaged in research? And are you familiar with the Alive Centre?

Mary O'Hagan (28:00):

Yes. Yeah.

Dr Ruth Vine (28:01):

Yeah. So, that's a particular example I guess. But what are the ways you would like to see people with lived experience engaged in research?

Mary O'Hagan (28:10):

Well, at the end of this reform period, by 2032, I would like to see a Department of Lived Experience Studies in Victoria, with various courses. I'd like to see people being educated in various lived experience specialties, like research and evaluation. I'd like to see peer support be lifted to the university, for those people who are interested in getting more academic about it. So, I'd love to see all these specialties developing, and a presence in the academy, an independent presence. I think at the moment, a lot of lived experience academics have been sort of working off the coattails of clinical academics. And while those clinical academics have done a good job at kick-starting the whole thing, I think there needs to be a much more independent and powerful presence in the universities and tertiary institutions.

Dr Ruth Vine (29:18):

Do you think the Collaborative Centre will do some of that?

Mary O'Hagan (29:22):

I hope so. I hope so, yeah.

Dr Ruth Vine (29:25):

Okay, Mary, I can't resist it because, but do you think psychiatry has a future?

Mary O'Hagan (29:31):

I think psychiatry has a future, not at the hub of the system, but as one of the spokes.

Dr Ruth Vine (29:39):

Okay.

Mary O'Hagan (29:39):

Yeah, and I think it's been a problem having psychiatry at the hub of the system. I think that what's happened is that the discourse, the resources, and a lot of the decision making, not so much in recent years but, has gone through psychiatry. When you think about the last 200 years, and the whole lens, that's been the dominant lens. And I think it's really had a narrowing impact on the way services are delivered, and on the mindsets they're delivered with.

Dr Ruth Vine (30:19):

Mary, I think that's an absolutely excellent spot for us to sort of stop and say, stay tuned for the next episode, because what you've just said, of course really opens a lot of debate about not just psychiatry,

but also also other areas, health in short, and the whole sort of mental illness and treatment compared with areas of psychological distress. And again, as a person who's worked in the public system, I've seen people in great torment and great distress, and that has been alleviated by treatment, and even treatments including electroconvulsive treatment, which I'm sure you might have views about as well. So, look, I think we're probably out of time, and I'm just going to say a big thank you to Mary for joining with me, and for being so open. And thank you to all of our listeners for joining us on this episode of MHPN Presents: In Conversation With, and you've been listening to me, Ruth Vine, and...

Mary O'Hagan (31:23):

To Mary O'Hagen.

Dr Ruth Vine (31:24):

We hope you've enjoyed this conversation. I hope it's raised some really interesting areas for further discussion and debate. I think I'm right in saying that MHPN has put some resources regarding both Mary and myself on the landing page, and there might be some hyperlinks there. You'll also find there a link to a feedback survey. We would be very grateful for you to fill that in and give us some feedback about whether you found our conversation helpful, and any suggestions about where your MHPN can meet your needs. So, stay tuned for further episodes. I really enjoy these conversations, and I absolutely thank you for your commitment to and engagement with interdisciplinary, person-centered mental health care. So, goodbye from me, and thank you.

Mary O'Hagan (32:13):

Bye.

Host (32:16):

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