In Conversation With… Dr Ruth Vine and Mary O'Hagan – Part 3

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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):

Hello, and 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 at the moment I'm also employed by the Commonwealth Department of Health in the role of Deputy Chief Medical Officer for Mental Health. I'm joined by Mary O'Hagan, Executive Director Lived Experience in the Mental Health and Wellbeing Division at the Department of Health in Victoria. Mary and I have actually had a couple of conversations, this is our third. Hi, Mary. Thank you for joining me.

Mary O'Hagan (00:50):

Hi, Ruth. Good to be here.

Dr Ruth Vine (00:51):

I'm looking forward to our conversation today. As I said, this is the third of three, and I think it's fair to say that the first one, we sort of touched on a number of different areas to do with the Royal Commission, your role, your past. In the second one, we really, I think, tried to delve into some of the service models that are likely to be led by those with lived experience, some of the workforce issues related to that expanding workforce with lived experience, and you sort of highlighted the need for that sort of time to mature, but also the need for that to happen pretty quickly.

(01:28):

So, we're sort of talking about these areas of interest through our respective lenses. My lens, as a person with 30 years of experience working clinically and administratively in the clinical roles, and of course yours, Mary, coming from a lived experience perspective. So, in this episode, Mary, I was sort of hoping that we'd move to talk a little bit about the service system, and you've touched on some of those challenges already. You've talked about the risk, and the limited range of things, but let's sort of tease that out a bit more, because it's pretty important. And I do just want to flag, just for people who are listening who may not come from Victoria, or even may not come from Australia, very, very briefly: in Australia, it's a federation.

(02:17):

We have various mental health services funded through the Commonwealth, that includes primary care services funded under Medicare, access to pharmaceutical benefits. Some of that commonwealth funded service is, in a way, subsidised private practice, so people have to pay a gap fee on top of that. And then of course, there's a private system, particularly bed based covered by private health insurance, largely. And then a really important part, which is the public health mental health system, funded through state governments under the National Health Reform Agreement, that includes both bed based services and community-based services. And it's probably that part of the service system that has been under most pressure in recent years, even decades. And indeed, that resulted or led to Premier Dan Andrews setting up a Royal Commission. And subsequent, one of the main recommendations of that Royal Commission in was in relation to lived experience, or many of the recommendations were in relation to lived experience. So, that's where Mary's role was born, and the department were very lucky to recruit Mary. So, Mary, does it sound all right if we explore some of those service elements a bit? And I thought we should touch on the risk, and maybe mental health legislation, and also some of the roles. So, let's start at the sort of less acute, less severe end. What's your thoughts about your exposure so far to the mental health system in Victoria? That is, the primary care sector, that is mental health provided through general practitioners, through psychologists?

Mary O'Hagan (03:59):

Look, I can't really comment on the primary healthcare system in Victoria. I have done a little bit of work with PHNs over the years, that's the primary health networks, but I really wouldn't be in a good position to comment on them. I mean, there is a new suite of services being developed that kind of sit between the primary health service and the area mental health services, and that's the locals. And they're designed to be walk-in places where people can get a variety of clinical peer support and wellbeing support services to meet their needs. None of them have been stood up yet, but there's been some design work done on that. But I wouldn't really be in a position to comment on primary mental health services.

Dr Ruth Vine (05:02):

I think the expectation is that the locals, as you call them, the local mental health and wellbeing, are likely to, the hope is, I guess, that people access them early on in a course of psychological distress, or mental illness. And indeed, that lived experience is part of the workforce in those centres. Is that correct?

Mary O'Hagan (05:20):

Very much so, yeah. Yeah. There will be peer support workers in all those local services.

Dr Ruth Vine (05:29):

Presumably, they will be diagnosis agnostic. We haven't talked about different types of mental illness, but I guess most of the people who access mental health services in the primary care sector are likely to experience anxiety, mood changes, maybe coexistent substance use, and are somewhat less likely to experience the illnesses I think we touched on in our first conversation, that come under that sort of severe mental illness banner, like psychosis, schizophrenia, schizoaffective. But, do you think it's expected that the local mental health and wellbeings will also provide an easy entry to people with, experiencing perhaps early on in, that sort of illness or early on in an episode?

Mary O'Hagan (06:15):

Well, one of the things that I think quite often in our service systems is that if we start with the promotion of wellbeing, and then we go into the primary health, and then the secondary services and so on, we don't want to close the door to those supports and those services further down the spectrum once you go up it. And this is what we do all the time, we say now you're too unwell for this service, so you've got to go into this service. And what often happens is that people miss out on some of the good things that that service at the middle of the spectrum had, and they're pushed into a clinical service that has a very narrow range of supports and treatments in it. So, I don't think of that spectrum as a place where people are permanently. I think we should go up and down, and I think we should not lose access to services that, when we're in the secondary services, I don't think people should lose access to what's available in the locals, because it's likely to be a lot more varied and in some ways a lot better. And I think that's almost a form of discrimination.

Dr Ruth Vine (07:44):

Oh, I couldn't agree more. I think one of the main areas for stigma and subsequent discrimination has been exclusion of people. Mary, the local mental health and wellbeings, as you said, they're a thing of the future and I think we're all looking forward to them. One of the other component parts of the Australian system, before we come to talk about the state funded system, is the private system where there are issues of affordability, but by and large, it's under intense demand at the moment. Psychiatrists have long waiting lists, psychologists have long waiting lists. People really choose to use that service when they can. What do you think people gain from using the private sector?

Mary O'Hagan (08:30):

Well, it's really interesting. There's very little private psychiatry in New Zealand. We have one private clinic that is based in the south, and that's been going since about 1880. There are some psychiatrists who offer consultations privately, and that's about it. And so, I don't have a lot of experience of private psychiatry. It's very big in Australia, and I do wonder if that creates a two tier system, a system where if you can't afford it, you get not very good services. And if you can, you get better services. And I think that's a worry. I'm not that in favour of a big private system, but that's historically what's happened in Australia.

Dr Ruth Vine (09:23):

One of the very interesting things I have found is that in any other area of medicine, in the private system, you might get a single room, you might get better food, but the treatment and care you get is very similar to that in the public system. That is, the same MRIs, the same surgery, the same investigations. But in psychiatry or in mental health, the treatment that is available in the private sector is very, very different from the treatment that's available in the public sector. And indeed, it is often split down diagnosis lines and risk lines. My sincere hope is that one day the public system will be sufficiently well-funded and staffed, and have sufficient amenity to be able to say, well, if you want to go to private, you can, but in fact, you'll get just as good treatment in the public sector, and just as individualised treatment in the public sector.

Mary O'Hagan (10:19):

And the private sector, I understand if you are under the Mental Health Act, you have to go into the public system, is that right?

Dr Ruth Vine (10:29):

Well, it's right at present, but of course Victoria is also in the process of developing a new Act. Some of the new services, for instance, the new women only service, which is at the Albert Road Clinic, is in the private sector, but it's publicly funded.

Mary O'Hagan (10:45):

But it's publicly funded, yeah. Okay, yeah. From what I understand with the private system is that it is very psychiatry based and medically driven, and that while it has something to offer people, it doesn't give them the full range of supports that they might need. So, it tends to favour one modality over others.

Dr Ruth Vine (11:10):

That's probably true, I think it's probably changing a bit. I think there's now increasing access to community supports. Private services are also employing people with lived experience. So, I think it's changing. But that does bring us to the third sector, which I really wanted to spend most of our time on, which is the public sector, which is the one that you'll have the greatest interface with. And you said in our first meeting that it had become overly risk, risk aware. Mary, I have to say that as a person working in that sector, almost every time a critical incident happens, there is a coronial inquiry, there are recommendations made, and most often those recommendations are to, in my view, worsen the amenity. Taking covered doors down, taking shower curtains down, taking shoelaces off people, taking all that sort of stuff. What's your view about that?

Mary O'Hagan (12:04):

In some ways, it goes back to stigma and discrimination, and the unrealistic, almost magical, expectation of the community for particularly psychiatrists to be able to predict when bad things will happen. And we all know that psychiatrists are humans, and I think the evidence suggests that their predictions are slightly better than chance. And then when something does go wrong, particularly the psychiatrists and

the other staff, they face all these inquiries. There's a whole number of regulatory kind of entities around that might decide to have an inquiry. Then you might have your internal inquiry. And I know of some, so-called critical incidents, and people have been through eight inquiries. In some cases, these have had very career limiting consequences for people. So, I don't think these inquiries really help. So, what happens is that in order to avoid these things happening, people don't take risks. And the best way of not taking risks is to have locked wards, and to use the Mental Health Act.

(13:21):

You can see the logic in it, and I can see why people want to use these powers quite frequently. And I think it has had a really bad effect on the whole system. It has a terrible effect on people's trust of the system. When we invoke these powers, as you can imagine, people don't really want to ask for help if they think they're going to be locked up, or forced to take medication. But on another level, I think it has almost a corrupting influence on the whole system. One of the things that surprises me about this, I mean, if I was a psychiatrist, I'd be bloody annoyed at this, and I'd be wanting to promote the idea that this shouldn't be our job, to make people do things. I mean, God, we were supposed to be healers of the soul or something. I mean, that was one of the origins of the word, or something. But I never hear the psychiatric associations get up and say, look, we've been put in a very invidious position, and we don't think that it's our job to be deciding when people should be forced to take treatment, and we shouldn't be held accountable for absolutely everything that goes wrong. But I don't hear that.

Dr Ruth Vine (14:50):

Well, you would've heard it, if you'd listened to all of the Royal Commission, because certainly Simon Stafrace and I both commented on that. But I would also say that there's, one of the problems that we just talked about, the difference between private and public is of course, many people would go and work in private because they don't want to be placed in such an invidious position.

Mary O'Hagan (15:17):

That's right. And they don't have that option in some countries, but they do in Australia. And I think we need to somehow, I don't know how, but we've got to do something about this community expectation. And the same happens in child protection.

Dr Ruth Vine (15:40):

It does.

Mary O'Hagan (15:40):

And in criminal justice. And I just think it's kind of ridiculous, and it does skew the system in some very unfortunate ways.

Dr Ruth Vine (15:52):

Mary, I am very pleased to hear your views on this. And I have to say, I think I'm in complete agreement with most aspects, if not all. One of the tensions that we have at the moment is we've got parallel but conflicting policy directions, and one of those is embodied in mental health legislation and other

legislations, which is around rights, and recovery, and presumption, and choice. And the other, in some other legislations like the work safe legislation, or some parts of the Coroners Act and other, which is about saying your workplace has to be safe. It has to be safe for everybody, visitors, patients, or that, as you've said, and I quite liked your terms, some magical ability to predict risk when we all know that prediction of something with a very low base rate like suicide is very, very difficult. So, we have that tension.

(16:54):

One of the phrases that is used sometimes in this area is dignity of risk. I think sometimes it's a difficult phrase, because if a person is, say for instance, in a delirium and absolutely not able to control their thinking or their actions, or interpret their reality, you might say, well, it's not very dignified to let that person wander out into the traffic. But in many other occasions, giving a person maximal choice absolutely makes sense. Do you have a view about how we keep having this conversation that says we are going to maximise people's choice and freedom, and we're going to tolerate a level of risk?

Mary O'Hagan (17:39):

Some people say to me, look, I was under the Act and I think it saved my life. Now, I'm not going to argue with that, but if I take a helicopter view of the system, I think if I had to weigh up the harm versus the help done by the presence of the Mental Health Act, if I had some measuring scales, which I don't, I wouldn't be surprised if actually more harm is done by the presence of the Mental Health Act than help. If you think about what it does to individuals, and how it actually skews the whole system, I would wager a bet that it does more harm than good. And so that's the position I come from, with that. And I think we need to try and imagine a world where we didn't have a Mental Health Act, and imagine how would we respond to people who were in a very bad way if we didn't have the legislation to force them to do things, or not do things. I think that would be an interesting conversation.

Dr Ruth Vine (19:03):

This is a point where I have to say I do disagree with you, because I think I have seen people who would not have accessed treatment had we not an Act which provided for rights and protections. And if you like, the benevolent part of the Mental Health Act is enabling people to access treatment. But mental health legislation is, not quite universal around the world, but it's pretty universal. And places that don't have mental health legislation often have very highly restrictive regimes, or high numbers of mentally ill people in their prisons. And we could even look at history and remind ourselves of Thomas Szasz and the Myth of Mental Illness, but surely there's an in-between somewhere.

Mary O'Hagan (19:47):

We can't really have a conversation about the Mental Health Act unless we also have a conversation about our criminal justice system. I mean, I think our criminal justice system is awful. If we took a trauma-informed view about criminality, and I'm not saying that's the only cause of criminality, but it's a pretty common one. If we took a trauma-informed view and got away from this primate need for revenge, and looked at people's mitigating circumstances, not just with the insanity plea, but there's a whole lot of mitigating circumstances out there, and took a truly rehabilitative approach to people who've offended, then I think we could do without a Mental Health Act.

Dr Ruth Vine (20:42):

Some of the Scandinavian countries have come a fair way to that. And again, I would say, these are conversations that we need to keep having because, I mean, the other thing I'd say is that if capacity was terrific, and the workforce was terrific, including the whole breadth of the workforce, not just psychiatry, then I do think we could avoid many of the negatives of mental health legislation, because we would be able to engage people from a relational way earlier. But I don't know if we could ever entirely do without it. And again, I guess I come back to my experience within the forensic psychiatric system.

Mary O'Hagan (21:20):

It's a bit like building motorways though, isn't it? If you build them, people will drive down them, but it's sort of interested me that in some jurisdictions there are compulsory treatment for people with alcohol and drug issues, and often they're hardly ever used.

Dr Ruth Vine (21:38):

Yeah, well, it's a much harder argument because there isn't the place. 20, 30 years ago, we had hundreds of beds in the drug and alcohol sector, and many people under various legislations. But there was a big schism really, that drug and alcohol went down a social path, and mental illness went down a medical path.

Mary O'Hagan (21:59):

And I think that's very unfortunate, that what we call mental illness went down the medical path. And that's not to say, I'm not suggesting, as in the drug and alcohol area, that medicine doesn't have a part to play. But I think that medicine in the mental health area has, and even the naming of mental health, the big problem is it's been so dominant. And if you look at the outcomes for people who use mental health services, it's not a great advert for the dominance of the medical approach. I really think that any emerging reform system needs to move from psychiatry, or that sort of medical approach, at the centre and just at the hub, and just have it as one of the spokes.

Dr Ruth Vine (22:57):

I think you mentioned that when we first met, I'm assuming you were saying there that I'm not talking about a medical model that equals prescribing, I'm talking about the bio-psychosocial, the holistic model.

Mary O'Hagan (23:07):

The whole, it's really that clinical world view that has been supported by the bureaucracies. I see evidence of it every day, that's been well-resourced, that has dominated the discourse, leaked into the popular discourse as well as the academic discourse, and has been the sort of architect of most of the services that exist. That's what I'm talking about.

Dr Ruth Vine (23:40):

I mean, I guess I'm not going to go into a history lesson, but of course many of the reformists within mental health came from a very sociological perspective, and really talked about the influence of society on presentation. But Mary, just, I'm going to jump topic soon, because we're going to run out of time. But if you sort of thought, now we are in the process of developing in Victoria a new Mental Health and Wellbeing Act. The intention of that Act is, I think, to try and promote a broader spectrum of engagement, and certainly a broader spectrum of service models. If you were sort of thinking what you'd like to see three years into your role, you are three months into it now, or four months, but three years into your role, would you like to see a significant change in the use of the mental health legislation, and a re-imagining of that risk dialogue?

Mary O'Hagan (24:42):

Yes, I would. I know there was great hope when the 2014 Act came in, and everyone was really excited and they thought, this is going to drive down rates of compulsory treatment, and it didn't. So, I'm not sure if the way the Act is put together has a lot to do with it. I just think there are drivers in the environment that we've talked about that have much more to do with how often the Act is used than the Act itself.

Dr Ruth Vine (25:15):

Certainly in the service that I ran previously, we had such a high threshold for anyone to get into our service that they almost had to be compulsory by the time we could make a space, because there was no space. And so, I do think capacity and funding, which hopefully the Royal Commission recommendations are addressing, will make a difference, but of course not a complete difference.

Mary O'Hagan (25:41):

Well, and sometimes people put people under the Act just so they can get them into a service.

Dr Ruth Vine (25:46):

Well, but they shouldn't need to do that if there's..

Mary O'Hagan (25:48):

Well, I know.

Dr Ruth Vine (25:49):

They shouldn't need to do that if there's sufficient capacity.

Mary O'Hagan (25:51):

Of course they shouldn't. But you get all these perverse drivers and incentives. I mean, the other thing about the Act is that, as I've said, there's a lot of drivers in the environment to use it. There's very little

incentives not to use it. Why don't we treat putting someone under the Act as a critical incident that needs some internal debriefing?

Dr Ruth Vine (26:17):

Which we're doing with seclusion at the moment.

Mary O'Hagan (26:19):

Yeah, there must be psychiatrists who use the Act more than others, and there may be some logical reason for that, but why don't we question people if they use it much more than their peers in similar circumstances? So, I just think we need some counterbalances to it. People say to me, oh, the Mental Health Act's got all these rights in it and it's great, and all this sort of thing. Actually, the Mental Health Act, as we traditionally understand them, I know the Victorian one's a mega Act, it's all about taking people's rights away from them. I just don't think we should fudge that issue.

Dr Ruth Vine (27:03):

Well it's the, the protection's limited, but we are going to have to wrap up, but I thank you for having this conversation, because it's a very significant one. It has impact on workforce, it has impact on scrutiny. You've just talked about the scrutiny of the system and the accountability mechanisms that exist. Many, many more things for us to think about. But Mary, we probably do need to wrap up, and because this is the third of our conversations, I just wanted to finish by both of us having a bit of a thought about how we viewed these three conversations. If I was to think of one thing that I'm going to think a lot more about, it's sort of what you just talked about, which is the centrality that has been the medical model and that notion of psychiatry being one of the spokes, but needing to absent from the hub. And I'm going to give a lot more thought to that, but is there anything that came to your mind that you thought, oh, during these conversations I've had to rethink, or change in my thinking about anything?

Mary O'Hagan (28:04):

I think it's really good to have these discussions. I mean, I don't think we have enough of them. One of the things that we're introducing into the department is deep dialogues, where people from different perspectives can come together and discuss these issues. And I guess this experience has underlined, that is a good thing to do.

Dr Ruth Vine (28:29):

Yeah. No, thank you. And I mean, I think too, one of the other things you said, I think it might've been our last conversation, was that many of the professions took a long time to mature, and we need to give people time to do this, but there's no doubt that the construction of the workforce, and the construction of the scopes of practice is changing. Is there anything that you might do or think differently, as a result of talking through some of those areas around workforce, and roles, and functions?

Mary O'Hagan (29:00):

Well, it's complex with the lived experience workforce. There's quite a lot of debate about how developed that workforce should get. You introduced the idea of a regulated workforce for lived experience. I'm not quite sure what all the implications are of that, but that was an idea I hadn't really come across before.

Dr Ruth Vine (29:26):

Thanks, Mary. And look, this is the last of our planned conversations, and again, I thank you for your generosity in being around for the three of them. If I thought about the unfolding, here we are in the very beginning of the Royal Commission. There's so much work happening. But if we were to go, to come back and have another conversation, is there something you'd want to talk more about, or learn more about?

Mary O'Hagan (29:51):

Maybe I could interview you, about psychiatry.

Dr Ruth Vine (29:57):

I'm up for it!

Mary O'Hagan (29:59):

Okay. I'll interview you. I did reflect on, and this is no criticism of you or anything, but I did thought, well, I'm being interviewed by a psychiatrist again, I'd really like the opportunity to interview a psychiatrist.

Dr Ruth Vine (30:18):

Oh, look. Don't hold it against me.

Mary O'Hagan (30:20):

No, no, no.

Dr Ruth Vine (30:23):

But look, we do need to wrap up. So, can I say thank you to our listeners, thank you very much for joining us on this episode of MHPN Presents: In Conversation With. You've been listening to me, Ruth Vine and...

Mary O'Hagan (30:36):

Mary O'Hagan.

Dr Ruth Vine (30:37):

And we do hope you've enjoyed this conversation as much as we have. If you want to learn more about Mary, or about me, or want access to any resources we may have mentioned, go to the landing page of this episode and follow the hyperlinks. I'm sure it's got the Royal Commission there, and maybe it's got draughts of the Mental Health and Wellbeing Act sooner or later. Please follow the link, and let us know whether you found this episode helpful, provide feedback, and any comments and suggestions about how MHPN can better meet your needs. You can also put in a star rating. Please stay tuned for further episodes in the series of In Conversation With, or listen to the other MHPN podcasts. I absolutely thank you, and I'm sure Mary does too, for your commitment to and engagement with interdisciplinary, person-centered mental health care. So it's goodbye...

Mary O'Hagan (31:28):

From me.

Dr Ruth Vine (31:29):

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

Host (31:32):

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