# In Conversation With… Dr Ruth Vine and Mary O'Hagan – Part 2

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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 (00:17):**

Welcome to this episode of MHPN Presents: In Conversation With, my name is Ruth Vine. I'm a psychiatrist, I'm based in Melbourne, but I'm currently working with the Commonwealth Department of Health in the role of Deputy Chief Medical Officer for Mental Health. But tonight, I'm absolutely thrilled to be joined by Mary O'Hagan, Executive Director Lived Experience in Mental Health and Wellbeing Division at the Department of Health in Victoria. And it's our second meeting. So, hi Mary. Thanks for joining me again.

**Mary O'Hagan (00:44):**

Hello.

**Dr Ruth Vine (00:45):**

I'm looking forward to our conversation today. We caught up a little while ago now, so this is the second of what I hope to be a series of three, and what we're going to do is chat about areas of mutual interest from our respective lenses. My lens is that I've been a psychiatrist for now about 30 years, and my role is therefore clinical.

(01:04):

I've worked in a range of different service settings, and your lens, Mary, is the lived experience lens. In the previous episode, we talked about a range of different areas. I think we talked a little bit about the role of lived experience in research, we talked about the toolkit, the rather sparse toolkit, that you described in terms of when people came into a mental health service, particularly after hours. And we talked a bit about your own experience, and your own journey. So, things are sort of, reconciling different voices within mental health service provision. So, Mary, I thought if it was okay with you, today I'd spend a bit of time really exploring in a bit more depth some of the new service models, particularly those that are peer led, but also some of the other new service models that you would've been immersed in in Victoria recently, and some of the sort of criteria and challenges that you expect.

**Mary O'Hagan (01:59):**

That's absolutely fine.

**Dr Ruth Vine (02:00):**

And for our listeners, I should just say, Victoria received a really hefty report, weighing many kilos, from the Royal Commission in about March of 2021. And that was on the back of a lot of consultation, but one of the many recommendations made was that there should be much, much greater engagement with lived experience, and indeed there should be some particular services that were largely peer led. Mary, can you outline some of those new service models, and I'm sure you're engaged with developing the models, of care and some of the details of that?

**Mary O'Hagan (02:34):**

Yeah, so the lived experience led agencies that were recommended by the Royal Commission was firstly, a lived experience residential service that is designed to be an alternative to inpatient admission. There's also a lived experience or a consumer development agency that is being set up, and also family carer led centres, eight of them around Victoria. There are also some initiatives for young carers, and something that's pretty important to us is the extension of the legal and non-legal advocacy services.

**Dr Ruth Vine (03:20):**

Goodness me, that's quite a few. Where would you like to start? Should we start with the residential one?

**Mary O'Hagan (03:25):**

Yeah, so the lived experience residential service, as I said, is an alternative to inpatient admissions. So, it's designed for people who are in a pretty deep crisis. Now, this service has not been quite procured yet, but the whole idea of it is that this is going to be peer led, so the manager's going to be peer, the staff are going to be peer, but one of the things that the commission said was, we need to bring clinical services into the residential service, so that there will be psychiatrists and nurses who will come in to provide clinical support to people as needed. Now, you could be under the Mental Health Act in this place. So, it's not designed for people who are just having a bit of a rough time. So, one of the things

that, and this is based on some similar services in New Zealand that are peer led, and they've become part of the range of options that people can have during a crisis. So, in Victoria at the moment, it's basically acute inpatient services. And one of the fascinating things about that, is that everyone hates them. People hate being in them, people hate working in them, people hate visiting them, and there are real issues of safety for everyone in them. Now, when we consider the community led or the peer led alternatives, a lot less goes wrong in them. And the satisfaction both for the guests, and for the staff is much higher. And international evidence suggests that clinical outcomes are similar, or better.

**Dr Ruth Vine (05:21):**

Mary, just again, this is just really for me, one of the other service options in Victoria, and indeed in some of the other jurisdictions now, is the step up step down, the so-called prevention and recovery care or park centres, but they are not designed to take people who need the level of crisis, if you like, or the level of risk of an inpatient unit. So, the residential service you're describing at the same level, if you like, of acuity as an inpatient unit or is it of a similar sort of level with a park unit, or somewhere in between?

**Mary O'Hagan (05:52):**

Look, it's probably up there with the acute unit. It might be somewhere in between, because there is a triage process, it'll be part of a triage process. We're just not actually sure of the details of this, but this is how it happens in New Zealand, and people weren't totally happy with this, but people are triaged into an acute inpatient ward, or one of these community places, or a home-based support, but often because there's so much demand, people aren't triaged where, in a perfect world, they might be indicated to go. So, you do get people who are in very deep crisis in the community-based services sometimes, yeah.

**Dr Ruth Vine (06:33):**

And look, I'd love to delve right down into the operational detail, because that's just the sort of girl I am. But just before we move on to another kind of service, another couple of questions about this. You said there'll be a triage process. Is it expected, I guess, that the people running the service, this peer-led service, that they'll decide who can come, and who can't? Is there some sort of entry filter?

**Mary O'Hagan (06:59):**

I'm not across the detail of that, and I know more about what happens on the ground in New Zealand. Peer led services aren't in the business of saying, you can't come to our service. No, I don't think that's part of the value system. I know that this very demand driven system that we are in at the moment, keeping people out seems to be the first job of the service, and then they'll deal with the people that they let in. But really, it's not part of the value set to say, well, we don't like them because, we don't want them because they're a bit disturbed or whatever.

**Dr Ruth Vine (07:36):**

No, give people a go. And I'm presuming these units, is it just the one of these?

**Mary O'Hagan (07:42):**

Well, it's one at the moment, but I'm very, working very hard to make sure there's going to be a lot more of them.

**Dr Ruth Vine (07:49):**

I'm glad to hear that. And so I assume they're mixed gender?

**Mary O'Hagan (07:52):**

Yes, I think they are mixed gender. Now, that's a very interesting point. As you know, in Victoria, there's been an awful lot of attention given to gender safety. So, that's another issue that needs to be dealt with very carefully, and with sensitivity.

**Dr Ruth Vine (08:10):**

Yes, it's been, again, one of the interesting experiences of my career in that when I started, certainly within the larger hospitals, it was very much gender segregated, not just by units, but even by where on the overall plan of the place that men or women's units were situated. But of course, there was a very big push for so-called normalisation in the eighties, nineties, and 2,000s. And now we're having to reconsider that because, as you said, of the issues of gender safety. And Mary, the other sort of aspect of this service, you've highlighted it's peer led. You've talked about the engagement with clinical services. If you were thinking about the staffing of something like this, what sort of selection criteria would you want the staff to have who worked in a place like a residential crisis, peer-led service?

**Mary O'Hagan (09:01):**

This sounds a bit funny, but I often think, wouldn't it be great if we educated mental health staff in, like they educate people in the hospitality business, because...

**Dr Ruth Vine (09:13):**

Like, sort of customer service?

**Mary O'Hagan (09:14):**

Well, one of the things that I'd want people to really understand is, how do you welcome people as guests into this place, that's incredibly important. Obviously the peer support staff, it would be good if they had been through similar experiences themselves, that they had experienced crises, that they had a good training in peer support. And I think, as the peer workforce develops, I'm wanting to see that there may be some peer support workers who specialise in crisis work, and so they hone their skills, and the use of their lived experience in that particular area, for instance. And I think one of the things that, obviously a crisis is a risky period for people, but one of the things about the peer workforce is that, and there are tensions with the clinical world in this, is that we take a different approach to risk. It's not to say that risk isn't there, it is there, but how do we work with people to support them to manage risk, and how do we do it in a way that's relational, rather than using the blunt tools of force that are often used in the system. The thing about peer support workers is that if you're using these relational skills, it

takes a lot of nuance and understanding of complexity to be able to do that. And I often think that people who are at the lower end of the hierarchy often have to deal with some really complex situations, and they often do it really well, but they don't get acknowledgement for it.

**Dr Ruth Vine (11:10):**

Actually, I think when we last spoke, I talked about my belief that one of the skills of a mental health clinician, a psychiatrist, was that sort of empathic containment, that notion quite apart from the more difficult side of external force. Of course, private practitioners use this all the time, that knowledge that they're providing a degree of emotional containment that lasts between appointments, or between conversations, and is very, as I said, empathic and therefore the person feels understood. So, I guess what you're talking there is that ability of a lived experience peer worker, or howsoever named, to know from their own experience, from their training, how to create that sense that a person is understood, is met on their level, and is safe.

**Mary O'Hagan (12:01):**

And I think it's much easier for a peer support worker to do that than a professional, a traditional psychiatrist or nurse. I think just by the nature of the job, it's a kind of shortcut to trust. I think clinical people probably have to work a lot harder at it. We all have to earn it with people. So, I do think it's one of the great advantages of the peer workforce.

**Dr Ruth Vine (12:30):**

I mean every individual, whatever our training, have our areas of strength and vulnerability. So, you mentioned some of the training, and of course one of those forms of training is intentional peer support. Do you, I'm wandering around a bit here, Mary, but go with me. Do you sort of feel that as that peer workforce is developed, as career progressions are developed, that there'll be almost expectations of levels of experience, or levels of training within that workforce?

**Mary O'Hagan (13:02):**

Yeah, so look, I think that we're at the very start, and if you look at the start of other professions, they start like, social work started off with church women going around visiting people in poor houses, I think. So, I do expect that the peer workforce will have an educational ladder that extends into universities, and goes beyond TAFE IV at the moment, that there'll be specialisms within that peer workforce, instead of the, sort of, being on the outer edge, 3% of the workforce, that it will be a major contributor to the workforce of the future.

**Dr Ruth Vine (13:52):**

And one day, they might even be a regulated workforce.

**Mary O'Hagan (13:57):**

They could be a regulated workforce. But I think one of the dangers of all this, and there's a lot of debate about this in the lived experience community, because a lot of people want it to stay pretty grassroots. And I actually think we need to keep the grassroots stuff, we don't want that to go away,

because that has a real value of its own. But there's a big worry that peer support will become acculturated into the system, and the system seems to have a genius for making things in its own image. So, that is a real danger. So, one of the things we have to do is keep to that fidelity, and the values of peer support without losing them, because we see people working in, especially in the clinical service system at the moment as peer supporters, who are being asked to help put people into seclusion, doing medication rounds to make sure people are taking their drugs, who may feel very unsafe, undervalued, not supported to follow the values of peer support. And so there's a whole lot of risks that we need to manage in order to make sure the peer workforce doesn't turn out like a bunch of social workers, or another profession.

**Dr Ruth Vine (15:31):**

That's the tension, isn't it? I mean, you're really talking about a person's credibility as a lived experience worker, or as a peer worker, their credibility to whoever they're engaging with, that that is where their core comes from. But at the same time, and you've moved a bit into the clinical services, it's really important sometimes for people to be part of a team, and to bring their particular lens, their particular skill, into that team, but not have it subsumed into all the parts of the team.

**Mary O'Hagan (16:06):**

And part of the whole peer workforce development has to be organisational readiness. Of course, I just think if you get a critical mass in there, that will just change things on its own. But we really do need to make the workplace a safe zone, where people can be effective in their own modality.

**Dr Ruth Vine (16:28):**

But without there being a horrible "us and them", because that would be, in my view at least, destructive to a person's recovery, that they sort of felt that the workforce was fighting each other in some way.

**Mary O'Hagan (16:42):**

Where it works, I think everyone has to change, but I think the clinical people have to do more of the changing.

**Dr Ruth Vine (16:50):**

And look, we might come back to that when we next meet, about some of those where the clinical workforce needs to go, but it sounds like at least the thinking around the residential service is well advanced, even if the service hasn't started. But you mentioned that there would be, I think, was it eight, sort of family welcoming hubs?

**Mary O'Hagan (17:10):**

Yeah.

**Dr Ruth Vine (17:11):**

Can you talk a little bit more about those?

**Mary O'Hagan (17:14):**

They're in a process of co-design at the moment with the peak family agency, Tandem. They're really going to be places where people go to get information and support.

**Dr Ruth Vine (17:27):**

"People" being family supporters, or?

**Mary O'Hagan (17:30):**

Family supporters, yeah.

**Dr Ruth Vine (17:32):**

So, not consumers per se, but carers?

**Mary O'Hagan (17:33):**

Well, this sort of interests me, and I'm not sure where they're landing with this, but there's a whole bunch of services for consumers. There's a few supports for carers. There's very, very little I've ever seen that is about supporting the whole family. There probably is a bit in the child and youth area, for obvious reasons, but I think there's a real gap in our system for just working with whole families who are affected by the person themselves, and the people who are affected, and helping them figure stuff out, and restore their relationship to some sort of sense of taking the stress off it, or feeling a bit normal. Now, that doesn't work for everyone. Some people decide, I don't want my family involved, but I think there's an awful lot of, instead of everyone going down their separate tracks, sometimes I think it's quite good to bring them together, and to offer support as a unit rather than separating them out.

**Dr Ruth Vine (18:43):**

I have to say that I absolutely agree with you, but from both sides really. I mean, I can think of a number of instances where a person had nowhere else to live but with their family, and it was most important for that person, and indeed that family, to work out some of their rules of engagement, to work out how they were going to live together when there weren't necessarily other choices. So, I mean, actually, I think when we last talked, we touched on that consumer-carer reconciliation, but this is an obvious place where some of that reconciliation might be able to be approached. So, it's in the process of design, it hasn't actually come to fruition?

**Mary O'Hagan (19:21):**

Yes it is, yeah. So, I can't give you too much detail. There'll be eight of them around the state, and one in each regional board area. I think the commission report said they'd have eight staff in them, which doesn't seem a huge amount to me.

**Dr Ruth Vine (19:39):**

There you go, it's a starting point. Sorry, Mary, it was one of the other models you mentioned, similar to the Safe Haven Cafe. Was that sort of drop-in?

**Mary O'Hagan (19:47):**

Yeah, so that's another thing. Our branch isn't working on that at the moment. There's a whole cluster of emergency responses that are trying to divert people away from the disastrous emergency room situation. And there are going to be some safe havens around, where people can just go, particularly after hours, they can just hang out, they're feeling distressed, and they can get some peer support, but there are going to be some other options as well. And I think really, I'm really keen to see, if you're in a mental health crisis, why are we going to emergency rooms? And I think they're trying to get places, different sites, where people can go that might be in the same building, but just a different space where people go. It just seems that, it's never made sense to me, that we would have people in distress waiting for hours in an emergency room, with a whole lot of people in a variety of conditions. And there's also great potential, I think, where people are in a holding pattern, to have peer supporters in those contexts as well. That's proven to be incredibly helpful.

**Dr Ruth Vine (21:13):**

Just, sort of, while a person is waiting for some next intervention?

**Mary O'Hagan (21:17):**

While they're waiting, or even just at any stage really, but while people are waiting, there's a whole potential labour force out there that could be brought in to make these experiences much more palatable for people, much safer.

**Dr Ruth Vine (21:36):**

Again, it's been one of those tensions, I think, that if we were to go back a long time, then many people with crisis were taken to assessment units on standalone service sites. Many indeed were detained by police, and transported by police, and then we moved to say, hang on, emergency departments should be competent in responding to people with mental illness, and mental health crisis. But of course, the staff might've improved, but the environment has always been very problematic. And then when inpatient units are under a lot of strain and, as you highlighted, people could wait there for hours or even days, which is clearly not satisfactory. So, having these sort of, if you like, alternatives and diversions, mind you, I'd say some people will always need an emergency department, because of coexistent physical problems or issues that need to be investigated. So, absolutely. So, family centres, the residential centre, safe havens. What were the other models, I'm sure you mentioned something else?

**Mary O'Hagan (22:43):**

There's a lived experience, a consumer led agency that's really going to be, that's at the beginning of the design phase two, not incredibly well defined in the commission report, but it's going to be a development agency, and it's probably going to trial new forms of peer-led service delivery, and could

have a very close working relationship with the collaborative centre that is another recommended new entity.

**Dr Ruth Vine (23:20):**

And maybe also, a very strong relationship with whatever training bodies are involved in...

**Mary O'Hagan (23:25):**

Yes, exactly.

**Dr Ruth Vine (23:26):**

...in the workforce development area. Goodness, Mary, again, I'm asking you to sort of put on your magic hat I guess, but you mentioned before, the development of any workforce often has a long history, and we could look at surgery or physicians, or as you've highlighted, social workers, it takes, in some cases, centuries, but I imagine you don't think we've got centuries.

**Mary O'Hagan (23:52):**

Oh, no. Look, I'm not as patient as that. No, I think that in Victoria, we have a unique opportunity to fast track some of this stuff, to fast track the development of the lived experience workforce. Where I come from, New Zealand, we've been waiting around for 25 years for something to happen, and not much has really happened. So, I think the direction is there, the funding's there, and we just need to take advantage of this unique opportunity.

**Dr Ruth Vine (24:32):**

And indeed they have, because they've recruited you. So, that's a pretty good start, and you were telling me last time, you've got about 20 FTEs, so that's another good start.

**Mary O'Hagan (24:44):**

Yeah, that's a great start. Yeah.

**Dr Ruth Vine (24:45):**

But there are also, again, I'm sure this is the case in other jurisdictions, for those who are listening to us in Victoria, there's been the Victorian Mental Illness Awareness Council, VIMIAC, you mentioned Tandem, the Carers Network as it used to be called. How do you think your role can bring together those sort of organisations that have their own history, and indeed training organisations as well?

**Mary O'Hagan (25:12):**

Well, obviously the peaks are there to represent the interests of their constituents. They want to see these workforces being developed as well. I mean, there's a few debates about how, and there's a few debates within that, but everyone wants to see lived experience workforce development. I mean, they're not the education agency, so that we need to work together with the training agencies. And I

think these peaks, really, their advocacy can ensure that what the training agencies do is actually, fits the intent and the values of the lived experience workforce. One of the problems is, again, you get a generic training agency to perhaps develop a curriculum, or to deliver training, and they don't always quite get it. So, this is where we really need to have the combined force of that lived experience advocacy with the expertise in the training agencies.

**Dr Ruth Vine (26:22):**

Mary, just about all of the clinical workforce has it some element of an apprenticeship model. You work on the job, you're supervised by someone with more experience. You get to sort of model after someone, and observe someone. Do you think that there should be the same, if you like that same sort of structure, for the lived experience? So, you almost have an intern type placement with supervision and support, and you gradually develop greater confidence in your role. What do you think?

**Mary O'Hagan (26:54):**

Well, I think that works well. One of the difficulties though, is that sometimes people in the services have felt that, for instance, that they need clinical supervision. We don't think that's appropriate, that for people who are learning on the job, that they need peer supervision. And again, it's about supporting people to stay true to the values of peer support, or the lived experience workforce. Also, having an education that comes from that perspective. So, we have a lot of education happening at the moment for the peer workforce, not just in Australia, but in other places, being taught by people who don't have that background. Now, they might be good people, and they might have some other things to offer, but they don't have that lived experience background, so they can't really teach with total authenticity about the lived experience perspective. So, we really need to keep the whole thing lived experience led.

**Dr Ruth Vine (28:03):**

Of course you do. And in the same way that, when I was a baby psychiatrist, I was supervised by psychiatrists, and I was supervised by psychiatrists with particular expertise in the particular rotation I was working in. But of course, that still means you've got really big workforce challenges, in terms of getting the right people in each of those layers, and keeping them true. We're nearly out of time, Mary, but one of the other things that I guess is often critical in working in this area, is a relationship that is in the best interest of the person needing care and support, not a relationship that becomes predatory, or indeed oversteps a boundary, because of inappropriate weighing up of what's right and what's wrong. Do you think that's going to be something that needs to be part of that peer workforce training, that whole notion of boundaries, and where a boundary sits, and what you can and can't transgress?

**Mary O'Hagan (29:00):**

Oh, absolutely. I mean, I think in the peer workforce, the boundaries are a little bit different. They're a bit more flexible, but we have to be very clear, as peer workforce, that we are there for the benefit of the other person, and everything we do needs to be geared towards their benefit, and what they're needing or wanting at that time. So, that's very strong feature in the peer workforce. And sometimes, clinical people have a bit of trouble understanding that you could have these more flexible boundaries, but there's still boundaries. And that's been a real tension that the clinical workforce haven't understood, and it's incredibly important for peer workers to be working in a way that is safe for people, and isn't exploitative, and isn't going to be emotionally confusing or anything like that for them.

**Dr Ruth Vine (30:01):**

Thank you. I mean, I guess we all come to our work hoping that what we're doing is being beneficent, not malevolent, and sometimes that's challenging, and it's another reason why we have supervision. Mary, look, thank you so much. As you know, I'm going to catch up with you again shortly, and I thought next time we might talk a bit more about the current service system and treatments, and again, your perspective of the roles of others, because this time we've really focused on the developing peer led workforce, and it's the range of different service options that you're involved in. But look, it's again been just a delight to talk with you. So, I'm just going to say thank you, and thanks for joining us on this episode of MHPN Presents: In Conversation With. You've been listening to me, Ruth Vine and...

**Mary O'Hagan (30:48):**

Mary O'Hagan.

**Dr Ruth Vine (30:48):**

And we hope you've enjoyed this conversation as much as we have. I hope, Mary, you've enjoyed it too. If you want to learn more about Mary or myself, or want to access any resources we may have mentioned, go to the landing page of this episode and follow the hyperlinks. And look, I do hope those hyperlinks include some of the Royal Commission recommendations that Mary's been talking about. Additionally, on the landing page, you'll find a link to a feedback survey. MHPN really values that feedback, please follow the link and let us know whether you found this episode helpful, and of course always provide suggestions or comments, and you could even give us a star rating. So, do stay tuned for further episodes in this series of In Conversation With, or listen to other MHPN podcasts. We absolutely thank you for your commitment to and engagement with interdisciplinary, person-centered mental health care. So, it's goodbye. Thank you very much.

**Host (31:41):**

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