In Conversation With… Mary O'Hagan and Dr Ruth Vine – Part 4

https://mhpn.org.au/podcasts

Release date:	Wednesday, September 28th 2022 on MHPN Presents
Presenters:	Mary O'Hagan, Executive Director Lived Experience in the Mental Health & Wellbeing Division, Department of Health Victoria Dr Ruth Vine, consultant psychiatrist, Deputy Chief Medical Officer for Mental Health

Disclaimer: The following transcript has been autogenerated and may contain occasional errors or inaccuracies resulting from the automated transcription process.

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.

Mary O'Hagan (00:17):

Hello, welcome to this episode of MHPN Presents: In Conversation With. My name is Mary O'Hagan, and I'm the inaugural Executive Director Lived Experience in the Mental Health and Wellbeing Division at the Department of Health in Victoria. With me today is Ruth Vine, psychiatrist, and Australia's first Deputy Chief Medical Officer for Mental Health. Hi Ruth, thanks for joining me.

Dr Ruth Vine (00:44):

Hello, Mary. It's great to be with you once again.

Mary O'Hagan (00:46):

Yeah, and I'm looking forward to our conversation. This is the fourth of five episodes where we have and will be chatting about issues of mutual interest from our respective lenses. My lens, as a lived experience advocate, and yours, Ruth, as a psychiatrist. Now, in the previous episodes we discussed a whole number of things, such as the opportunities and challenges of including lived experience in mental health services, having lived experience leadership and partnerships, innovations in and new models of peer support, managing risks and the challenges of that, the mental health reform agenda about where the dominant lens has been traditionally in mental health service delivery. For those of you who haven't listened to those episodes, you can find them on MHPN Presents. Ruth, you took a lead in those conversations, and we discussed issues that, in particular, you were keen to talk to me about. But in the next episodes, I'm going to take the conversational lead, and suggest topics that are of interest to me, and which I'm really curious to hear from you about, because one of the things I've noticed about all the years I've done this work is that we talk a lot about psychiatry, but we don't really talk to psychiatrists very much.

(02:14):

So, in this episode, I'm going to chat to you, Ruth, about your motivation for doing psychiatry, and some of your own views on the profession, and your experiences of it. And in the next episode I'm going to ask you for your responses to some of the critiques of psychiatry. The first thing I'd really love to know from you, Ruth, was what were the influences in your early life that led you to medicine and then psychiatry?

Dr Ruth Vine (02:45):

Mary, I'm going to give you really dull answers to this bit. So, I could say, and it's true, my dad was a doctor, he was a surgeon in a country town, but I actually don't think that was the influence. I think, at the time that I went to school, and at the time that I sat my final exams, they asked you to put down what you wanted to do, and for people who were doing sort of general subjects, the usual ones where you put down medicine and law, and I put down medicine and law, and I got into medicine, and I did medicine. So, I can't pretend that I went in with a sort of vocation to bring particular services to anyone. But I can say that I mostly enjoyed my medical studies, and I have to say that I was so lucky, Mary, because I was a medical student at a time when university was free, where you were expected to enjoy your time being at university.

(03:42):

I didn't incur any debt, in fact, the government paid me. By that time my father had died, and my mother wasn't very well off, so I actually got a living allowance to go to university. So, I think those things shaped me quite a lot. And I was also at university at a time when Medicare, or Medibank as it was back then, was just sort of emerging. And I think that notion, that notion of equity, and particularly concern about those less advantaged, was sort of real back then, but I can't pretend to any great higher calling. In terms of psychiatry, I actually didn't think much of psychiatry when I was an undergraduate. I probably mixed with some leftish people, and we read R.D. Laing and stuff like that. We didn't have a great view of psychiatry, but when graduated and I did, I started off doing medicine, Mary, I'd done well in my exams, which meant that I could choose, pretty much.

(04:36):

So, I did a range of things, and I sort of moved from a few different ideas. I taught anatomy for a while, I started the physician training, and it just wasn't for me. And then I just got a job in psychiatry at the Austin Hospital, and it was in the crisis service, and I enjoyed it, and I think I was quite good at it. And that led me to apply to join the psychiatry training. And off I went on my merry way. And I had a really, again, I think a really positive training experience across a mixture of general psychiatry in a general hospital, what was still, then, the large standalone. So, service a time at Larundel, and time at Mont Park, and then a time in forensic psychiatry before I finished. And then I topped it off by being very, very lucky, and being able to spend a year in Toronto working with elderly people who were survivors of the Holocaust.

(05:33):

So, working in a Jewish hospital, and that again, was a really enriching experience, and a very interesting one. And then I came back to Melbourne, and off I went with my career. So, I can't say that I'd thought it through, that I'd planned something. I guess I found that invitation to be curious about people, that invitation to engage with people, and particularly that sort of close engagement with people who had had amazing things happen in their life. Sitting with these elderly people who'd come to Canada, having lived through and having lost many relatives in that hideous world of the Holocaust, it gives you an amazing perspective, and I think encourages you to try and engage with, contain, be with people from all sorts of backgrounds.

Mary O'Hagan (06:26):

And you wouldn't get that through doing anatomy, no.

Dr Ruth Vine (06:31):

No. I mean, I can't say I didn't enjoy anatomy. I got my best exam result in anatomy, so I was pretty good at it. But it's different. I mean, the human body is an amazing thing, and anatomy helps you understand that. But I think that engaging with people, and again in my, I did forensic psychiatry for about a decade, and you cannot ignore, again the thing that I think is terrific about psychiatry, that you cannot ignore the biological, the psychological and the social, and that you cannot ignore the longitudinal impact of previous life experiences on a person's take on their world, on how they interact with others. For many of the people I saw when I was doing forensic psychiatry, bad things had happened to them early on in their life, which had certainly not happened to me. But had they happened to me, I couldn't say that I wouldn't be in their circumstance. So, there is that broader perspective, and psychiatry I think has worked hard to understand those broader perspectives.

Mary O'Hagan (07:31):

And yet, when you talk to people who use mental health services, they often say that psychiatrists don't really appear to respond to that broader perspective, and that they really just take a very biological view. And this has been something that has probably been more pronounced in the last generation than before. I mean, what would you say to that?

Dr Ruth Vine (07:58):

Okay, I'm going to have to say a few things. And firstly, I do have to tell our listeners that I have been a public psychiatrist, because I have many friends who work in private psychiatry, and I do think in Australia, and perhaps Mary in New Zealand as well, there is a difference in the relationship a person has with his or her private psychiatrist than they may have with public psychiatry. That's one thing. The second thing I'd say is that, again, I count myself as very fortunate because I did my training at a time when there was general psychiatry in general hospitals that was not under the Mental Health Act, and then there was psychiatry that happened in gazetted services that was, not entirely, but for many people who were involuntary or compulsory patients. The third thing I'd say is that I have experienced a time when there was energy and enthusiasm and funding and reform, and I've also experienced a time when there was less funding and constricted services.

(08:59):

And I think it's really important to separate out a person's experience of a system from a person's experience of an interaction with an individual. Now, I'm absolutely, Mary, not going to say that every psychiatrist is a terrific human being and always at the top of their game. Of course not, you couldn't say that of surgeons, physicians, GPs, anybody, but I do think that people go into psychiatry by and large because of that curiosity, and because of a desire to be able to think more broadly about a person rather than just down, as you said, just down an anatomical path, or a pathology path. And I have seen people who have not been able to deliver the service they wanted to deliver because of there not being the capacity, or there not being the time, absolutely. That's how come Victoria ended up with a Royal Commission, for heaven's sake, because there had been such a contraction of services, such a contraction.

(09:59):

I just can't believe how, at times, how reduced services had become compared with when I was a registrar to when I was a, I'm going to call myself middle aged, but I could be elderly, consultant. So, I think, of course there are people, and of course there are people who go into psychiatry and who don't convey empathy, or don't look beyond narrow biological things, but I would absolutely hope that those were in a minority because, as I said, I think it'd be pretty dull just to think about whether you needed more lithium or not. And yet lithium, lithium's a fantastic drug and it was an Australian discovery, and so you just want to go with both. That's what I mean about that bio-psychosocial understanding of a person's feeling.

Mary O'Hagan (10:46):

The other thing you talked about just before was your experience of working in the old psychiatric hospitals, before they were closed down. What was that like for you?

Dr Ruth Vine (10:58):

Mary, firstly, remember I was working there as a registrar. So, as a registrar, clearly you don't have a lot of experience at the system, but I did go into forensic psychiatry, and that meant that I actually worked in a place called J Ward, which was in Ararat, which was just the pits. I mean, just the pits. The people who worked in it, I'm sure, were great people, but the place was terrible. And even Larundel and Mont Park, they had some advantages. I mean, I do believe that the original intent around setting psychiatric

institutions in large, well-cared for grounds had benefit, I think to Mont Park and Larundel, and they had the loveliest spaces around them. But the buildings, Mary, were built when they were built. They were not well maintained. So, they were looking pretty shoddy by the time I got there. But they were very institutionalised, in the sense that there were male wards and female wards, and people got up when they got up, and they went to bed when they went to bed, and they ate when they ate.

(11:59):

And that was a pretty structured institutionalised day. So, I certainly don't want to look at this through rose-coloured glasses, that the amenity within the buildings was often poor. I think the nursing staff are actually pretty fantastic. One of the things that I think is a bit depressing about my profession is that we've certainly got improved treatments, and I think we've got different kinds of treatments, but unlike, for instance, oncology or even certain sort of practices of surgery like anaesthesia, we just haven't had those game-changing advances in understanding that would allow us to really lessen the torment and distress of illnesses like schizophrenia or schizoaffective disorder, or for some people bipolar affective disorder and addressing, I think we're better at addressing some of the traumas. But again, Mary, when I was a baby psychiatrist, we weren't that good at personality disorders back then. And I think in some regards we're better now, but often that came with a custodial or a restrictive response rather than, I think now we are much, much better at weighing up that longer term outcomes compared with shorter term interventions.

Mary O'Hagan (13:12):

I guess psychiatrist is the only profession in the mental health sphere where you've got a prescription pad, and you can shout the drugs. But a lot of people say, well, the drugs, some of them harmed me. Some people might say that, oh yeah, some of the drugs were helpful, and then a lot of people would be very ambivalent about them. And what people say is that, well, I needed a whole lot of other things to help my recovery. I needed help to get a job, or an education. I needed a restoration. I needed to deal with the trauma in my life, and I needed a house and social connections. And yet, when you look at the way psychiatrist sits at the centre of the system, with the pills and the pillows, and the rest of those needs aren't well addressed in the system. What's your response to that, especially given there hasn't been a big moment of, even in lots of ways, terribly incremental improvements in psychiatry in terms of the biological treatments. What if a psychiatry's sort of barking up the wrong tree, and in fact, the solutions for people are more in that psychosocial area? Where would that leave psychiatry?

Dr Ruth Vine (14:34):

Well, gee, what a great question, and I'm going to take up, I'm sure I'm going to take up nearly the rest of our half hour talking about this. Mary, one of the other things that I've been very fortunate about, I did quite a bit of work with a group at St. Vincent's who were providing, or supporting, the development of mental health in other countries. Solomon Islands, China, we went all over the place. And what that showed me is what happens when you don't have ready access to biological treatments, and you don't have ready access to the sorts of care and containment, and that it is a tragedy that relatively recently, and maybe it's still happening, some families had to deal with family members with a severe psychiatric illness, and the only thing they could do was contain them. And that's horrible. And of course, we see that in America today, probably the largest population of people with severe mental illnesses is in American prisons.

(15:28):

So, where again, people haven't had access to appropriate treatments, and they end up with that containment instead. So, at its best, and again, this comes back, as I said, to bio-psychosocial, at its best, and I think about this when I worked in public mental health services in Victoria, a person's other needs, family therapy needs, support with getting to Centrelink, support with placement, vocational placement services that have been researched largely in Australia, done a lot of research around that, get that on top of psychological treatment and biological, and look, it's always a chicken and egg. Mary. I think a person with a severe mental illness struggles to retain housing and obtain housing stability without symptom control as well. I'd absolutely admit our treatments are not perfect, but when I started psychiatry Stelazine and Haloperidol were the ones, were the go-tos.

Mary O'Hagan (16:22):

I remember them well.

Dr Ruth Vine (16:23):

Yeah, absolutely, so do I. And I do think that, used well and appropriately, Clozapine has made a major difference to many people. And, as I mentioned, lithium used well, monitored well by people who'd understand its metabolism and its side effects. I would hate to see a time when there was not an availability of well-researched, well-tested biological treatment, as well as the sort of social supports you are talking about. But just the social supports, I just think that that's asking too much. And I think in some countries, and America's a great example, where if you don't have both, if you don't have really clever, informed medical intervention as well as social support, and that's why I love many aspects of our current system. I'm on the board of Mind. I really appreciate the psychosocial work that goes into those recovery services. And I'm also on the board of Forensicare, and I absolutely get the tragedy that happens when a person with an untreated psychosis commits an act that they would never have done if they had been under treatment, and well looked after.

Mary O'Hagan (17:37):

So, you're probably familiar with the studies that the World Health Organisation did on the outcomes for people with psychosis in various different countries. There was one done in the seventies, and another done in the nineties. And what they found is that in the places where there wasn't much psychiatry and there wasn't much medication, the outcomes were better. How do you explain that?

Dr Ruth Vine (18:03):

Well, look, I think some of those, and you're going way back now, but some of those studies did show that, for instance, I think there was improved outcomes in some of the rural areas around India. And so, I'm not, absolutely not denying that having a close and loving family and accepting community is important. That takes us back centuries, actually, to where it was shown that having a community that was very accepting improved outcomes. I'm just saying that I don't think people with mental illness should be disadvantaged in medical worlds than in others. I think, Mary, the other evidence that we have at play at the moment that, again, causes me distress is people with significant mental illness have worse physical health outcomes. And some of that's about lifestyles. Some of it's around economics, but some of it is just that they don't have access to the same level of healthcare, investigations, monitoring, all of the things that you and I might hope for.

Mary O'Hagan (19:03):

And actually, some of it Ruth though, has to do with the long-term effects of some of the medications.

Dr Ruth Vine (19:09):

Yeah, indeed, indeed. So, I mean, mind you, of course, if you looked at almost any branch of medicine, there are drugs that have long-term side effects and that are lifesaving, nonetheless. I guess I could point to the steroids.

Mary O'Hagan (19:21):

Yeah, that's true.

Dr Ruth Vine (19:21):

They're fantastic drugs. But they have terrible side effects longer term. But that's, again,

Mary O'Hagan (19:27):

But people aren't put on steroids compulsorily. This is the difficulty with psychiatry is that yes, there are damaging drugs in other parts of medicine, but people go on them consenting.

Dr Ruth Vine (19:40):

Yes. I think most people who use psychotropic drugs go on them in a consenting way too, Mary, if I think about the hundreds of thousands of people who see their general practitioner or their private psychiatrist.

Mary O'Hagan (19:50):

I'm just worried, I'm worried about the people who don't go on them consenting.

Dr Ruth Vine (19:57):

So again, I have a problem with that. I actually, I see mental health legislation as benevolent. I see the reason for compulsion is in order to access treatment. I know you talk a lot about management of risk, but I remember seeing a woman who had just killed her children in the context of a major depression, and I and that woman worked together for months, years. But that person, that would not have happened if that person had a) recognised; b) sought help; and c) received help. And that help would inevitably have included treatment. It may have included electroconvulsive treatment. Mary, you talk about lived experience. And I have to say, I reckon I've had a lived experience in working in forensic and general psychiatry, general adult psychiatry over a few decades now. If we did not have an ability to, at times and for the shortest time possible and in the best facilities, I'm not trying to pretend everything's rosy here, to provide treatment to people who did not a) recognise the need for that treatment; or who understood their symptoms in a way that was very much external to themselves. I remember being involved in the treatment and care of a man who, he had an implant from the KGB in his teeth, and that implant was doing terrible, terrible things to him, and that implant dissolved and didn't worry him when

he had received treatment. But getting that treatment, he would never have accepted that treatment voluntarily because he had an implant from the KGB.

Mary O'Hagan (21:33):

There are other ways of responding to those beliefs other than medication. I'm not saying don't give people medication, but I do worry that medication is seen as the mainstay for responding to people with these beliefs when there are other ways of responding, probably relational psychotherapeutic ways.

Dr Ruth Vine (21:58):

Yeah. Mary, I think we talked about this actually in one of our earlier sessions, and you said that the toolkit equals a drug and a restrictive intervention. And I said, whoa, whoa, whoa, I don't agree with you. Because I don't, I think treatment is a necessary part, but I think how that treatment is provided, I think the place in which that treatment is provided, and it's not a stationary thing, isn't it? A person might come into a service on day one, and that relationship with the treating staff will change from day one to day five, or to day 10. I don't know if you've ever read a book, I think it's by Joanna Green, called I Never Promised You a Rose Garden?

Mary O'Hagan (22:37):

Yes, I read it years ago.

Dr Ruth Vine (22:39):

Yeah, it's an old book. But that was a book about someone who was receiving, at the time, a lot of psychotherapy in addition to lots of other things. Or do you remember Kate Millet and The Looney Bin Trip?

Mary O'Hagan (22:52):

Yes, I've read that.

Dr Ruth Vine (22:54):

There are various ways of describing the benefits and the horrors of certain things. If someone said to me, get rid of mental health legislation, then I would say, okay, we'll build more jails because, not everyone by any means, Mary, but many people will be distressed and disturbed by what they're experiencing and take it out on an external environment. And I think that's a tragedy, because I think it's avoidable. What I think is the other tragedy is that we don't give mental health the prominence it should have in research dollars, or as I said before in amenity, because I think we could do so much better than we do.

Mary O'Hagan (23:35):

One of the issues though, there is the occasional tragedy, and they're relatively rare, but what psychiatry is expected to do is to avoid those tragedies, and in fact put out the net a lot wider to do that. And that's something that worries me about the compulsory treatment, is that, I don't how they work this out, but

they said in order to avoid one homicide, you'd have to lock up 10,000 people, or something. I'm not quite sure where that came from, but you get the point, that there's a lot of avoidance of these very rare and tragic things happening.

Dr Ruth Vine (24:14):

So, I think, as I said before, if I think back to when I was a baby psychiatrist, I think we had a less sophisticated understanding. And I also think, not just we as in we the psychiatric profession, but we the community. So, I remember for instance, being before a coroner talking about a person to who a tragic incident had occurred while they were on a community treatment order. And the coroner said, well, this person was on a community treatment order, how could they have done this? And there's a certain sort of education that says we can only control some things as a profession. And indeed, in terms of, for instance, people who may experience severe personality disorder, in fact, I think there's now a much better recognition that in order to manage longer term negative outcomes, you need to be, if you like, braver about shorter term negative outcomes. And I think we've done a lot of education of the community, of practitioners, of coroners and others around that. And of course, that's been also a discussion about balancing human rights. There's the human right to make your own bad decisions just as there's a community desire perhaps, particularly, again, I think we talked about this in our first conversation, Mary, particularly perhaps from a carer perspective of keeping people safe, and that that's a tension. And again, I'd come back to how that tension is managed, rather than if we manage that tension.

Mary O'Hagan (25:42):

There was a movement of people that came up, that emerged in the 1970s, that came out of the institutions that said, we've been harmed by psychiatry. And there's people ever since who have come out of the mental health system who say, yes, I've been harmed by psychiatry. How does that make you feel as a psychiatrist?

Dr Ruth Vine (26:05):

Well, firstly, I think we have to be honest about it, and we have to be honest that, for all sorts of reasons, again, I would say mostly, originally, the original intent was not to create harm, but I accept that things went awry. But I equally think that there's also an enormous amount of literature about when those institutions were closed down, and the failure of the appropriate community services to be realised. And I guess Fuller Torrey is one of the main proponents of that, of talking about what was lost by really going from the wrong service, which was institutionalisation, containment, to no service, which was a failure of that shift to community. And it makes me very, I hope it makes my antennae quite high. So, for instance, Mary, there's quite a push at the moment for psychostimulants. Now, there may well be benefit and future and good outcomes from psychostimulants, but I look back at our history and say, well, we just need to be a bit careful here, because remember what happened with barbiturates.

(27:10):

Remember what happened with benzodiazepines. Remember, equally, I'm now looking at supporting the idea of deep brain stimulation for severe OCD, and someone's put in an application for that. I've met people with severe OCD, I'm sure you have too, Mary. It is a horrible, horrible, horrible illness, just paralysing. Now, no one would want to go back to frontal leuchotomy. We don't need to revisit that. But if our understanding of technology, and our being precise has advanced, then neither should we shy

away from saying, hang on, maybe there is some sort of incredibly accurate surgical intervention or, deep brain stimulation has changed the life of some people with Parkinson's. I don't think people with mental illness should be excluded from some of the technological advances because of our history. I would never want to shy away from that history. You learn a lot through knowing history in all sorts of ways. But I also would say that we need to keep being open to new treatments and new advances. Just, let's make sure we are regulating, we're examining, we're researching in a way that is for people's benefit.

Mary O'Hagan (28:20):

There's a long history of what I call cruel and desperate remedies, and some is recent, some are relatively recent. How are we going to protect against those sorts of remedies emerging in the future? Some people experience anti-psychotic medication as pretty cruel and desperate, but some people don't. But how do we ensure that people feel helped by these things, and not harmed?

Dr Ruth Vine (28:51):

The first thing I'd say is I think if I compared, again, we both work in Victoria, so if I compared the Mental Health and Wellbeing Act that's before parliament now with the 2014 Act, with the 1986 Act, with the 1957 Act, one of the things that's different in those acts over time is the degree of external review, external accountability, oversight mechanisms. So, there has been a progressive improvement in that. I think that the other thing I'd say is...

Mary O'Hagan (29:22):

And yet, can I just say, that the rates of compulsory treatment continue to go up despite all these external, all these review mechanisms in the Act.

Dr Ruth Vine (29:34):

Absolutely. And again, I would say the reason that those go up is because of the way the system was degraded. If you cannot get a service until you are absolutely very, very severely unwell because there is no capacity in the system, then you are far more likely to receive treatment as a compulsory patient. I did my PhD on this, Mary, so I feel quite strongly about this. And again, in Victoria we ended up with a Royal Commission, but that's to do with funding to the system. It's to do with capacity in the system. It's to do with the whole notion that, of course, it's much better for me to engage with my patient and my patient to engage with me as a matter of equals explaining, advising, bringing each other information, and bringing each other our experience and our reactions to have a treatment plan.

(30:28):

Sorry, the other thing I'd say, Mary, is that there are also other external influences. So again, in my experience, the advent of increased use of methamphetamines led to a major increase in occupational health and safety issues, violence towards staff, violence towards other patients. And I absolutely feel that anyone receiving treatment, or providing treatment to a person with mental illness needs to be able to do that in a way that does not create risk of violence and aggression. And so, I think that's made a difference. But I'd also, I mean, I think it's also important to realise that most people, if we think about Victoria, we've got a lot about, my numbers will be a bit out of date, Mary, because I haven't been

working in the system for the last couple of years. But if you think about, I dont' know, 60 or 70,000 people receiving treatment in Victoria, and about 16,000 of those might receive treatment as an inpatient.

(31:24):

The number of CTOs is around 3,000 I think, or was. So, it's still something, an intervention, that is for the minority of people receiving treatment and care. And that's as it should be. And I used to work on the mental health tribunal, and I think the tribunal takes its work very seriously, and really does question whether people do meet the criteria under mental health legislation. But you also need to recognise, I think just about every country in the world now has mental health legislation. There's a reason for that. And it's because sometimes it is better to provide treatment to a person than the alternative, which is to not provide treatment.

Mary O'Hagan (32:03):

It's true. Every country in the world probably did bloodletting once. I don't know, I mean, because it's universal doesn't necessarily mean it's the right thing to do, Ruth, but we have to finish there. And I would just like to thank you for joining me. I hope our listeners have found this a really stimulating conversation. And thank our listeners for joining us on this episode of MHPN Presents: In Conversation With. You've been listening to me, Mary O'Hagan.

Dr Ruth Vine (32:35):

And me, Ruth Vine.

Mary O'Hagan (32:36):

And we hope you've enjoyed this conversation. And if you want to learn more about Ruth or me, or want access to any resources we may have mentioned, go to the landing page of this episode and follow the hyperlinks. Additionally, on the landing page, you'll find a link to the feedback survey. MHPN values your feedback, please follow the link and let us know whether you've found this episode helpful, interesting, annoying, whatever, and provide comments and suggestions about how MHPN can better meet your needs. You can also provide a star rating. So people, stay tuned in for a further episode in this series In Conversation With, or listen to other MHPN podcasts. Thank you for your commitment to and engagement with interdisciplinary, person-centered mental health care. It's goodbye from me.

Dr Ruth Vine (33:33):

And from me, goodbye.

Host (33:35):

Visit mhpn.org.au to find out more about our online professional program, including podcasts, webinars, as well as our face-to-face, interdisciplinary mental health networks across Australia.