In Conversation With…Dr Ruth Vine and Jonathan Wells

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Release date:	Friday, December 10th 2021 on MHPN Presents
Presenters:	Dr Ruth Vine, Psychiatrist and Deputy Chief Medical Officer for Mental Health Jonathan Wells, Social worker

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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, welcome to this episode of the Mental Health Professionals' Network presenting In Conversation With, my name is Ruth Vine. I'm a psychiatrist, I'm based in Melbourne, but at the present time I'm employed by the Commonwealth Department of Health as the Deputy Chief Medical Officer in Mental Health, and I'm joined by Jonathan Wells, who's a cousin of mine, a social worker based in the United Kingdom. Hi, Jonathan.

Jonathan Wells (00:42):

Hi, Ruth. And I'm delighted to be here for this conversation. Thanks very much.

Dr Ruth Vine (00:47):

Yeah, it's going to be good. I'm looking forward to our conversation today, because over the years, Jonathan, you and I have had various times when we've been on holiday together, and we've explored some of our working life, even though we work in different hemispheres. And today, we're going to talk a bit about what we think is going well, going great, what excites us, but also perhaps, some of the things that we are less hopeful about. So, if you were going to start, I'll get you to start. What do you think would excite you at the moment about mental health care in Australia, if you know about it, but particularly, from your perspective, in the United Kingdom where things are at?

Jonathan Wells (01:26):

Yes. Well, I'll just say for the audience, a little bit about myself, just so they understand where I'm coming from. I'm a social worker by training. I'm retired now, but I've had a 35 year career working in adult mental health, in a whole range of roles. So, I got keen on the idea of working in mental health when I was a student. I just thought, what more interesting thing than working with people whose thoughts and feelings and behaviours were sometimes, let's say, at an extreme. I thought that was just a fascinating whole area, but perhaps more importantly, I've always felt that any civilised society can be measured on how well it looks after the most vulnerable people. So, that was a huge driver for me, I think, and always has been. So, there've been many things I've found exciting, or very positive through my career. We might want to go back to one or two of those. It was very interesting in the 1990s, how suddenly we borrowed three ideas from Australia, early intervention and psychosis, assertive outreach teams and crisis resolution, and home treatment. That's an interesting story in its own right. But it was a great success and we had a lot of new funding in those days. It's the naughties really. So, that was a very positive experience for me.

(03:01):

So, I'm just still very committed in a variety of voluntary sector roles to better mental health care. And I think it's a really, it's almost, and people use the word privilege, it's sort of a privilege to be still meeting, and getting alongside people with mental health difficulties, and their families. So, those are some of the positives over all those years.

Dr Ruth Vine (03:27):

Yeah, it is fascinating, Jonathan, that the UK borrowed some of those ideas, and those ideas, I have to say, are still alive in Australia. They're not necessarily alive and well, and I'll come to some of the things that excite me at the moment, but just before I leave you at that question, if you moved towards the end of your career, not the end of your, but the end of your, when you were working, what were the things then, which would be what, two years ago, maybe a couple of years ago now. What were the things then that you thought, wow, this is going really well, and this is going to develop into something good?

Jonathan Wells (04:00):

Well, a couple of things that spring to mind. One goes back a little bit longer, but what we call, I mean, it's full of acronyms, the world of mental health. So, it is, our acronyms in the UK might be different from

yours, so this may be a problem for us. But anyway, improving access to psychological therapies or IAPT, which has been a massive step forward in the last few years in the UK, with very clear and simple standards about how it should be provided. And just two or three targets. I don't mind one or two targets, as long as they're sensible, and not too many of them. Even having to demonstrate whether they're effective or not against a measure aiming for 50% effectiveness, and very ambitious in the numbers of people who should have received that service. Each year it's done as a proportion of everybody who might be diagnosed with depression or anxiety in a given population, which is a huge number. And we now have 25% of all those people are expected to at least be offered that service. So, they've been very, very, and they advertise what they're doing on buses and everything, in a very confident way. They're looking to help more people. I mean, it is a little bit limited, because it's time limited CBT. I'm having it myself at the moment, so I could, and actually it's going very well, I could easily say more about that, but I'm benefiting. I'm actually benefiting from that now.

Dr Ruth Vine (05:47):

You could give us the user's guide to IAPT. What's really interesting, Jonathan, and I say this a bit for our listeners, we probably have a similar range of types of workforce in mental health. We have psychiatrists, psychologists, social workers, OTs, people with lived experience, but in Australia compared with the UK, we organise that workforce rather differently. And so, the Australian equivalent of IAPT, perhaps, started back in 2006 as Better Outcomes and turned into Better Access, was predominantly psychologists. Whereas I think the IAPT started out with a broader workforce back at the beginning. But if I was to, this is terrible, isn't it, Jonathan, because we're going to talk forever. But if I was just to briefly talk about some of the things exciting me at the moment, having worked for 30 years, 30 years in mental health, and seeing some of the waves of reform, I think I'd say, I hope not too naively or pollyanna-ish, that there is an interest in reform again.

(06:59):

And there is an interest in exploring not just how people access treatments, but also about how they experience those treatments, and how they experience the interventions. And that sense that you're talking about, of advertising on sides of buses, and trying to make a service as accessible, as effective as it can be, I think is just terrific. But let me, perhaps we might come back to this, but let me move a little bit. If you were to think about the other side of the coin, the things that bother you about, that you've seen, and again, perhaps particularly towards the end of your time working, about mental health care in the UK, what comes to mind when you flip the coin and think about things that haven't been so successful, and perhaps why do you think it hasn't worked?

Jonathan Wells (07:52):

Well, yes. I mean, because I have depression, Ruth, sometimes I find it very easy to talk about the, let's say the gloomier side.

Dr Ruth Vine (08:02):

Well, I'm going to hold you to time then, you can't talk too much.

Jonathan Wells (08:05):

Well, that's very, very therapeutic. So, thanks. Well, I do feel I need to mention access to good, clinically effective, timely mental health care and treatment for the people, let's say, at the heavy of the mental health spectrum. We're all aware of this huge spectrum of mental health challenges. So, people with severe mental illness, if you still use that term, certainly in the UK, are finding it extremely difficult to just get the help that they need. There've been lots of, in Cambridge where I'm from, I should have said that at the beginning, but in Cambridge here, we've tried very hard to bridge this gap. But for GPs, there's a huge amount of wasted effort referring people to a community mental health service, which has the right staff in it to provide the right treatments. And a few years ago, 90% of those people were being sent back again, which was very demoralising for GPs, and for patients and their families.

(09:34):

And since Covid, I mean, we haven't got time to go into the detail of the impact of Covid, but this year, the number of people, the demand has steadily grown. And the capacity of, I call it planned mental health care rather than crisis care, the capacity of planned care and community mental health services has gone down for various reasons to do with workforce, et cetera. So, if you just do the maths, it's proving impossible to help a lot of people with really quite severe mental health problems. And that's when the families that I hear from pick up the pieces as well as they can. So, that's about access. There's rather a lot in that.

Dr Ruth Vine (10:23):

Well, there is, and in fact, you've touched, just in that brief time, you've touched on what I think are at least four of the perennial problems. And the first thing you touched on was language. You said mental illness, if we can call it that. And yet, you and I know that there is, as you said, a vast spectrum from distress, normal distress in abnormal circumstances. I think many people in Covid have experienced distress and anxiety, but it's almost a normal reaction to a very abnormal circumstance. And Jonathan, you might not know this about Melbourne or you might, but we're Lockdown City and we've been stuck in our, stuck in our homes or our suburbs for a very long time. But yeah, language in this area is really important, because people talk about mental health and wellbeing as being akin to mental illness and psychological distress, but they're very different things.

(11:19):

But you also talked about the importance of making sure that there were services for the people who were most experiencing the most severe kinds of illness. And one of the things that many listeners to this podcast would be aware of, is that there's been a lot of discussion in Australia about a thing called the "missing middle", people falling through gaps in the system of care. But very, very important not to forget, and I would agree with you, the absolute importance for people to be able to access effective, caring, available treatment and supports whatever their presentation, from the most severe. And also, so you touched on access, which is a bit of a perennial problem in Australia, because we've got such different geographic areas as well as different workforces, and we might come to that. And your last point was carers. And I think you are currently working with carers, but equally as we've emphasised, people with mental illness or distress or whatever, receiving that support in the community, it's clear that they spend an awful lot of time with their carers, and that their carers share a lot of the need to provide those supports, from a whole range of emotional support, financial support, housing support, whatever.

(12:47):

And I think, remembering just how important it is that carers get support is another really critical part of mental health services. But thank you, Jonathan. If I was to take my turn, as I said, my optimism, in a way, is that that we are going down a path of reform where we will get much greater cooperation between different service streams, and much cooperation between different parts of the workforce. But the risk of that, and the other side of that coin is that, we have a very fragmented system. We have lots of different providers, lots of different parts of the system. They don't always work well together. Governments often like funding particular programs without thinking how that program might fit in with the rest of the system of care. And having two levels of government in Australia, as we do, between the commonwealth or federal government and the state and territory governments, often compounds that tendency to fragmentation and complexity.

(13:55):

And that makes the system a bit, what you were saying, people get referred to the GP, the GP refers them somewhere else, but that somewhere else is not the right place, or isn't able to accept them. So, can you talk a little bit more, Jonathan, about how you see the workforce, because the people listening to this podcast are probably going to be primarily those who work in mental health. And what did you feel about, when you were working as a social worker within that broader group, multidisciplinary sort of group of workforce? Did you feel that was a plus?

Jonathan Wells (14:32):

I certainly did Ruth, I very much, I mean multidisciplinary team was what we always called it. And I guess it still is. And it just seemed to make sense, both from the professional point of view, and patience, that people have a range of needs and you might as well have a team that can address as many of them as possible, working effectively together. As a social worker, I try to be strong on housing, and employment, and homelessness, and helping people with their financial situations, but I was always very interested in psychiatry and psychology. And so, I felt I had a separate identity, but appreciated everybody else's roles. And it seemed to make sense, when we were responding to the needs of the individuals that came our way. And the politics in the UK tends to separate, well, it does separate health services from social services. There's not time to explain how, but we've been talking for many years about integrating all of that.

(15:50):

And indeed, this week, politically we still are talking about, it doesn't make any, if once you are on the receiving end, it doesn't really make much sense to be referred to several huge great separate organisations, just to have help with accessing the welfare benefits that you want to, or something. So, it's always a good idea. And the extra part of that, in the last 10 years or so, has been peer support workers, which, in other words, people with lived experience, which is a very positive development. Just very quickly on language, which we haven't had time either to do justice to fully. But I, I'm, I'm very pleased indeed, that everyone is talking at least about mental health, and what it is, and what it isn't. I spent many years in my professional life thinking it was a pity that people didn't seem able to talk about it. I always find it quite easy to talk about, but I do feel that the conversation, having Prince Harry on the front page of The Times talking about EMDR or something, is fantastic. But it's got us to another level, which is where the level of ignorance, and confusion, and muddled and misconceptions, is huge. So, I'm

pleased that we're talking about it, but we're still striving to have good, sensible, calm conversations when we all use the words to mean the same thing. But that's sort of going back a bit.

Dr Ruth Vine (17:36):

No, but you're absolutely right. And it's one, I mean, in a way, it's one of the joys of working in this area, that we are never short of a controversy. We're never short of a bit of a debate about what is the right language. I mean, at the moment, there's a lot of criticism of the medical model. Now, as a psychiatrist, I sort of think that that is holistic, it's biopsychosocial, and it should bring all three, but some people narrow it down to think the medical model just equals a prescription pad. So, I think language is really important. But you're right, we shouldn't talk more about that today. But Jonathan, you've sort of touched a little bit on some of the, sort of, hopes you might have. But if you now, having had all the experience that you had during your career, and your current experience working with carers as well, Jonathan, as your own experience of experiencing both depression and treatment for depression, what would your aspirations be, not just for yourself, but for the whole mental health system in the UK? What would your nirvana be?

Jonathan Wells (18:53):

Yes. Well, a great many things. I mean, just try and organise this in my mind, I have high hopes of, let's call it the dialogue that exists now between people with lived experience and mental health professionals. I'm a bit worried about it as well, but just to say, I mean what we do in Cambridgeshire, and it's often me actually, sitting around a sort of virtual table representing, I tend to have the public perspective. That's me speaking on behalf of half a million people in Cambridgeshire, which is a bit ridiculous in a way. We do try and involve a lot, we involve a lot more people. But just making that, I do sort of training with people with lived experience to help them be as influential as they can be. So, if it's just antagonism, or unconstructive criticism, it's just not going to work. So, we try and have an attitude of being good influencers. In other words, speaking up strongly and being true to, with people we represent, but in a calm and constructive way, to actually, and to have credibility.

(20:24):

So, every week I'm involved in those sorts of conversations, trying to help people develop influencing skills actually, rather than just shouting. I mean, although I do sometimes feel that frustration myself, but I try and monitor it and use it constructively. So, if we could just get that right, I think it's very, very fertile ground, the idea of both sides of the same coin. I've got plenty of examples about the professionals having a good understanding of things from their perspective, and the people that I work with bringing the other perspective. And then we fully understand what the problems might be, and how we can resolve them. So, I'm just coming back to that whole debate saying I do have, I'm hopeful that we can really make the most of that, and end up with, well, actually more of a consensus about what good mental health, and good mental health care actually looks like. I mean, it can be fun arguing, but we need to get beyond the arguing stage. And it is a contested area, perhaps it always will be, but I think we can have a much better consensus.

(21:52):

I have a huge aspiration in the UK for us to achieve community mental health services for people with severe mental health conditions, which can be provided when somebody needs them. And also achieve that biopsychosocial approach that you mentioned, Ruth, in other words, and can continue for as long

as someone might need them. An awful lot of our services in the UK are time limited, which is okay up to a point, but it's very hard to find that needs-based service. And the other key ingredient of that, for me, is that at the heart of that service is some sort of good relationship between a mental health person, who may well be a peer support worker, and the customer. So, that's a very big and simple statement, but it is quite hard to find sometimes, nowadays.

Dr Ruth Vine (22:55):

It is indeed. And unfortunately in Australia, I could say the same, particularly for those who either can't afford the private sector, or who are in a place where that sort of broad range is not available. If I was going to talk about my aspriation, you've put that so nicely, because what you've really highlighted is the person, the person at the centre, and also the relationship, the importance of the engagement, and that engagement being for as long as required, in a way, in a place that best meets that person's needs. And I don't know if I can top that, Jonathan, but if I was to add to it, I'd say that my aspiration is also about workforce, and having people who really want to work in this area, and who feel that they are rewarded by working in this area. And I don't just mean financially. I think sometimes, in Australia, some of our amenities aren't good for either the worker or the person receiving treatment and care.

(24:08):

And it changes the morale, and often leads people to feel that they're not able to bring their best self to their work, because they're not working in an environment that nurtures their best self and provides them with that support. So, my aspiration would be to have a better joined up system, most important in Australia, staffed by people who want to be there, and who feel rewarded by being there and who, but a continuation of what is good in what you mentioned before, that multidisciplinary team, and that respect that people have for each other's areas of expertise or specialisation, and what they bring to that. And to feel that they're able to do that, that they're able to bring their skill and their full scope, if you like, full scope of practice, and that that is provided to people. And some of that is about money, but it's not all about money.

(25:08):

It's also about how people work. And your other comment I think, was about that, sort of, reaching consensus. And again, I hope that where, this is an evolving conversation, as you say, sometimes a contested space, but hopefully we can reach consensus. Jonathan, you worked in that, in mental health for a long time, as have I. If you were to sort of, I guess, reach back to your younger self, and think that you were going to start in the mental health area now, what would you want to be bringing to that work now? If you were a little bright-eyed, bushy-tailed baby social worker, do you think you'd approach your career in the same way now as you have?

Jonathan Wells (26:06):

That's a good question. Not exactly the same way. I mean, I would still want to have a career in mental health. I think we've both found it very rewarding, as you say, not necessarily financially, but in all sorts of other ways. So, I'm proud of what I've done. I might not even go into social work. It's become very bureaucratic in the UK, and very much about rationing resources, and finding ways to not help people, actually, although I put that a little bit strongly, because obviously you want a community to look after each other as much as they can, but for various reasons, social care has been under so much pressure for a number of years, that it is hard for that to be a rewarding job. But I would want to bring, I do

believe in professional skills, clinical skills, although, as we've already touched on, sometimes the word clinical is even seen as less important.

(27:14):

It's not less, clinical expertise is as important as it ever was, or professional expertise. I'd want to bring that. And I'd just want to bring curiosity, which I think is crucial in good mental health care, and freshness of approach, and optimism. Those are, again, quite obvious things to say, but the climate, even before Covid, it was tough enough. Since Covid, if anything, it's got tougher. And I fully understand why staff find it hard to keep themselves going in those ways. But it's tremendously important work. And if anything, the importance is only growing. And just touching on workforce, you're absolutely right about the importance of that. When we make a fuss in Cambridgeshire, it used to be about funding for mental health, and it's not about funding anymore. There's been quite a lot of money sloshing about, especially on the back of Covid. And quite often, we can't use the money because we can't recruit staff. And that's a big worry. But I think, there's got to be a way of attracting people to working into mental health, because such an important area.

Dr Ruth Vine (28:39):

It is. It is. Thank you. I mean, we haven't really seen where the impact of Covid is going to end. Here in Australia, we're sort of in the vaccination mode at the moment. And as you say, Covid has actually resulted, it's resulted in a couple of things I think, it's resulted in some light shining on some of the pressures in the health system that pre-existed Covid. But it's also brought, I think, a willingness to work in different ways, and highlighted the needs of many, many people for an avenue to get some support as well as, we've touched on before, not in any way diminishing the importance of support for those with really who are very, very distressed, and very disabled by mental illness. But we will see how that plays out. And again, I think it has absolutely brought a focus on the importance of mental health and wellbeing in how we function, perhaps, particularly in our young people, but for all of us. So, thank you to anyone who's listening to this, on this episode of In Conversation With, and you've been listening to me, Ruth Vine.

Jonathan Wells (29:51):

And you've been listening to me, Jonathan Wales, from the UK.

Dr Ruth Vine (29:54):

And isn't it interesting how similar, and yet dissimilar our mental health services are on opposite sides of the world? But we hope you've enjoyed this conversation. I certainly have. And Jonathan, I hope you have.

Jonathan Wells (30:08):

Yes, me too.

Dr Ruth Vine (30:09):

If you want to learn more, or have access to some of the things we're talking about, please go to the landing page of this episode and follow the hyperlinks. And you'll find on the landing page a feedback survey, a link to the feedback survey, and MHPN does value that feedback. So, please let them know whether you've found the episode interesting, helpful, or not. And please be free with any criticism you may have as well. Then I hope there will be many other episodes of In Conversation With. Thank you very much for your commitment and your engagement with multidisciplinary, person-centered mental health care. Goodbye from me.

Jonathan Wells (30:47):

And goodbye from me. Thanks very much.

Dr Ruth Vine (30:49):

Thanks, Jonathan. Bye.

Host (30:52):

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