Royal Commission into
Victoria's Mental Health System

WITNESS STATEMENT OF JULIE DEMPSEY

I, Julie Ann Dempsey, Senior Consumer Consultant of Forensicare, of Yarra Bend Road, Fairfield, in the State of Victoria, say as follows:

1 I make this statement on the basis of my own knowledge, save where otherwise stated. Where I make statements based on information provided by others, I believe such information to be true.

Background

2 I hold a Bachelor of Arts from Monash University.

3 I am the Senior Consumer Consultant at Forensicare and have organisational oversight of the Forensicare Lived Experience Team.

4 I was an Executive of the Victorian Women's Mental Health Network Victoria (**WMHNV**) from 2006 to 2018 and I was the Chairperson from 2011-2016.

5 I have received the following awards:

(a) in 2014, I was awarded the Minister for Health's Victorian Public Healthcare Award for outstanding achievement by an individual or team in mental healthcare.

(b) in October 2018, our Thomas Embling Hospital Community Advisory Group (**CAG**) was recognised when we won the CAG Award at the 2018 Victorian Mental Illness Awareness Council (**VMIAC**) Consumer Awards for significant contribution to the experiences of consumers to a service.

(c) in May 2019, I was awarded the 2019 Meritorious Service Award by the Victorian Branch of the Royal Australian and New Zealand College of Psychiatry (**RANZCP**) for outstanding contribution to improving the care of those with mental illness.

Experience of mental health services

6 I have personal experience of mental health services, spanning over the last three decades. Given my experiences in the mental health system, it is a miracle that I am functioning as well as I am. I have gotten to where I am today despite the mental health system, not because of it. However, for all its flaws, I must acknowledge that I would not be alive today if I had not accessed help.

7 In High School, when I was in Fifth Form, I had my first psychotic breakdown. At the time, I was under extreme stress. My parents had split up and it was a difficult divorce. I felt a tremendous amount of guilt that I was responsible for my dad moving out (I wasn't). At that time, my identical twin started dating boys and it felt as though our connection was being torn apart. She went to live with dad. I felt that my whole world was being taken away from me bit by bit.

8 The breakdown involved hallucinations – I'd see primal colours such as the colour red and would start screaming and I wouldn't know why.

9 I sought help at High School through the school counsellor, however all my life I'd had nightmares about being taken away from my family and friends, so I didn't divulge a whole lot of information to the counsellor. I didn't feel safe. I am now so glad I didn't because it meant that I avoided the psychiatric system for that little bit longer. If I'd opened up then I probably would have ended up in hospital in the psychiatric system and that would have been the end of my world from that point on.

10 I managed to pull myself together enough to finish school and complete my High School Certificate. I was one of the top students in English in the whole State. I got a commendation for every subject I did in Fifth Form, despite what I'd been through. My solution instead of opting out was to really apply myself to my school work. I did really well at school and got into university, where I started a Bachelor of Arts.

11 I did brilliantly during my first year of university: I was the top of 400 students in sociology. I received high distinctions in each of my subjects. In my second year, I started Honours but then I crashed halfway through the year and had another major psychotic breakdown. I ended up in hospital, and that really was the end of any sort of normal life.

12 It felt as though I had everything before me, and all of a sudden this door shut and I was in a psychiatric world with doors shutting all around me. What I could do was becoming more and more limited.

13 I lost my normal supports, like my friends, who were gradually replaced by psychiatric system supports. These were very limited, medical and inhumane. Medication became a crutch, replacing my independent thinking and the side effects, such a dramatic weight gain, ruined my personal body image. Everything I did was pathologised. For example, I once read a sci-fi book which had the word "megalomaniac" in it. I asked the nurse what this meant and from then on the clinical team assumed that I was researching my own symptoms.

14 When I did relaxation classes I was told that I had to lay on the floor with my legs apart, resting on a chair. This made me feel exposed and vulnerable and so I chose to use a

different position. I was then ridiculed and made an example of by the psychologist who was running the class.

15 The unit I was in was supposed to be progressive but some of the things they did were downright cruel. For example, no one told me my diagnosis – apparently, they thought it was too "heavy" for me to handle and so they led me to believe I was neurotic. I had all this guilt and shame that I couldn't cope. I didn't fit in with the outside world, but I also didn't fit in with the people at hospital because they were being treated for serious mental illness and I felt I was just being a spoilt brat.

16 I spent nine months in the psychiatric unit and then I went back as an outpatient for another year. During this time, I was still attending university. I spent eight years going back and forth between university and hospital. It was a nightmare. It was so hard to stay awake in class because I was so doped up. I'd just go and lie on the chairs in-between class to catch up on sleep before the next tutorial. Writing essays became a tortured process, when it was something I used to love. I laboured away and I just missed out on completing my degree by half a unit. Years later I was awarded my degree posthumously after I contacted the Dean with the assistance of a social worker who thought it was outrageous that I never received my degree. I attended the graduation ceremony – it really meant a lot to me to receive my degree. This achievement and recognition was the first real peace I had felt within myself for years. It was a turning point.

17 Over the years I have had extensive ECT, primarily against my will. The ECT typically destroys my cognitive ability for at least two years. I have extensive memory loss – the last time I had ECT I was a practicing Buddhist, meditating two times a day and in advanced level dharma classes, having read extensively on the subject. After ECT I had no recollection of any of my learnings and my spirituality was destroyed. I attempted to go back into Buddhist study, however I have not been able to regain my sense of spirituality, it is only limited theory to me now.

18 As a result of everything I've had to live through, I got to a point where I felt that I was irrelevant to society and that I did not deserve to exist. I attempted suicide several times – either because I was not coping with the horror of the psychosis, or because I felt totally degraded by my experience in the mental health system and that I was invisible and did not matter. Killing myself seemed like the next logical step. I haven't attempted suicide for over two decades now.

19 Medication inevitably has dramatic physical side effects. Over the years I have suffered from eye sight disturbance, sedation, weight gain, increased appetite, high cholesterol, confusion, akathisia, dry mouth, dental issues, constipation, diabetes, low blood pressure, low motivation resulting in lack of exercise, incontinence, asthma

complications, clashing with other medications, urinary retention, sex drive impairment, stomach reflux, cognitive impairment, parkinsonian type tremors, nausea and a stomach ulcer.

20 I was on Olanzapine for nearly 20 years with disastrous physical side effects. I repeatedly requested a medication change, but was denied. This resulted in me trying to go off it by myself and having traumatic hospital stays and enforced injections and seclusion.

21 The seclusions during my hospital stays occurred because I refused medication. I wasn't violent or aggressive to start with. However, staff would surround me with blue gloves and a needle in a kidney dish, which made me feel cornered and threatened. I believed the medication was turning my brain to concrete. No one listened to me or reassured me. This would go on for weeks until they broke my spirit. Getting out of hospital for me means completely submitting and surrendering to the system, even if I don't feel any better within myself, I feel that I must sacrifice my own self-respect and principles. I give in.

Police interaction

22 I was treated brutally by the police when they arrived at my house after I found my partner, Kerrie, dead on the kitchen floor after taking an overdose. I had been sitting with Kerrie holding her hand when the police arrived. Upon arrival, they immediately directed me to sit by myself in the bedroom, at the other end of the house, with the door closed. They explained that they needed to search for a suicide note. When I told them I wanted to stay with Kerrie and keep holding her hand, I was told that *"there were to be no arguments about this"* and that I had to *"go to [my] bedroom."*

23 I didn't understand why I had to be in another room while they went through all our belongings searching for a note that didn't exist. This made me feel ashamed and guilty, like they were searching for evidence that I was to blame somehow for her death.

24 In contrast, the ambulance officers were very supportive and empathetic saying that they were very sorry for my loss. They waited with me until the police arrived and each one of them touched me on the arm as they left. That physical and emotional contact meant so much to me, it was an important connection to humanity when the rest of my world had been ripped from me.

25 Aside from the death of Kerrie, being put in the back of a divvy van was one the lowest points of my life. I had been certified by the staff at a hospital emergency department and needed to be transported to a psychiatric unit. As there were no ambulances available, the police van was used instead. I was not violent or agitated and I still don't understand why I had to suffer the indignity of being put in the police van, in front of a

packed waiting room full of people in the Emergency Department when I had not done anything wrong, I just needed treatment. At that moment, I lost my sense of citizenship.

26 If I see police out on the street, I don't feel protected, I feel vulnerable.

Rebuilding a meaningful life

27 I have spoken publicly about my experience of the mental health system many times. Attached to this statement and marked '**JD-1**' is a copy of a talk I gave at the WMHNV 'A Meaningful Life' forum on 2 August 2013, about losing a meaningful life and being able to rebuild it.

Senior Consumer Consultant at Forensicare

28 I have been working at Forensicare for over a decade. I started in 2009 on a 15-hour week backfill trial. I am now the Senior Consumer Consultant, based at Thomas Embling Hospital, working 53 hours a fortnight. My role involves promoting consumer perspectives and concerns to staff and management to help improve the organisation's services, as well as giving consumer perspective to clinicians and in meetings. I also consult extensively at government and departmental levels.

29 My role stretches across Thomas Embling Hospital, Community Forensic Mental Health Services and prison services. This includes supervising social work students who complete their placements at Forensicare. Forensicare gave me a chance. I had not been in formal paid employment for thirty years.

30 Being a part of WMHNV and Forensicare has given me an effective and supportive avenue to advocate for and meet other consumers, carers and mental health workers, and network with other key players in the mental health sector and Victorian Government. For me personally, it has lifted me out of the confines of isolation and horrific psychosis back into the world of the living, with shared social meaning rather than mere survival instincts that dominated my life for decades.

Art Recovery

31 One of the methods I use for coping when I am seriously unwell is my art. Attached to this statement and marked '**JD-2**' is a copy of some of my artwork. In the picture titled "*Julie Sees the Bigger Picture"* from the comic *"Recovery Struggle Back to Planet Earth"* I go from being doomed to having some hope and freedom to move forward and try to get better, which I didn't think I could do anymore. I drew that picture when I went on an art excursion. I remember the art teacher telling me how to draw a tree, to look at the light and dark and follow the outline. It was a revelation for me, a different way of seeing the world and this sparked some hope in me that had long since been trampled on by

illness and the system that was supposed to treat it. I can no longer access those social rehabilitation services because the Psychiatric Disability and Rehabilitation Support Services /Mental Health Community Support Services sector has been destroyed and I do not qualify for the National Disability Insurance Scheme. Now when I am in crisis I have no formal supports to fall back on other than my friends and the private psychiatrist and psychologist that I pay for out of my own pocket.

32 I have lectured to social work students at universities and used my artwork to illustrate what it can be like to be in psychosis. I have received so many positive reports back from students saying it was so powerful and that because of my lecture they are going to work in mental health. I feel that art gets across what I can't say. It is a non-harmful way of exorcising my demons.

Mentoring

33 Over the years I have mentored various patients and colleagues, including senior clinical staff.

34 I want to give people hope that I if I can get through it, anyone can. My extensive experiences and successful recovery journey has been empowering for them.

The mental health system and reform

Mental Health Act 2014

35 The implementation of the *Mental Health Act 2014* held much promise. However, the underpinning recovery principles and general consumer participatory nature of the Act have been limited in uptake. The culture of the mental health system essentially hasn't changed, in particular:

(a) Advance statements are often ignored, if consumers are supported to do them in the first place. There is limited uptake on advance statements due, in my view, in large part to consumers feeling cynical and disempowered. The consumer movement has lobbied for advance directives, which have the potential to be binding. Having experienced involuntary forms of "treatment" by the mental health system, I think advance directives should be binding within reasonable circumstances

(b) Psychiatrists maintain ultimate power, often acting unilaterally. For example, in my relapse plan it was highlighted that frequent changes of medical staff were a trigger for me. As such, a kind and understanding consultant psychiatrist agreed to see me every 4-5 weeks instead of the rotating registrars. When my consultant psychiatrist was transferred, I was met by a new consultant at my next appointment. This psychiatrist said words along the lines of he *"hadn't read*

my file and knew nothing about me". We then proceeded to discuss my needs in relation to not having to retell my story every six months and be re-traumatised. I was told the system could not accommodate this need and I would need to seek treatment in the private system. I was booted out of the service that day after 25 years with that service. I was dismissed with no referral to a GP, private psychiatrist or any other clinic details to help me. At that point, I was truly in crisis.

Use of natural environment

36 Current psychiatric units were set up as attachments to mainstream hospitals as a move to integrate back into wider society, away from the isolation of the old asylums. However, what this has achieved is an intensification of the medical model at the cost of real person-centred recovery.

37 Inpatient units should not be attached to mainstream hospitals, they should be located next to parks, or at the very least be part of the natural environment, so that consumers can connect spiritually with nature and the external world, providing them with respite from their tortured inner mental distress. Today, inpatient units are sterile concrete jungles, with no soul.

Gender issues

38 Attached to this statement and marked '**JD-3**' is a copy of a talk I gave at North East Victoria Innovative Learning (**NEVIL**) in March 2017 on my experience of inpatient psychiatric wards and of the gender-specific problems that exist in the mental health arena. The talk details my experience of how women are disadvantaged in the mental health system compared to and because of male dominance.

39 I consider that the hospital system should be rebuilt with a gendered lens approach, rather than manipulating a system that is set up for males that women are forced to fit into. This must be comprehensively done from the bottom up with top down support, based on a coproduction model. Initiatives such as "women only" corridors have not worked in practice because of the pressure on beds – they end up putting men in those corridors anyway, compounded by staff cultures that fail to promote gender-sensitive and trauma informed care. Hospitals would be improved by having women only units where women can be safe from predatory men and feel secure in non-threatening environments with a supportive culture from staff.

Mental health workforce

40 It would be useful for the mental health sector to expand its staffing profile beyond psychiatrists, to recognise the expertise held by other disciplines. For example, the

sector would be improved by having more social workers who focus on person-centred care and social justice principles. We also need more housing workers (and housing), peer workers, occupational therapists, dentists, art and music therapists and PSO's (psychiatric service/support officers) who are mentors and practical connectors to community resources.

41 Many consumers have bad teeth and gums, including halitosis due to inadequate dental care. Community health service waiting lists can be up to four years for a check-up. Psychiatric medications cause a dry mouth which leads to increased tooth decay and poor oral health. Consumers need to be supported economically to have regular work done on their teeth to aid social confidence, basic health and comfort and be presentable to potential employers.

Lived experience workforce

42 The mental health system is overly complicated, not user friendly and difficult to navigate. The various systems, such as housing, disability and alcohol and drug support services should work seamlessly with the mental health system, but they do not. We need peer-run respite and drop in services, similar in model to VMIAC, that is, run for consumers by consumers.

43 Despite the fact that the lived experience workforce is crucial to the mental health sector, we are significantly under-paid and often exploited. Our workloads can become burdensome, as organisations scramble to tick the "Standard 2" box for accreditation. We are not respected or treated as a discipline in our own right. Furthermore, the impact of professionalising lived experience, which can involve dealing with trauma, grief and loss, powerlessness, stigma and shame, is often underestimated.

44 Peer workers and other lived experience workers are often employed as solo workers, which leaves us extremely vulnerable and exposed, feeling alienated from the multi-disciplinary team, often lacking peer support and supervision. Lived experience workers also face stigma in the workplace and are often subject to "micro aggressions" from other staff who are in the "clinical clique". We need a "Noah's Ark" approach, that is to employ at least two lived experience workers in the role in organisations so that we don't feel isolated and can debrief with like-minded souls without the inherent consumer clinician power imbalance being present.

45 In my role at Forensicare, I play a large part in managing "the Hub" at Thomas Embling Hospital. It is a portable unit in the corporate section of the hospital where our lived experience workers are located, working side by side with the social workers. We are planning to grow this model in the prisons, soon Ravenhall Correctional Facility will have the first ever lived experience "Hub" in a prison, which means that lived experience

workers can feel more like a team. Previously at Thomas Embling Hospital we were located at the top of one of the psychiatric units, which although connected us to the pulse of the hospital, left us quite distant from management, who we also need to actively engage with. While the model of the Hub has attracted criticism from some consumer purists, we have found it to be extremely effective for us, making everyone feel that they are part of an equal "ally ship", learning from each other and going in to battle together!

46 When the *"Expanding post-discharge peer worker support initiative"* was rolled out by the Department of Health and Human Services, Forensicare did not qualify for the initiative. Forensic mental health consumers are arguably among the most stigmatised consumer groups and a peer workforce is essential. Forensicare has been required to fund its own peer worker in prison, as well as its own consumer consultants, which is disgraceful. It is my hope that the importance of Forensicare's work will be recognised more and appropriately resourced based on real consumer needs.

Stigma

47 Stigma is a huge issue for people who have a mental illness. Diagnoses like anxiety and depression have become more "socially acceptable" after the highly successful normalising promotions and campaigns from organisations like Beyond Blue. Even bi-polar disorder has been somewhat romanticised in film and the arts.

48 Other serious psychoses such as schizophrenia are viewed as dangerous and are feared and shunned by society. In addition, borderline personality disorder casts the unfortunate recipient as hysterical, attention seeking and maladaptive.

49 What people don't understand is that mental illness is just that, an illness, like Cancer or Motor Neurone Disease.

50 People who suffer from mental illness have often been exposed to significant trauma in their lives – however it seems that any sympathy for them ceases once they hit a certain age or stage. What we need is specialist support that is also humane in nature, not just so called "medical best practice" which can be cold and deny the person at the centre.

51 Personally, I have experienced stigma and discrimination numerous times, for example having to move out of my shared accommodation every time I had a relapse/inpatient stay; forming relationships is difficult because you are seen as a psychiatric patient first and a person second.

52 Stigma is a major barrier to recovery.

53 What we need are mental health champions for adults, like Patrick McGorry is for youth, or Glenn McGrath is for Breast Cancer.

54 The forensic mental health sector faces the additional stigma of being both "mad and bad" and desperately needs a champion who can demystify and liaise with the media effectively. A dedicated media unit for the mental health sector would be an effective way to get the real stories across to the community rather than the messages given by radio shock jocks and populist current affairs TV shows.

55 A more positive approach would encourage community support as opposed to exclusion and help create broader social movements for fundraising and research.

56 We need a proactive dedicated state-funded media department monitoring the press on negative reporting and redressing that reporting actively, like SANE Australia's StigmaWatch, with positive follow up stories/explanations of such events in the public eye. The media department could source stories of lived experience of carers and consumers to promote education about mental illness and health, and reduce stigma. This would increase the understanding and appreciation of struggles faced by consumers, carers and their friends and families, fighting the ongoing and devastating nature of mental illness. The community needs to be educated and equipped to deal with mental illness, for example through education programs in schools and university curricula, delivered by people with a lived experience.

57 We are all someone else's someone else. Mental illness does not discriminate and neither should we. We need to share the struggle together, not push consumers to the fringe of common social existence. The system needs radical change, not more Band-Aid solutions. To make this happen, serious funding needs to be allocated. If we can do it for railway crossings we can do it for distressed, vulnerable and marginalised people. With the right systems and supports in place we can make hope for a meaningful life achievable and real.

sign here ► 

print name JULIE ANN DEMPSEY

Date 23/7/19

Royal Commission into
Victoria's Mental Health System

ATTACHMENT JD-1

This is the attachment marked 'JD-1' referred to in the witness statement of Julie Dempsey dated 23 July 2019.

WMHNV - A Meaningful Life Forum Aug 2 2013:

(Julie's Notes)

Introduction:

Loss of Meaningful Life

Conversation between Julie and Sandy about losing meaningful life

Sandy – A nothing, loss of identity by illness, loser

Julie - illness led to dropping in and out of Uni, being left behind friends, combined with psychiatric system became sub-human and disgusting, Uni I had been in my element then destroyed and torturous struggle

Main:

How Rebuilt Life

Hope - For a long time others held hope for me, Cheryl and Heather reinforced my potential and value of personality, there was life beyond my sabotaging mind, had felt I could not plan for anything

Self-determination – I have some control over my mind, having Job forced to focus, given a commitment to meet, led to discipline in other areas of my life, stabilizing with effort to have good food and sleep etc., reason for staying well and protecting myself more, pension allowed financial independence and security, work income can have more than 1 latte a week

Respect – Others faith in me helped me redevelop my self-respect, WMHNV gave opportunity to travel with Cheryl around state – her support gave me the personal strength to leave Melbourne city limits which I had not done for over a decade or more, now I go interstate and will be going overseas in September.

Cheryl, Heather, Jude, Anne and others I presented with took me at face value and did not undermine my intentions with second guessing and game-playing accusations as common in psychiatric treatment circles. At work I also felt that my experience and opinion mattered, and that I was there for the patients, not just myself.

Empowerment – Gained respect and purpose at work as compared to going to see psychiatrist, who fortunately is one of the good ones, but still disempowering with questions like "Is there anything else you should be telling me?" Also sitting in the waiting area with the security screens and locked access to the clinic staring at boring walls and putting up with other, at times, intimidating patients is demoralizing.

Communication has been so bad in the past that my only indicator of how I was travelling or how much staff realised I was suffering was indicated by what they did with my medication doses. If it went up I felt valid, if it stayed the same I felt like I was ineffectual, alone in my suffering. Now I have other meaningful relationships with friends and work colleagues than just psychiatrist appointments. A life of total psychiatry will take away your soul.

Community and Family Supports – Family involvement is important when well, sense of belonging and caring, giving back to my mother as she gets older. Previously had limited community when unwell and would go into hospital. Now last two relapses, one in recent weeks, I have stayed out of hospital with help of my treating team, CATT, friends and work colleagues supporting me.

Having private psychologist as well as being in public system has helped stop alienation from community and given dignity and consistency of treatment that the underfunded public system cannot unfortunately provide.

If I did end up in hospital I have a back-up plan for work colleagues to look after my dog, Eddie, which is a big weight off my mind. Not to be totally negative about the psychiatric system I do feel a part of a patient community from various hospital stays and can trade war stories with ex-patient comrades joking about some pretty torrid times in the past to help deal with the future. We survived that, we can survive anything.

Invitation to Audience

Share your experiences of constructing a meaningful life.

How familiar or useful do you find recovery concepts?

Services and Recovery – do they get it?, The importance of relationships.

Julie Dempsey

23.07.13

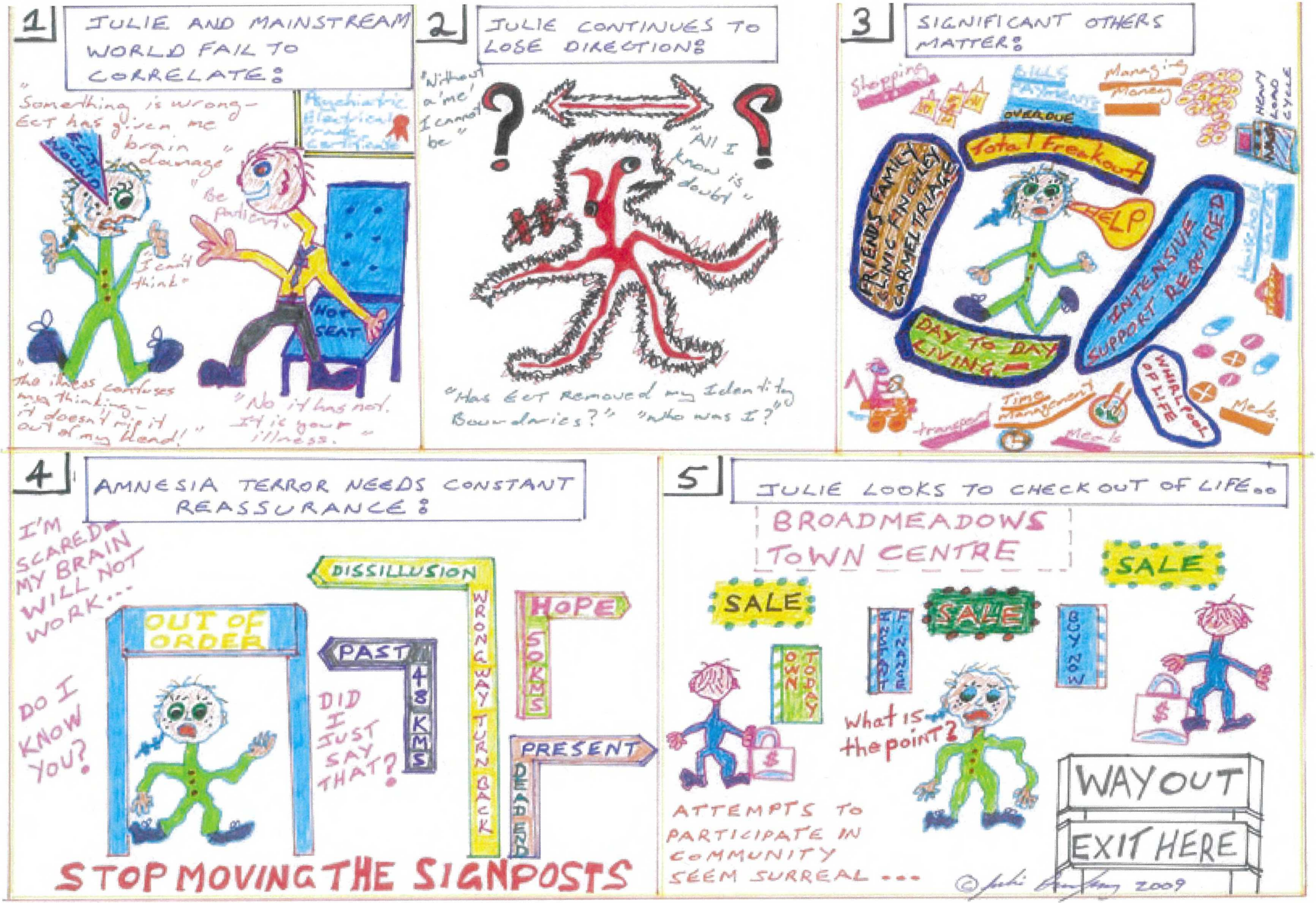
Royal Commission into
Victoria's Mental Health System

ATTACHMENT JD-2

This is the attachment marked 'JD-2' referred to in the witness statement of Julie Dempsey dated 23 July 2019.

BACK TO PLANET EARTH: RECOVERY STRUGGLE

A POST-HOSPITAL COMIC BY JULIE DEMPSEY



6

MR SPOCK: VOICE FROM HOSPITAL STEPS IN...

Mr Spock Protects And Re-orders

JULIE'S WORLD

"Be my Friend"

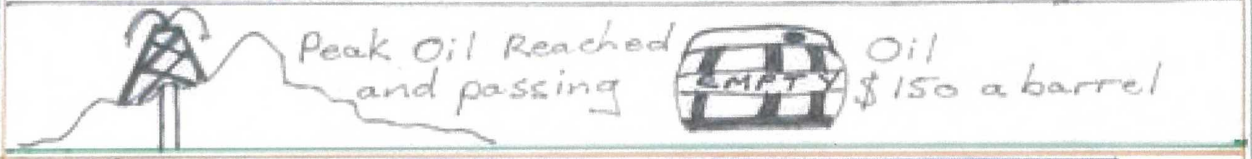
RENEWED ALLIANCE

7

MR SPOCK REVEALS ABSURDITY OF HUMAN EXISTENCE ...

NON-ENLIGHTENMENT FLOURESCENT TUBE

INCREASING MODERN COMFORT INVENTIONS DRIVEN BY DECREASING FUEL SOURCE...



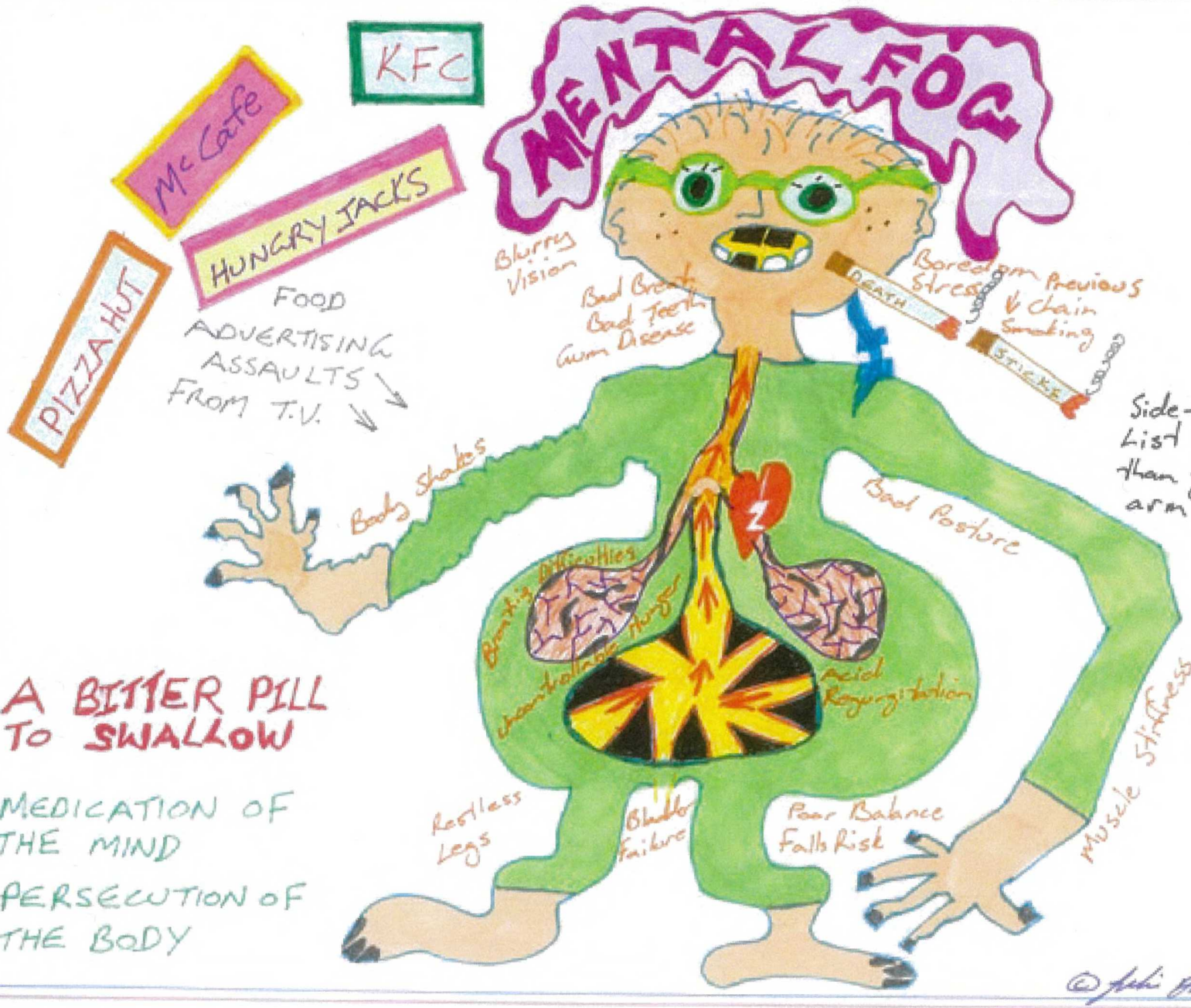
8

SCIENTIFIC SIDE-EFFECTS BECOME PLANETARY LETHAL EFFECTS:

PROGRESS THROUGH AGGRESSIVE DIVISION CREATES DARK RESULTS...

9

MEANWHILE MODERN MEDICINE HAS ACCUMULATIVE 'CENTRAL-EFFECTS' ON JULIE'S BODY:



Side-effects- List Longer than your arm...

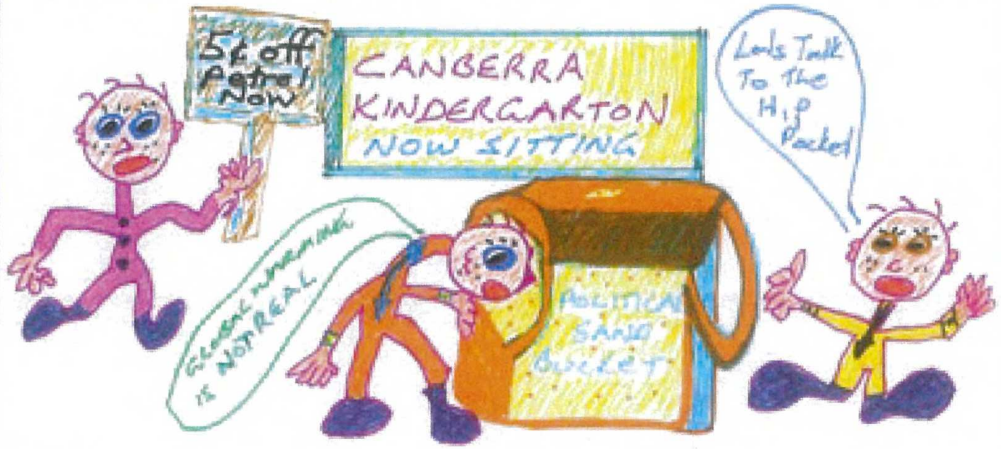
- Eye sight Disturbances
- Sedation
- Weight Gain
- Increased Appetite
- High Cholestrol
- Confusion
- Akathisia
- Dry Mouth
- Dental issues
- Constipation
- Pre-diabetes
- Low Blood Pressure
- Low Motivation
- Lack of energy
- Incontinence
- Vision Disturbances
- Asthma Complications
- Contraindications- non-psychiatric medications.
- Urinary Retention
- Sex drive impairment
- Stomach Reflux
- Cognitive Impairment
- Parkinson type Tremors

A BITTER PILL TO SWALLOW

MEDICATION OF THE MIND

PERSECUTION OF THE BODY

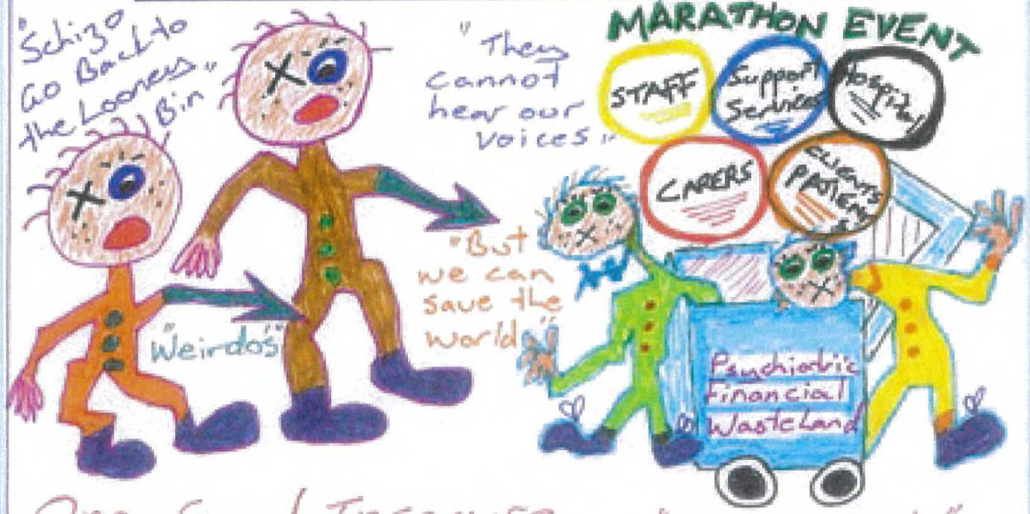
10 IN WIDER COMMUNITY
Spin Doctors mask planet's pain with political panadol:



PROCRASTINATION AND RHETORIC RE-ROUTE CHRONIC WORLD ISSUES IN EXCHANGE FOR INSTANT GRATIFICATION

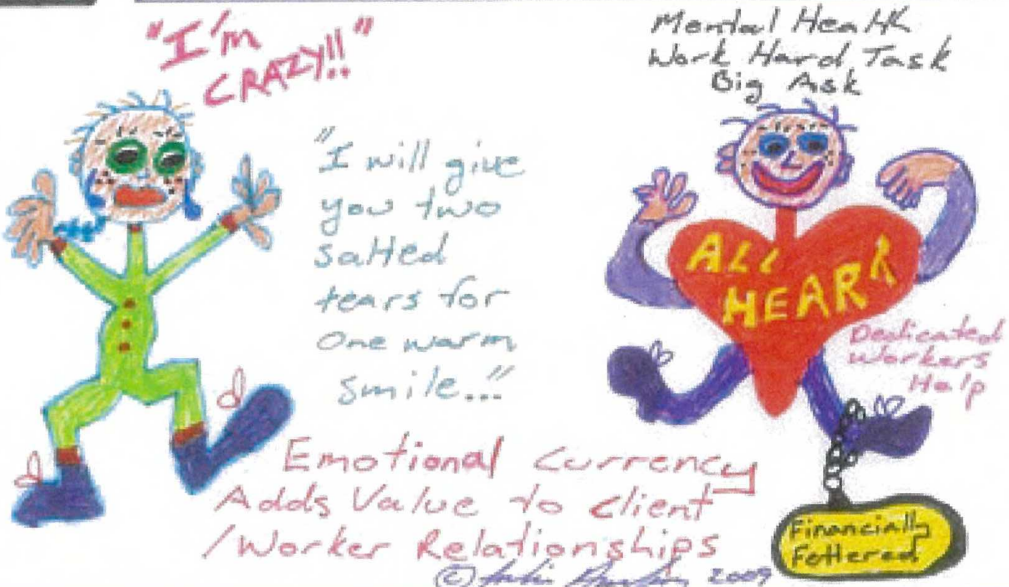
11 JULIE SHOWS CONCERN FOR REAL WORLD ISSUES:

12 MENTAL HEALTH STIGMA STALLS PROGRESS:



One-Eyed Insecure Attitudes Dominate

13 DEJECTED JULIE RETREATS TO PSYCHIATRIC COMFORT ZONE:



Emotional Currency Adds Value to Client/Worker Relationships

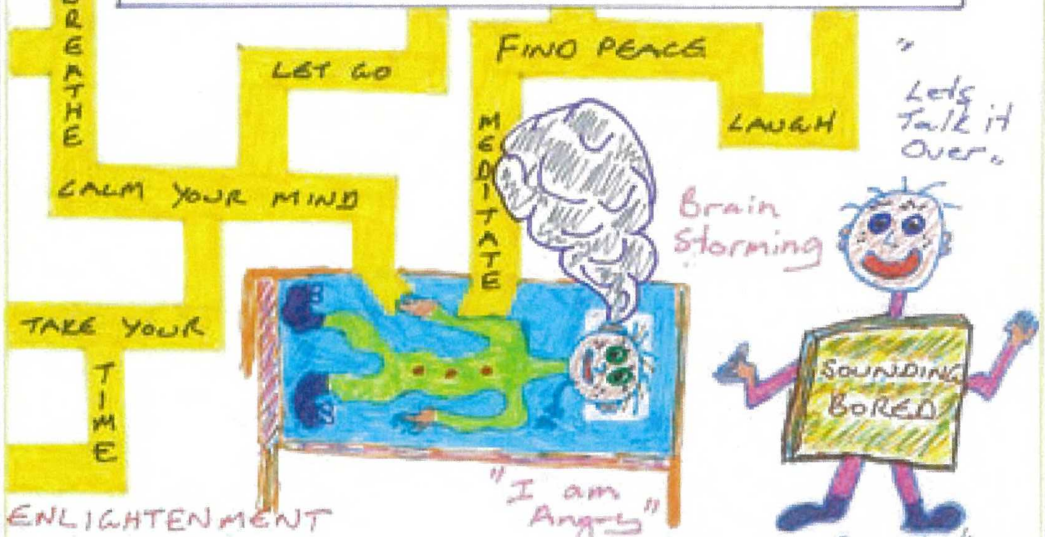
14

ART OUTING A STEP BACK TO COMMUNITY:

15

JULIE SEES BIGGER PICTURE:

16 THERAPY SESSIONS PROMPT FURTHER ILLUMINATION IN JULIE'S RAPIDLY EVOLVING BRAIN:



ENLIGHTENMENT STRUCTURES CREATED ...

Unknowing Revelation Interaction Releaser

17 WORLD VIEWS HIGHLIGHTED BY PARALLEL THOUGHT PROCESSES:

ABNORMAL WORLD

SHADOW WORLD

"Schizophrenic" Brains capable of co-existing in Multiple Dimensions...

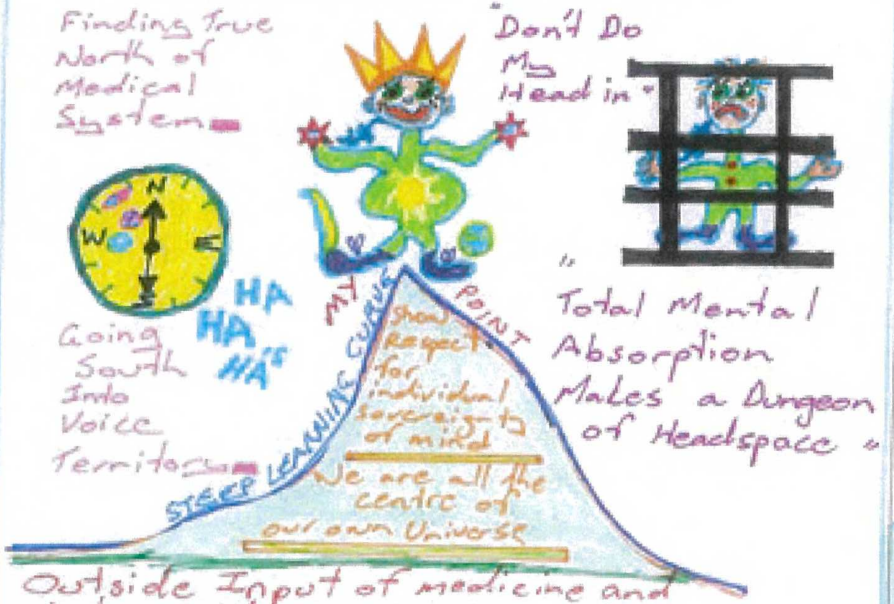
18 COMBINING WORLD VIEWS A CATALYST FOR GROWTH AND CHANGE:

Area Manager Encourages Consumer Outlook on Service Level...

19 MUTUAL GROWTH A TWO-WAY STREET:

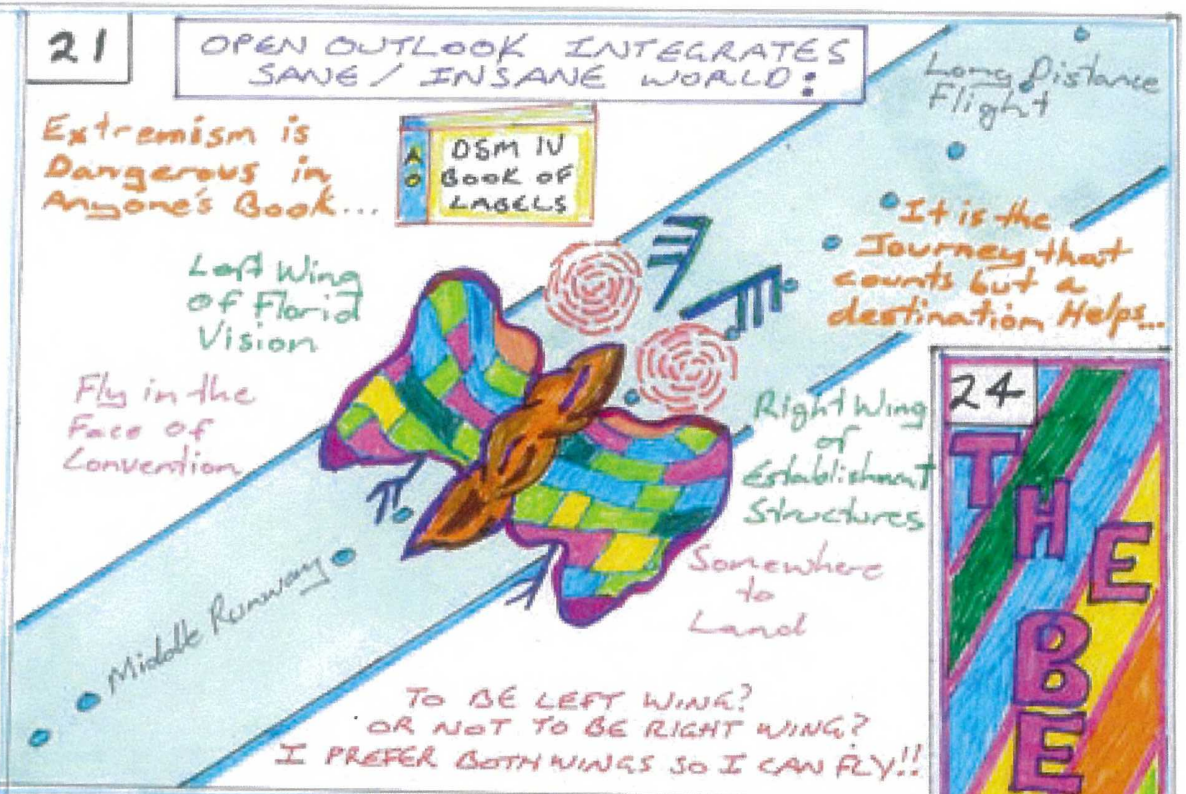
TRUST A LIFELINE TO FREEDOM

20 JULIE COMES TO REAL POINT OF VIEWS:

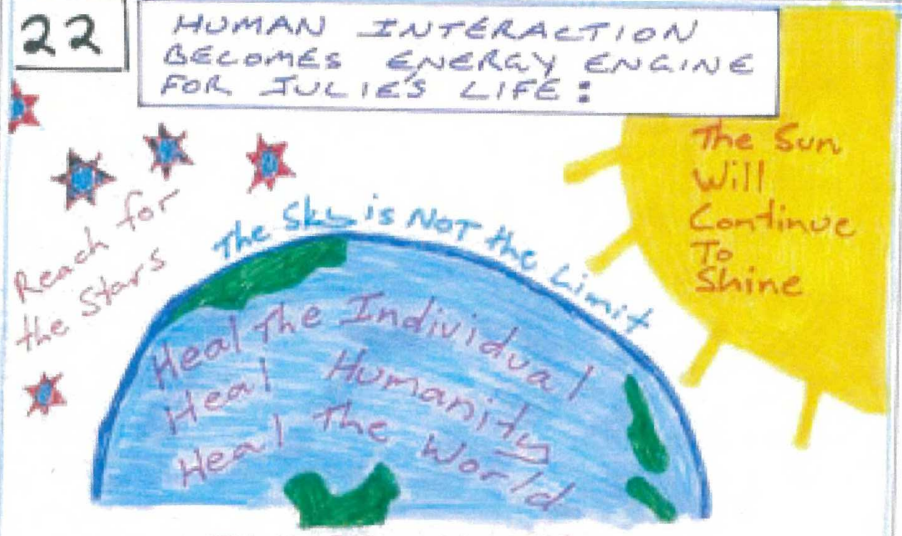


Outside Input of medicine and workers aids navigation of Internal/External Worlds...

21 OPEN OUTLOOK INTEGRATES SANE/INSANE WORLD:

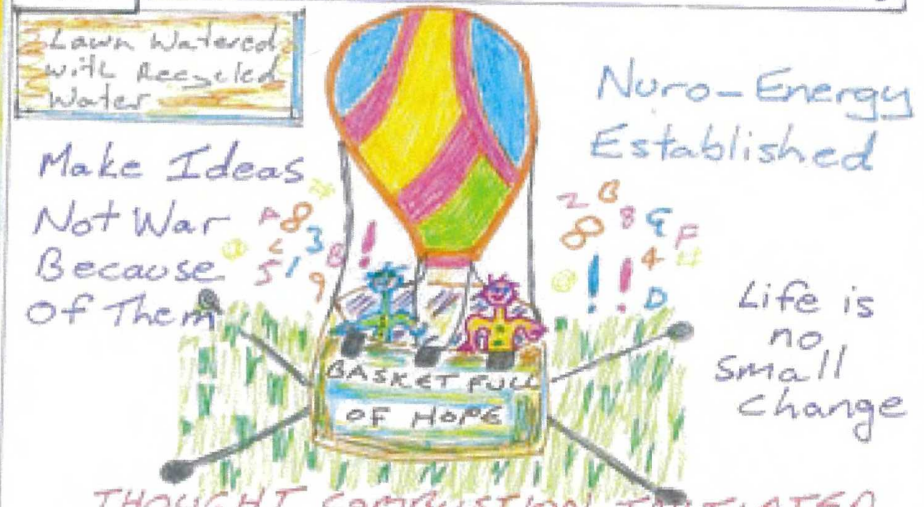


22 HUMAN INTERACTION BECOMES ENERGY ENGINE FOR JULIE'S LIFE:



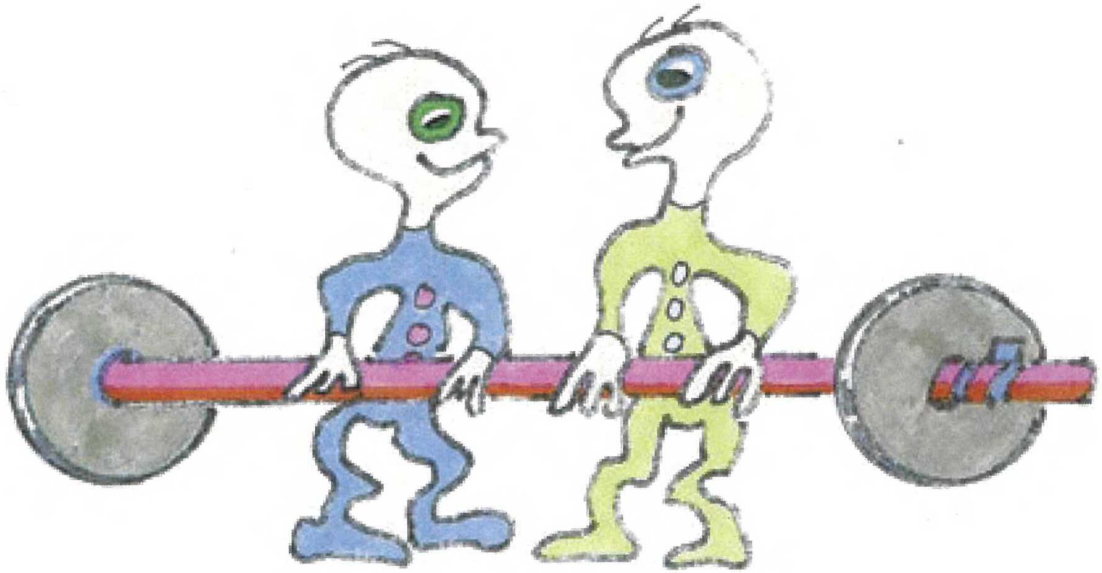
ATTITUDE MATTERS
Do not induce conformity from electrical current. It is the wrong fuel.

23 REGENERATION IS NOW POSSIBLE:



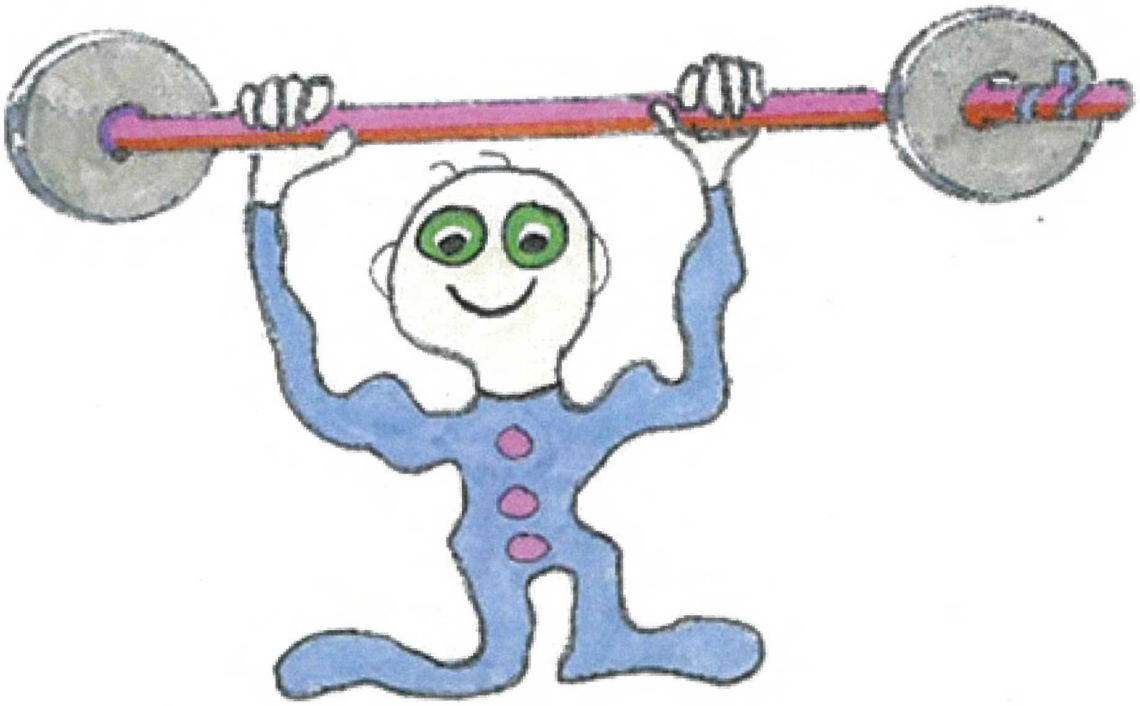
THOUGHT COMBUSTION INITIATED
NEW BRAIN WAVES EMITTED

24 THE BEGINNING...



Birth of Hope Acceptance

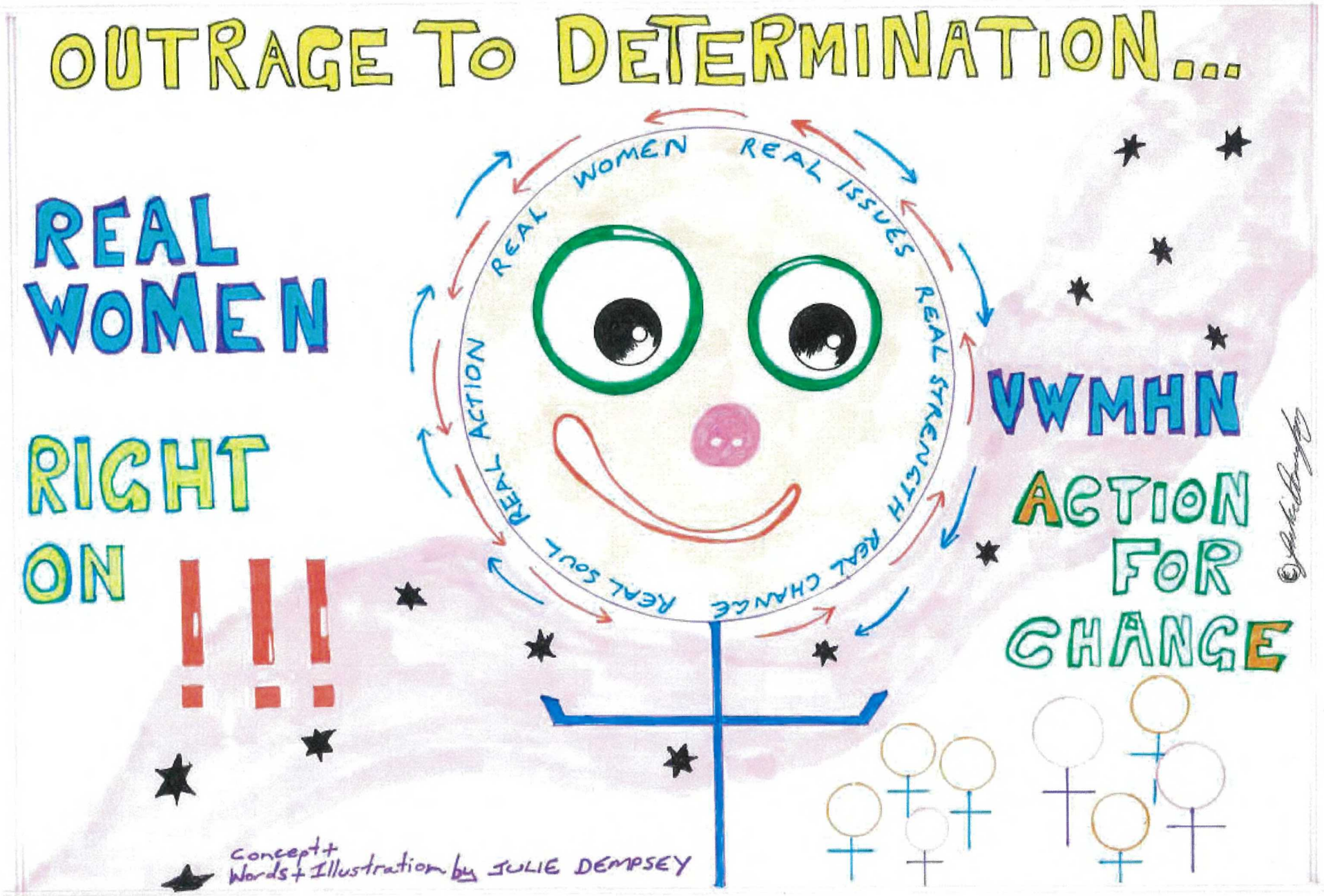
3–4 Accepting Help



Meaningful Life

9-10 Self-Reliance

Artist's contact email: jd@unrulyjulie.me



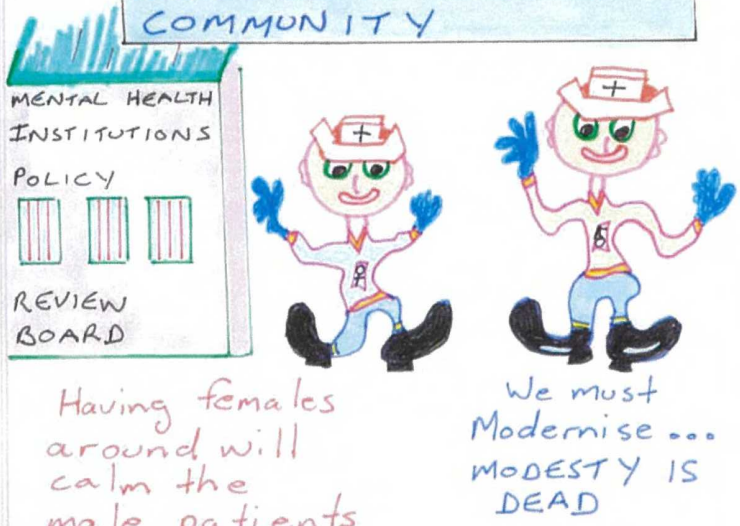
1

PSYCHIATRY ENTERS UNISEX ERA

1960's: SOCIETY MORE "PROGRESSIVE"

2

MIXED GENDER WARDS CREATED TO MIRROR COMMUNITY



3

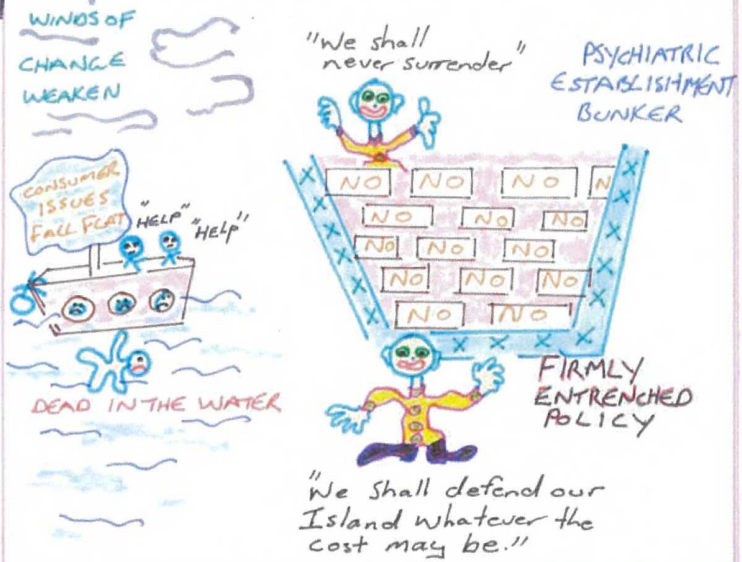
EXTREME SITUATION RESULTS

YEARS PASS BY...

4 1997 VWMHN BOOKLET "SPEAKING OUT" LAUNCHED

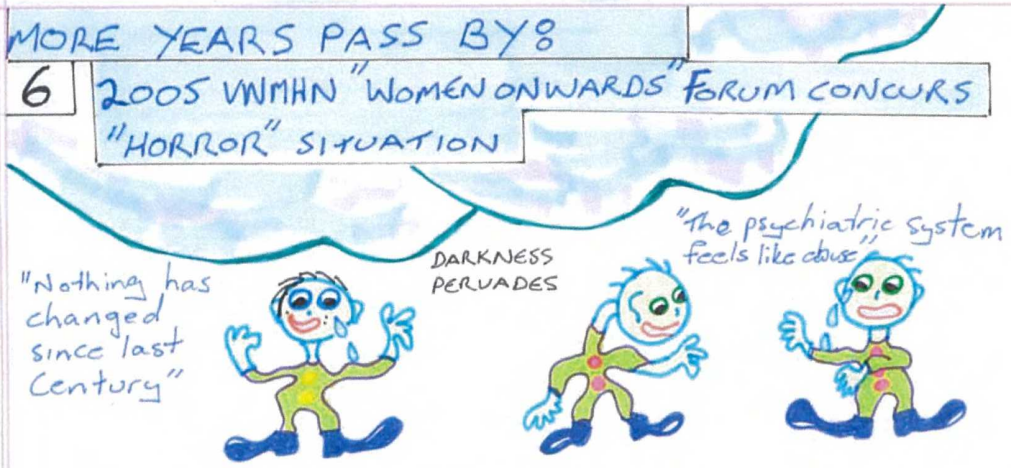
WOMEN'S LEGACY OF BEING SUBJECT TO ABUSE IN MIXED WARDS CONTINUES...

5 CALLS FOR CHANGE STONEWALLED



MORE YEARS PASS BY...

6 2005 VWMHN "WOMEN ONWARDS" FORUM CONCURS "HORROR" SITUATION



"We are living a NIGHTMARE Hospital has to be survived"

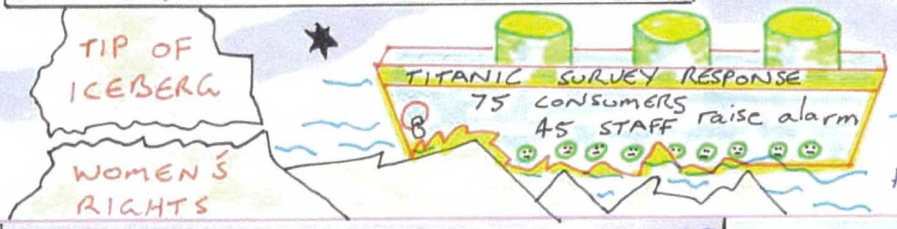
7 OUTRAGE BECOMES tive DETERMINATION

TOGETHER A FORCE TO BE RECKONED WITH

8 PHASE 1 BATTLEPLAN LAUNCHED 2006:

VWMHN SEND OUT SURVEYS TO TEST THE WATER ...
A RATHER UNPLEASANT TASTE...
61% of interviewees identified harrassment

9 SURVEY RESPONSE DAMNING



CURRENT GENDER DIVISIONS INEFFECTUAL
FLOOD OF CALLS FOR REVIEW
PSYCHIATRIC FACILITIES ...
A BROKEN SHIP IN THE NIGHT

10 VWMHN CONSOLIDATE AIMS

NOT ON THE MAP

DECLARATION OF INTENTION

① New Wards – Incorporate female only spaces for sleeping, lounge and recreation areas, and bathroom facilities into new building designs.

② Existing Wards – Review of space to achieve above criteria in current mental health facilities.

③ Policy Development – Creation of Mental Health Branch Guidelines to promote safety in Acute Inpatient Units.

④ Culture Change – Raise awareness of gender issues with staff.

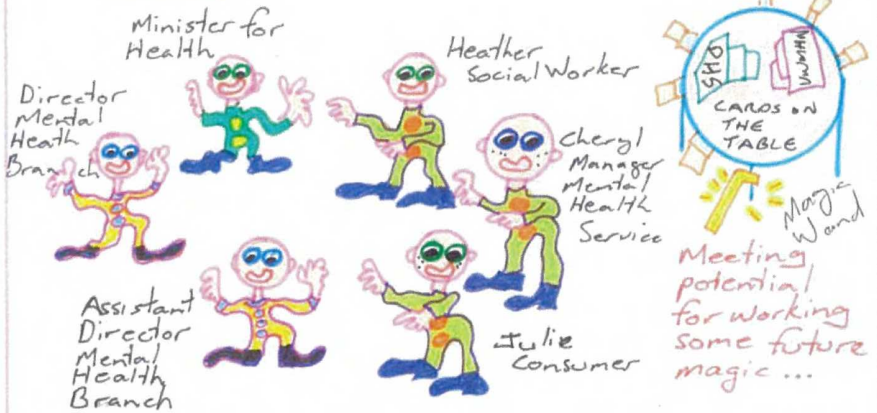
11 PHASE 2 NOVEMBER 2006

POSTCARD CAMPAIGN MAKES IT POLITICAL

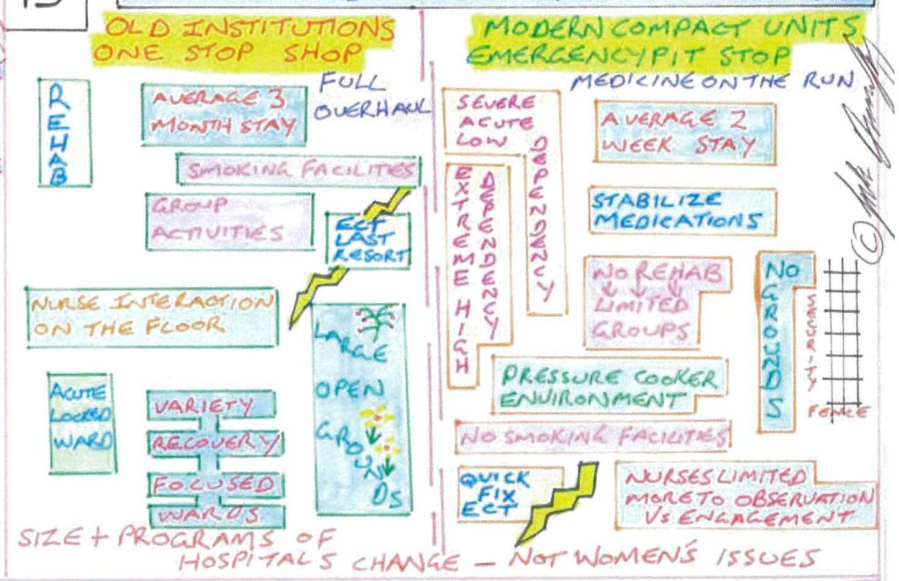
VWMHN distribute postcards to Mental Health services users/workers/general public to forward to Minister for Health in lead up to Victorian State Election

12 AUDIENCE WITH MINISTER GRANTED

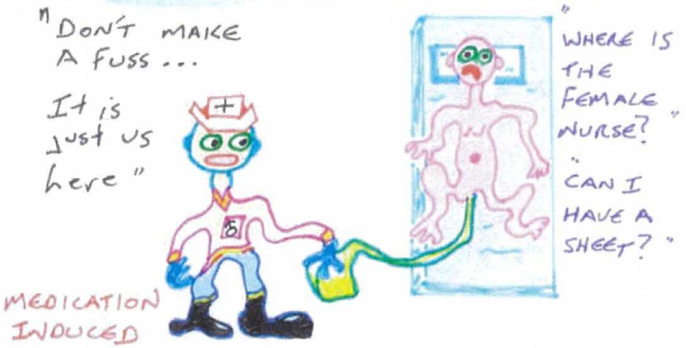
LATE 2006



13 JULIE OUTLINES TYPICAL EXPERIENCES SINCE 1982

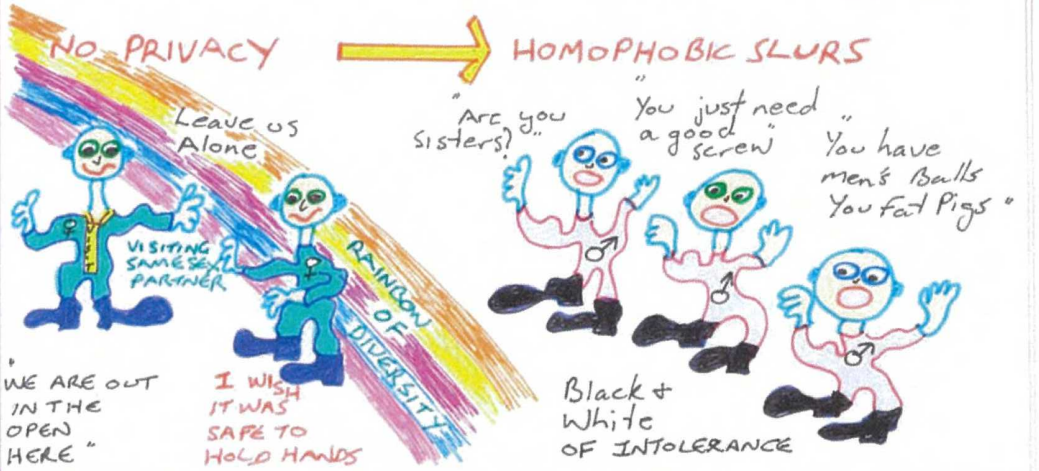


14 NO CHOICE OF FEMALE NURSE PROMPTS PAST HORRORS



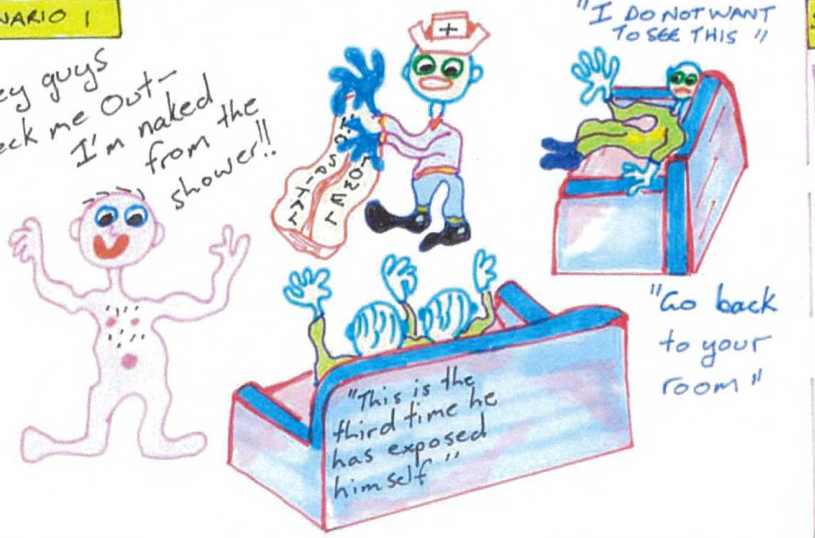
MEDICATION INDUCED URINARY RETENTION – CATHETERISED REPEATEDLY EACH DAY BY MALE NURSE

15 SEXUAL PREFERENCE ATTRACTS ABUSE

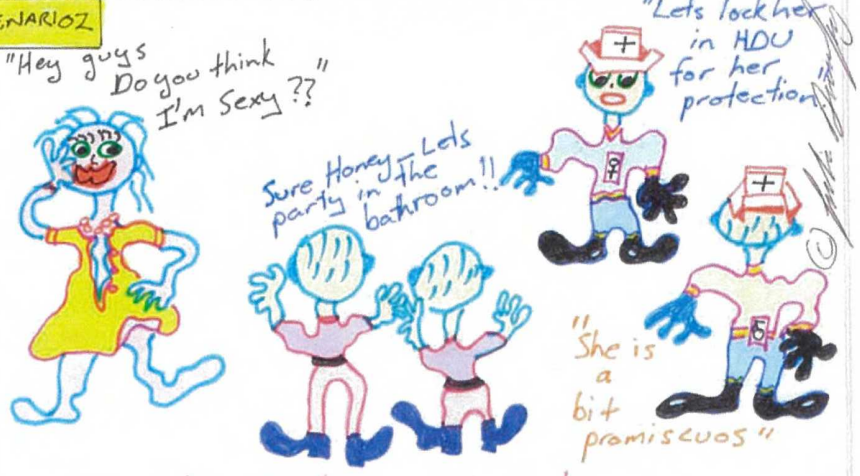


16 DISINHIBITED BEHAVIOUR TREATED DIFFERENTLY DEPENDING ON GENDER

SCENARIO 1

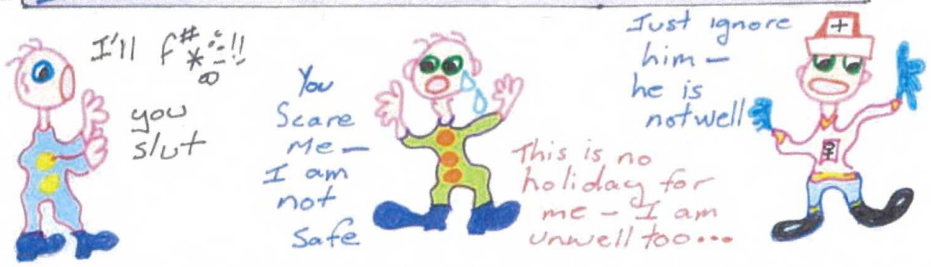


SCENARIO 2

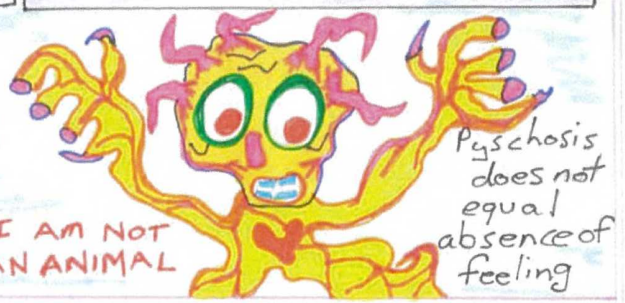


Heavy handed approach or safe nursing practice?

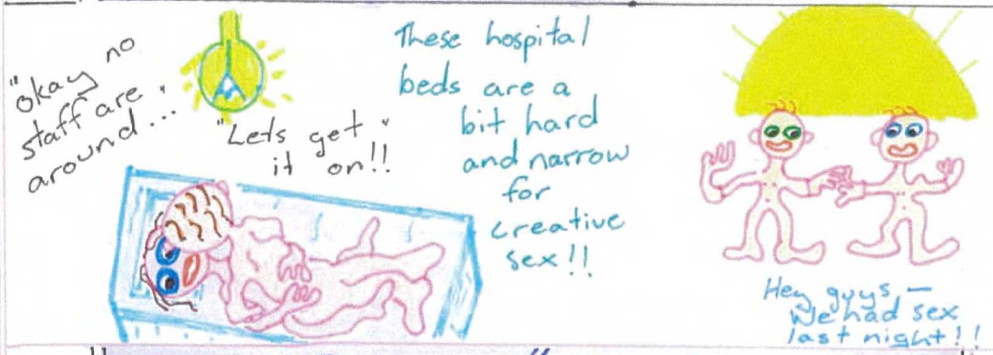
17 FEMALE PATIENTS EXPECTED TO ACCOMODATE INAPPROPRIATE MALE BEHAVIOUR



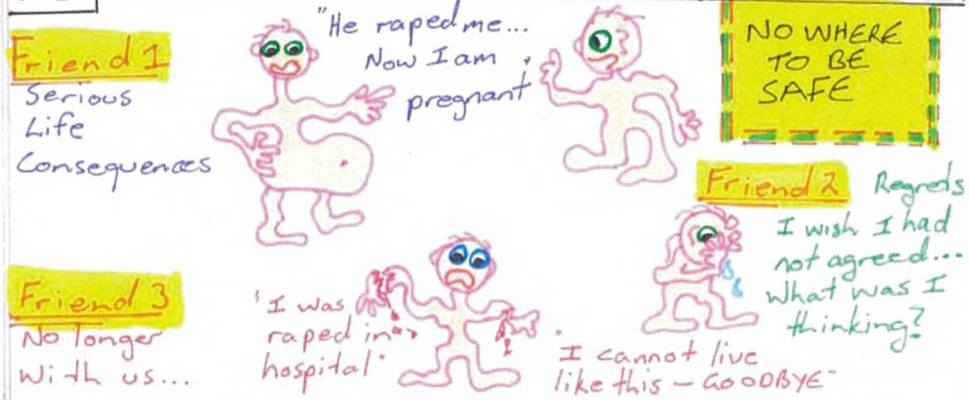
18 ACUTE DOES NOT MEAN INHUMAN



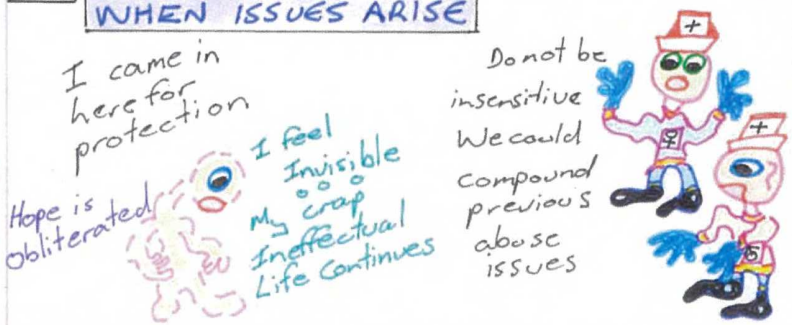
19 SEX ON WARD - NO STAFF IN HDU AT NIGHT



20 ASSAULTS FREQUENT // RESULTS DEVASTATING



21 SEXUAL ABUSE TRAINING NECESSARY WHEN ISSUES ARISE



ABUSE CYCLE OF HUMILIATION AND SUBMISSION REPEATED IN ANOTHER ENVIRONMENT THAT SHOULD BE SAFE

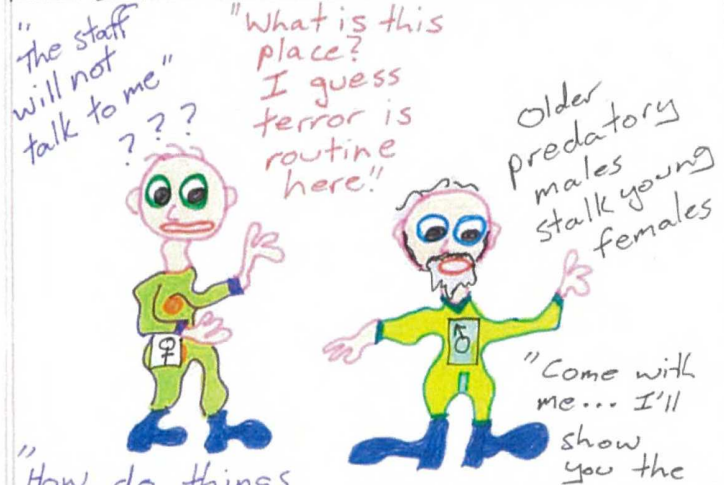
22 EVEN BEDROOMS NOT A SAFE RETREAT

23 SHARED BATHROOM FACILITIES UNHYGENIC

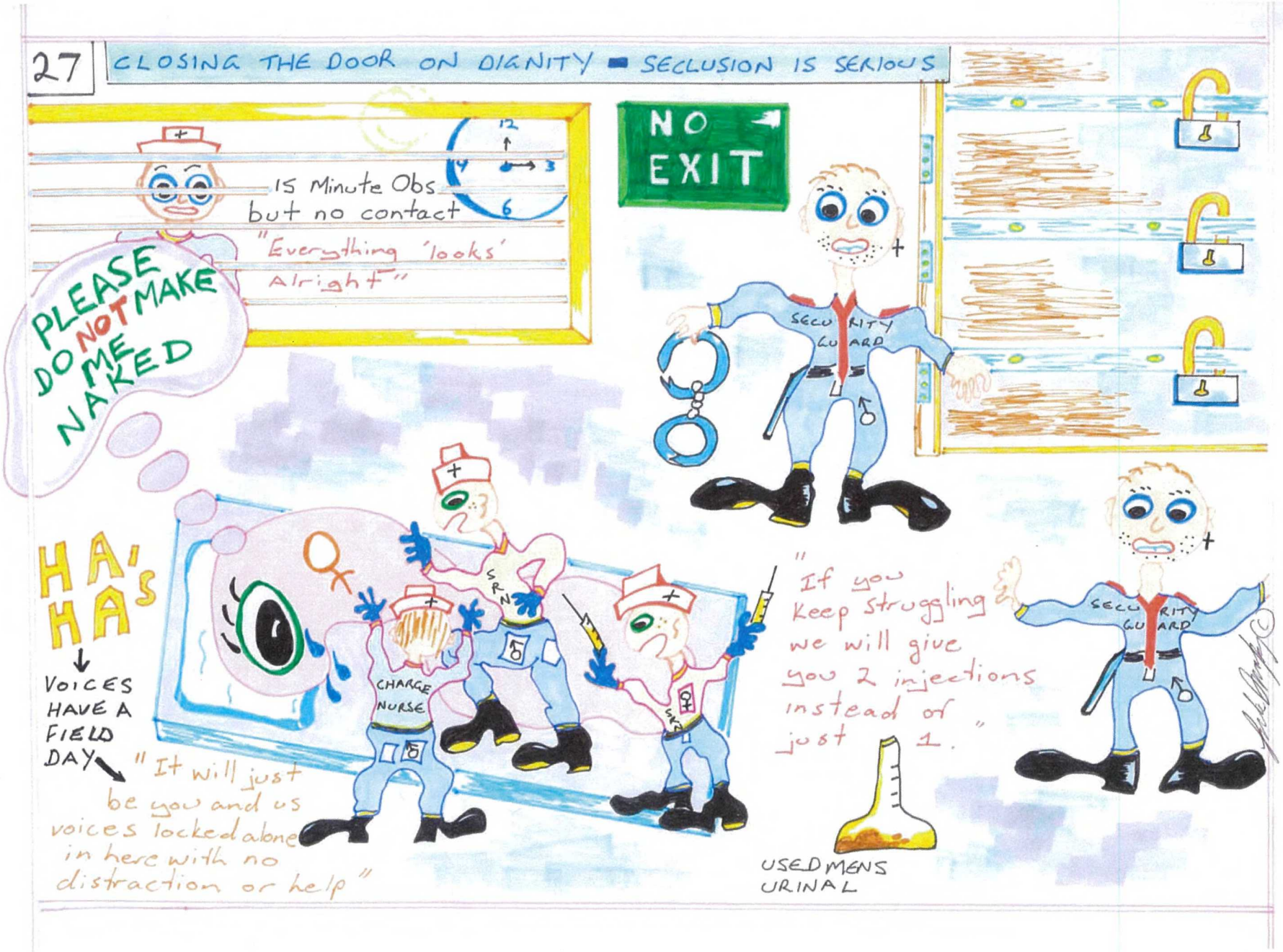
24 BASIC DIGNITY DESTROYED

1st night in HDU Locked Ward

25 NEW PATIENTS = "Fresh Meat"

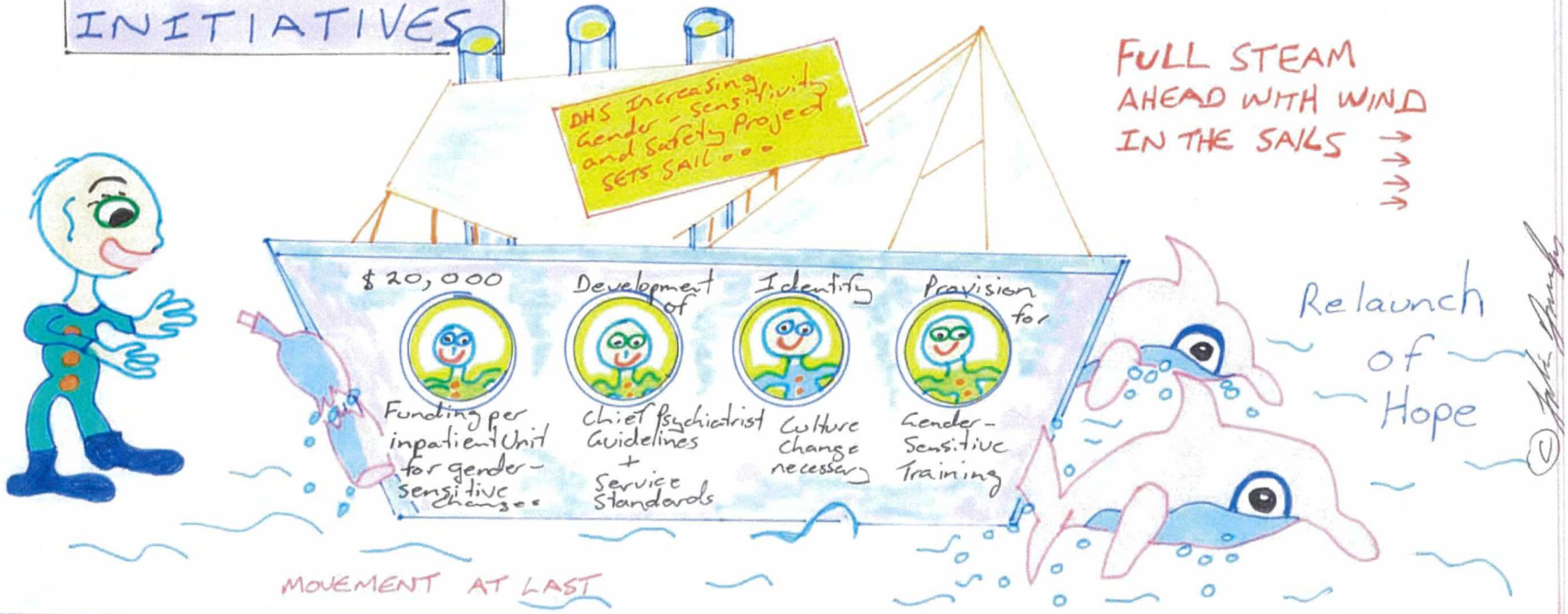


26 VISITORS MAGNET FOR OTHER PATIENTS & CONFRONTED WITH LACK OF PRIVACY, INTIMIDATION, AND AGGRESSION



28 MINISTER MOVED BY PRESENTATION

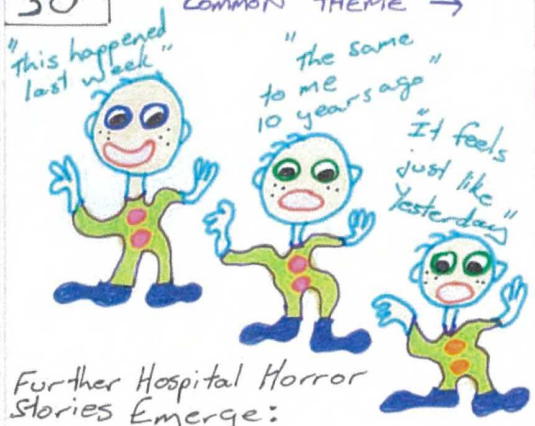
29 MINISTER COMMITS TO FUNDING GENDER-SENSITIVE INITIATIVES



PHASE 3 — IN 2007 VWMHN HOLDS 'LISTENING' EVENTS WITH FEMALE CONSUMERS

30

COMMON THEME →



Further Hospital Horror Stories Emerge:

WOMEN BOND →

Soothing Activity making postcards with messages for Area Mental Health Services

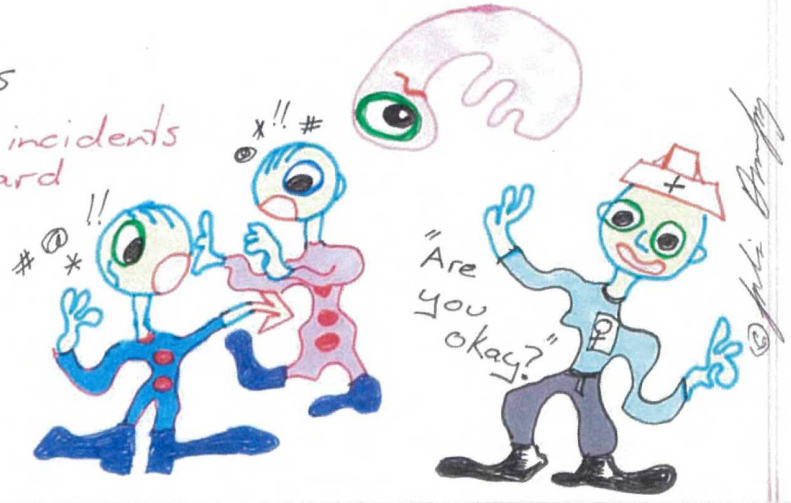
→ SOLIDARITY

Strength in common ground + numbers.

FIRST OPPORTUNITY TO FEEL SAFE TO TALK OPENLY ABOUT EXPERIENCES AND FEEL HEARD

31 FURTHER NEEDS BECOME APPARENT IN PLAIN BLACK AND WHITE

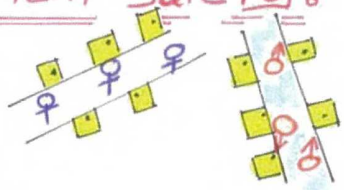
- Training to deal with previous abuse issues
- Training and support to deal with sexual incidents on ward
- Female Contact nurse
- Female presence when secluded
- Debriefing of patients after incidents whether patient is directly involved or Witness to an incident



32 | "NOWHERE TO BE SAFE" REPORT PUBLISHED | IN THE RED

APRIL 2008

Womens' Ten Priorities for Improving Inpatient Safety:



1. Locate bedrooms in separate women's and men's corridors

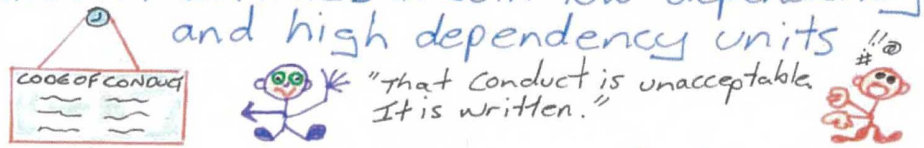
2. Separate women's lounges, outdoor and family visiting areas

3. 

Lockable bedroom and bathroom doors

4. Dedicated women's and men's bathroom facilities in both low dependency and high dependency units

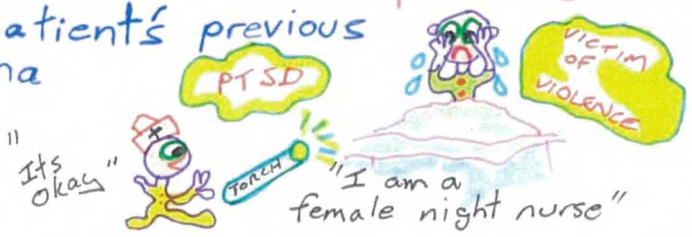
5. Introduce Patient Codes of Conduct which clarify unacceptable behaviour



6. 
"TIME OUT" Earlier intervention by staff to protect women and prevent escalating patient conflict

7. Better support by staff for women who experience harrassment

8. Staff to be aware of patient's previous experiences of trauma



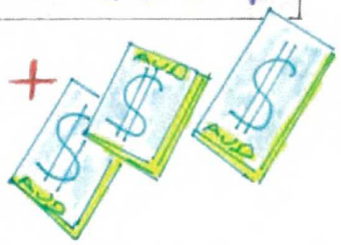
9. To be treated by female staff where possible, particularly at night

10. More opportunities for communication and therapeutic contact with staff

33 PHASE 4

BUILDING ON ACHIEVEMENTS ... NETWORK ATTRACTS FUNDING 2008 — 2009

MENTAL HEALTH COUNCIL OF AUSTRALIA +



THE AUSTRALIAN GOVERNMENT DEPT. OF HEALTH AND AGING

FUND REPORT BY VWMHN

"Gathering Information About Clinical Mental Health Service Initiatives":

ⓐ 25 Psychiatric Inpatient Units
Mixed Corridors → Women Only Corridors
Decline Majority Mixed Gender → ↑16 W.O. Corridors

STEPS TO SAFETY

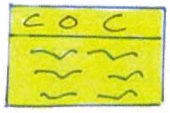
ⓑ Women Only Spaces Created

Butterfly's Women's Room Lounge Mildura

ⓒ Women's Outdoor Recreation Areas

ⓓ Locks On Doors

ⓔ Code of Conduct



Defining Acceptable Behaviour

ⓕ Nurse Call Buttons/ Sensory Motion Detectors

ⓖ Female Portfolio Positions/ Gender Sensitive Practice

On the Look-Out for ♀ Patients

34 PHASE 4

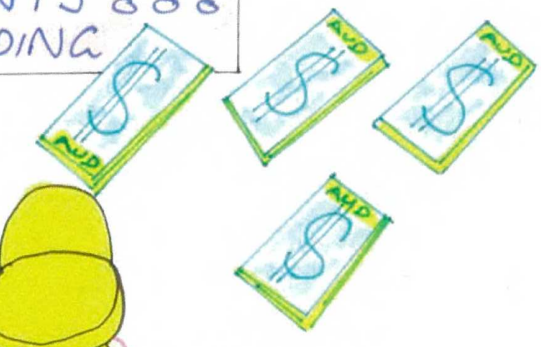
BUILDING ON ACHIEVEMENTS ... NETWORK ATTRACTS FUNDING 2008 – 2009 – 2010

REICHSTEIN FOUNDATION FUNDING →

WOMEN MAKING AN IMPACT

1. Sustain Achievements
2. Broaden Spectrum
3. Develop/Implement Strategic Plan
4. Promote Culture Change

MHCA + Dept. of Health fund →
Training on Nurse Level at Inpatient Units
Doing the Conference Circuit + Area Clusters



A 2008-2009

Consumer Julie and Worker Cheryl
Travel Victoria during bushfire Season

B 2009-2010

500+ STAFF SEEN

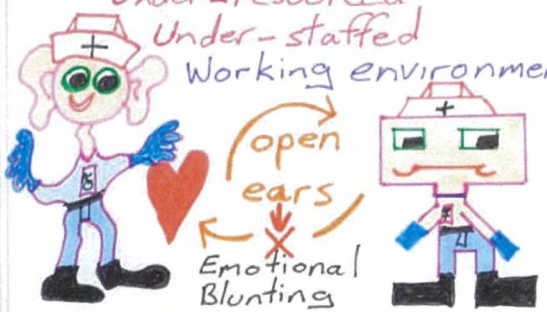
VWMHN
Keep on Driving
the gender-Sensitive
message home in
near and far away
places...

New Blood – Ongoing training with Consumer
Jude and Worker Cheryl...

35 SERVICE DELIVERY HAS POSITIVE IMPACT

Rejuvenates staff Sensitivity to daily blunting accrued in

Under-funded
Under-resourced
Under-staffed
Working environment



36 STEPPING OUTSIDE THE FISHBOWL

INITIAL RESISTANCE TO GENDER-SENSITIVE CHANGES CREATES WAVES on Inpatient Units:

(A) Muddy Waters of Women Only Corridors being "logistically problematic" clears to "actually in practise → easier to manage ward overall → less conflict."

(B) Nurses on floor More → Overall Safer for both patients and staff... ↓ Escalation lessened

(C) Separate toilet/bathroom/Sleeping facilities → ↑ basic dignity/Safety.. Obvious when male patient is in wrong area

(D) Female staff presence when Secluding... "Not just a Job for the Boys"

DO NOT TAP THE GLASS IT UNSETTLES THE FISH

(E) Patients are people Too
Staff are people Too

↓ Create Environment of Dignity

↓ Develop Mutual Respect

NO-ONE SHOULD BE A BOTTOM FEEDER

37 ANOTHER ELECTION

ANOTHER POSTCARD CAMPAIGN...

ADD A STAMP - MAKE A DIFFERENCE

♀ Rights 50% 60%

2010

ATTENTION: MINISTER FOR HEALTH

MORE STEPS TO ENSURE SAFETY FOR WOMEN IN PSYCHIATRIC WARDS

CONCERNED CITIZENS FOR WARD WOMEN POSTCARDS

38 VWMHN 5 POINT PLAN

1. New Design Guidelines provide choice of Single-Sex Environment

2. New Wards Provide Adequate Separate Women's Areas
   - ♀ Rooms
   - Women's Lounge
   - ♀ Bathrooms
   - Outdoor Recreation Space

3. Establish Women Only Corridors in ALL Adult acute Inpatient Units

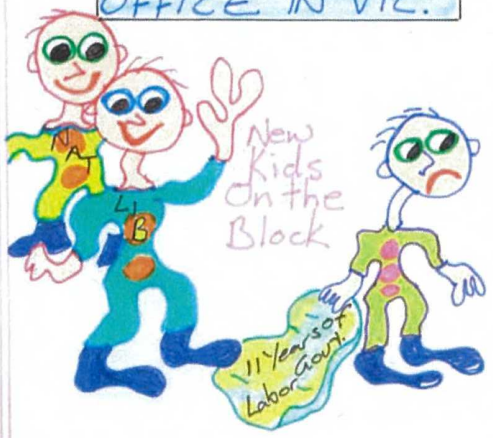
4. Restore Funding for Women's Mental Health Consultants
   - Establish Statewide Women's Mental Health Coordinator Position

5. Culture of A.S. Practice Embedded in Acute + Community Services
   - Supportive Training for Staff

♀ issues in the Spotlight -

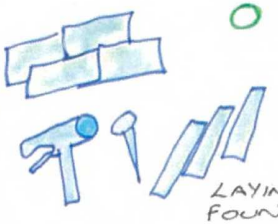
MEDIA BLITZ OF RADIO/PRINT/AND TELEVISION TO RAISE AWARENESS OF CAUSE...

39 LIBERAL/NATIONAL COALITION WIN OFFICE IN VIC.



40 CONSTRUCTIVE 4 MILLION DOLLAR INVESTMENT IN CAPITAL WORKS OVER 4 YEARS

- Establish Separate ♀ spaces in Existing Psych. Facilities
- Build a PARC specifically for Women
- Create 3 new Mother and Baby Units in Regional Victoria



LETS BUILD SOMETHING INTO THE FUTURE...

41 COMMITMENT ACROSS GOVERNMENTS

PREVIOUS HEALTH MINISTER INDICATED FUNDING OF $100,000 TO DEVELOP COMPREHENSIVE TRAINING PACKAGE TARGETING MORE GENDER-SENSITIVE PRACTICE

VICTORIAN COALITION GOVT. HITS THE MARK COMMITING TO FUND PROJECT

42 PHASE 5 BRANCHING OUT

VWMHN + Dept. of Health COLLABORATE to develop Gender Packages across ALL Services funded under Mental Health and Drugs Division

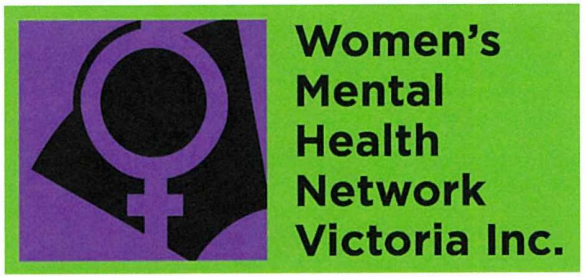
MORE UNIVERSAL APPROACH

43 PLANTING THE SEEDS OF CHANGE

FURTHER DEVELOPMENTS AN ONGOING STORY OF HOPE AND COMMITMENT –

PLEASE JOIN IN...

WOMEN'S MENTAL HEALTH NETWORK VICTORIA INC
100 Drummond Street, Carlton Vic 3053
PHONE: (03) 9663 6733 **EMAIL:** administration@wmhnv.org.au **WEBSITE:** www.wmhnv.org.au


Women's
Mental
Health
Network
Victoria Inc.

ACURATE PARANOIA

THE DRILL POINT?

OR

THE POWER POINT?

IS THERE ANY POINT?

COMIC BY JULIE DEMPSEY APRIL - MAY 2008

1

JULIE VISITS ANDREA AT ACUTE PSYCHIATRIC WARD:

2

TIME FOR ACTION:

"JULIE WRITES LETTER TO DIRECTOR OF MENTAL HEALTH"

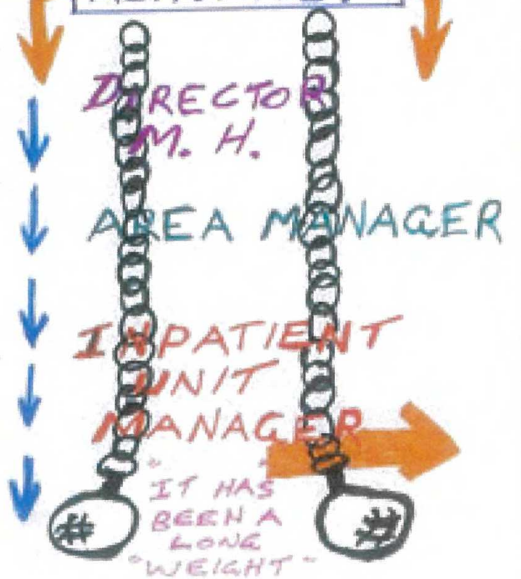
3

DIRECTOR RECEIVES LETTER:

"This is Bad"
"NOT HAPPY"

4

CHAIN OF COMMAND IS ACTIVATED:



5

MEETING OF THE (DIFFERENT) WAYS (OF DOING THINGS):

6

SINK OR SWIM CONSUMER ADVISORY GROUP TAKEN ON "BOARD":

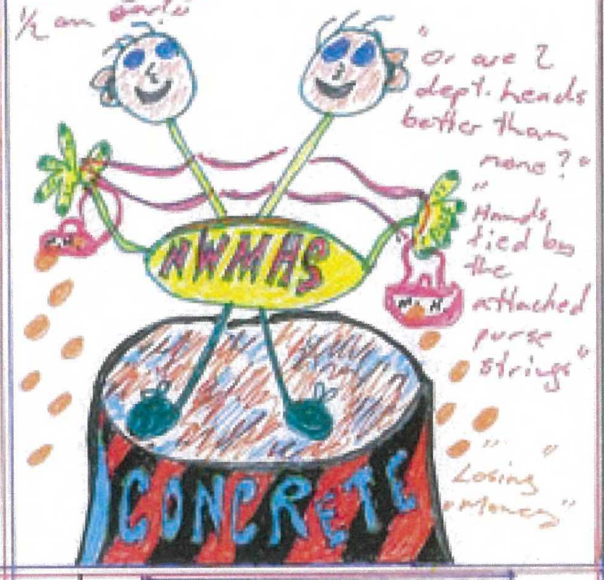
7

SUB - COMMITEE ON WARD ESTABLISHED:

8

MANAGERS TO CONSULT:

Need sticking out time!!



9

MEANWHILE JULIE GAINS INTELLIGENCE REPORTS FROM VOICES:

10

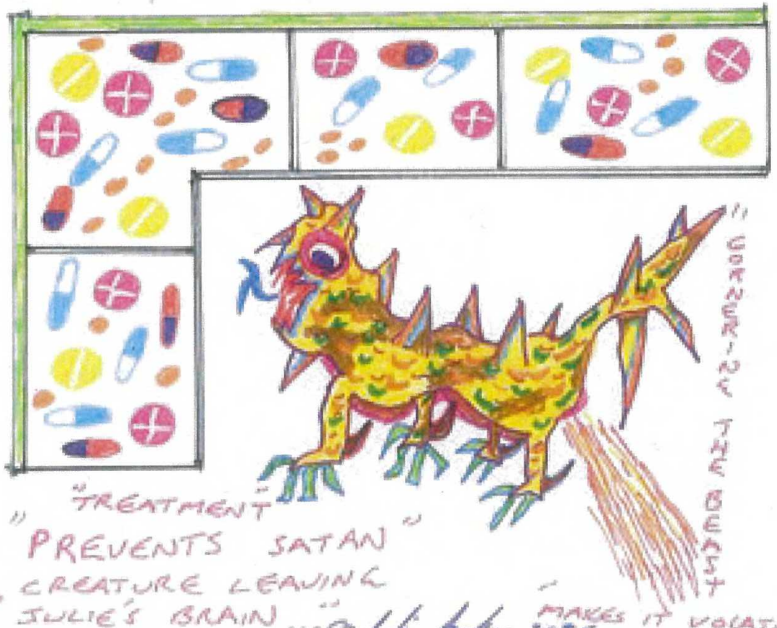
JULIE'S CASE MANAGER BECOMES CONCERNED:

11

CATT CALLED:

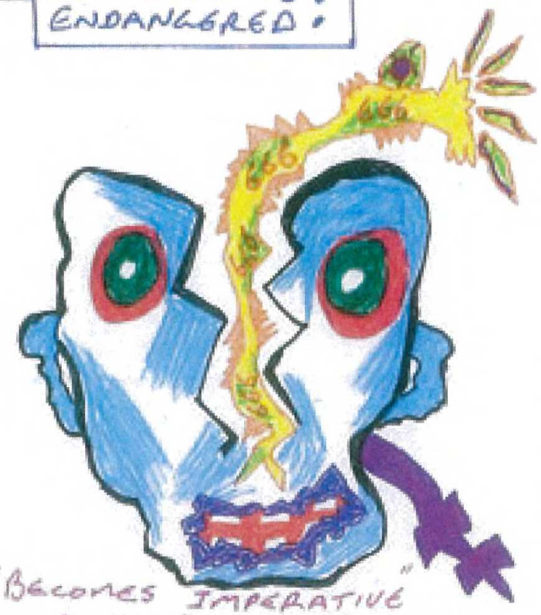
12

MEDICATION BLOCK ESTABLISHED:



13

HUMANITY IS ENDANGERED:



"BECOMES IMPERATIVE TO RELEASE SATAN CREATURE!.."

14

JULIE REMOVES MEDICATION BLOCK:

15

BUT FIRST TIME TO CLEAR OUT THE CRAP:

"JULIE CHECKS OUT IMAGE OF DECEASED PARTNER KERRIE ON TOILET FLOOR..."

16

HUMANITY IS NOW EVOLVING AT WARP SPEED THROUGH JULIE'S BRAIN:

"ALL TOO MUCH — JULIE" RINGS CATT FROM SAFE "-HAVEN of BEDROOM..."

17

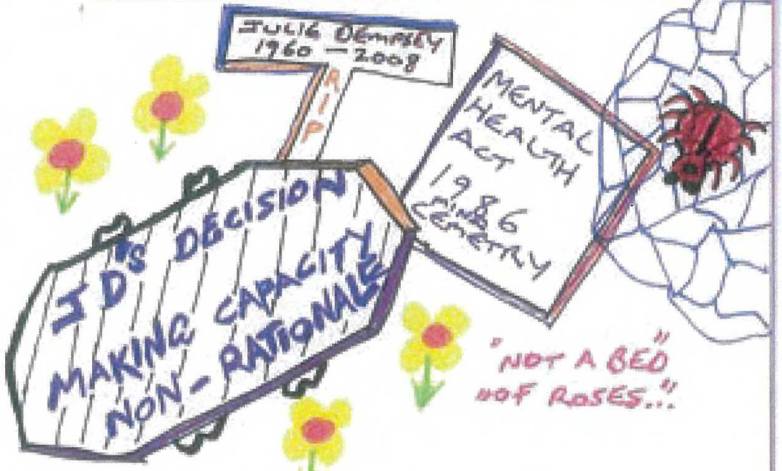
CATT TAKE JULIE TO HOSPITAL:

"DON'T STRAY"

"Julie NEEDS to go but does NOT WANT to go to hospital..."

18

JULIE REMAINS UNRESPONSIVE... E.C.T. IS SUGGESTED:



"NOT A BED OF ROSES.."

"YOU ARE UNDER THE MENTAL HEALTH ACT... BUT WE WANT YOU TO AGREE"

PSYCHIATRIST

19

JULIE "AGREES" TO TREATMENT:

"YES!! I AGREE TO E.C.T. IT WILL FRY THE SATAN CREATURE"

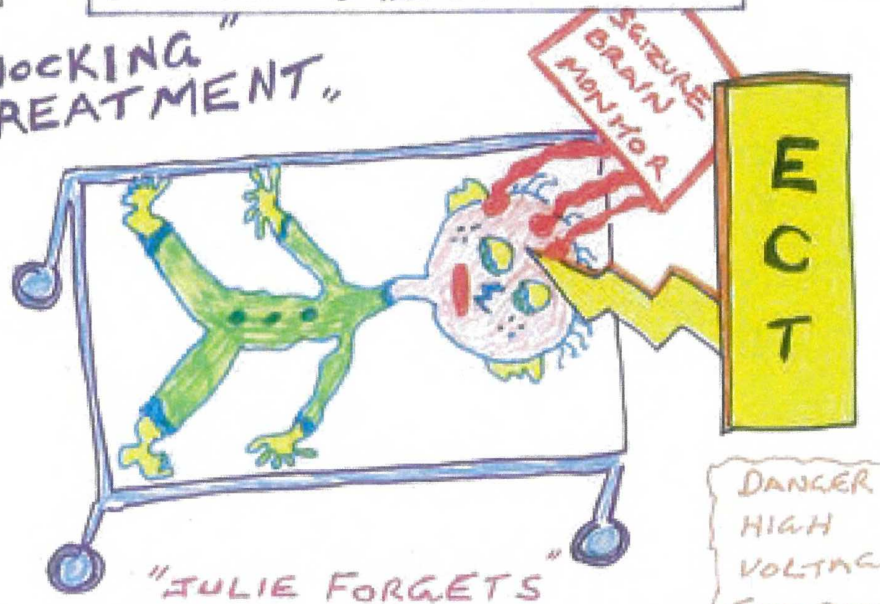
"AT THIS POINT JULIE WOULD AGREE TO ANYTHING ..."

"OUT OF THE FRYING PAN" "INTO THE FIRE..."

20

ONE WEEK – 3 TREATMENTS LATER:

"SHOCKING" "TREATMENT"



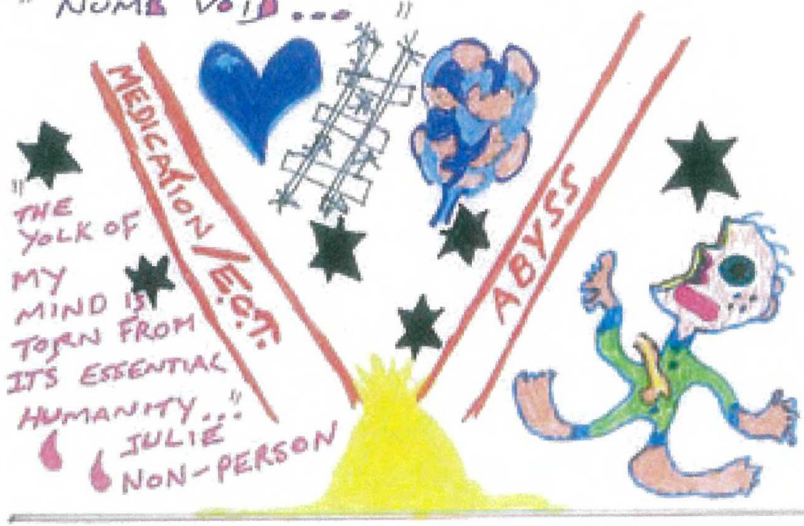
"JULIE FORGETS" "ABOUT SATAN CREATURE..."

DANGER HIGH VOLTAGE EQUIPMENT IN USE

21

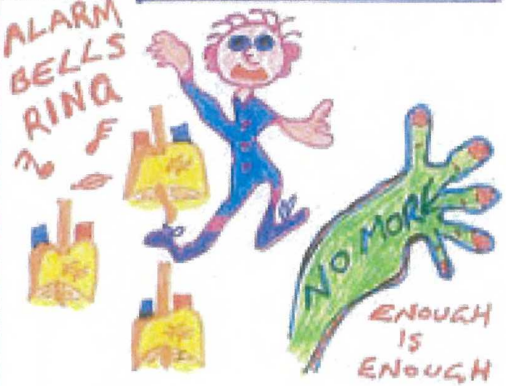
TREATMENT CONTINUES:

"BRAIN/HEART" AND "ME" ARE SEPARATED INTO AN EMPTY "NUMB VOID..."



22

CARMEL VISITS:



"CARMEL SUPER DR." PSYCHOLOGIST BECOMES CONCERNED → SUGGESTS "STOPPING TREATMENT..."

23

5 WEEKS LATER – 14 TREATMENTS ON:

"JULIE FORGETS ABOUT EVERYTHING... INCLUDING "HOW TO SPELL =="

IT HURTS TO THINK → RESULT → NO MORE LETTER WRITING...

24

E.C.T STOPPED... AFTER-SHOCKS CONTINUE:

"I FEEL LIKE I HAVE BEEN AWAY SOMEWHERE — BUT I DID NOT GET TO GO..."

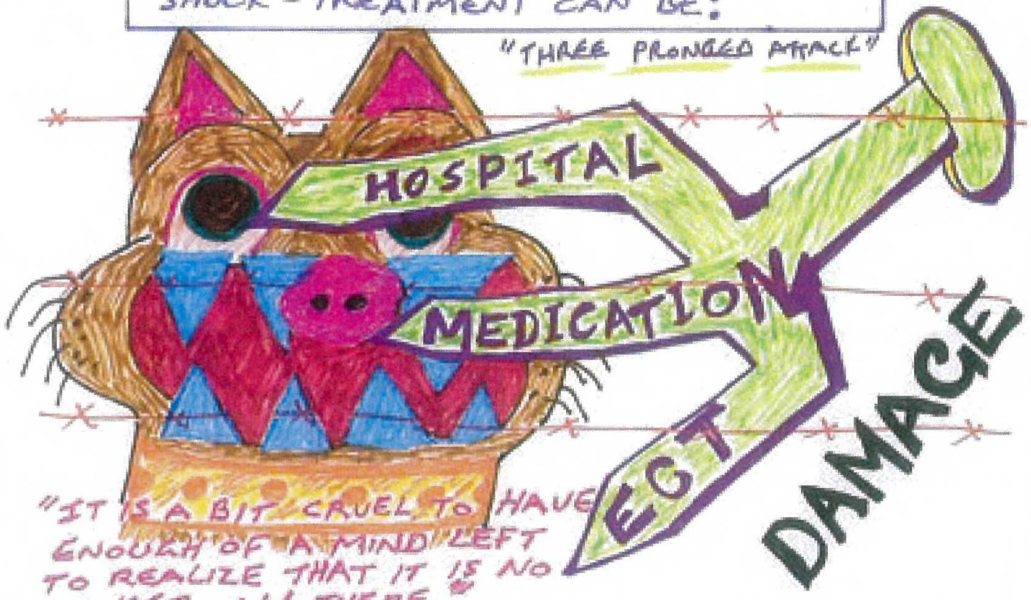
"MY BRAIN IS BROKEN."

MIND BREAKING ILLNESS

MIND BREAKING TREATMENT

25

JULIE RE-DISCOVERS HOW BARBARIC SHOCK-TREATMENT CAN BE:



"IT IS A BIT CRUEL TO HAVE ENOUGH OF A MIND LEFT TO REALIZE THAT IT IS NO LONGER ALL THERE...

26

PRIMAL DARKNESS SETS IN:

JULIE LEAVES HOSPITAL..

JULIE LEAVES HER MIND..

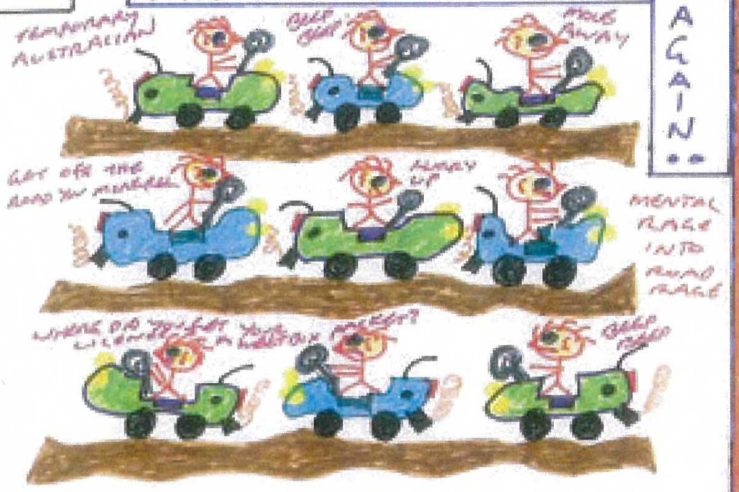
JULIE IS HERE BUT NOT HERE...

JULIE IS NO MORE..

JULIE'S MIND IS BLOWN

27

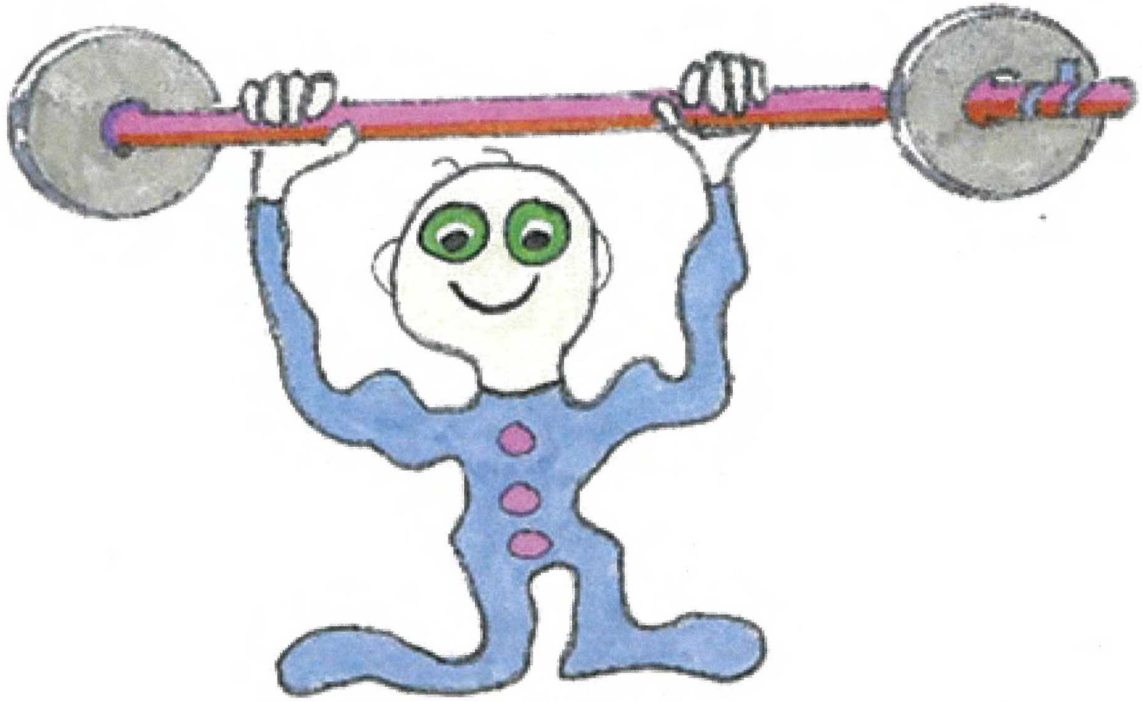
FREEDOM TO POLLUTE AGAIN..



JULIE IS PRONOUNCED FIT TO RETURN TO THE MINDLESS NEUROTIC WORLD...

28

THE END.



Meaningful Life

9-10 Self-Reliance

Artist's contact email: jd@unrulyjulie.me

Royal Commission into
Victoria's Mental Health System

ATTACHMENT JD-3

This is the attachment marked 'JD-3' referred to in the witness statement of Julie Dempsey dated 23 July 2019.

JULIE D'S EXPERIENCE OF INPATIENT PSYCHIATRIC WARDS. MARCH 2017 NEVIL TRAINING

Hello, I am going to talk to you today about some of my personal experiences of gender-specific problems in the mental health arena. Many issues arise from an admission to an acute public psychiatric facility.

Often women must deal with confronting conditions in order to receive treatment.

Resolution is not easily attended to but rather an ongoing process as a consumer journeys through the mental health system.

This is my story, but just one of many.

I have been in the hospital system since 1982 with multiple admissions to Parkville Psychiatric Unit, Willsmere, Larundel and Broadmeadows Inpatient Unit. Although the size and program of the hospitals change, the issues of safety for female patients in mixed wards remains the same as it did over thirty years ago.

It is only just recently that these issues are starting to be effectively addressed and need our constant attention not to slip backwards into Dickensian style conditions.

I first became involved with the WMHNV in September 2005 after giving a talk about my experiences in acute psychiatric inpatient units at the VWMHN's "Women on the Wards" forum. This was to be a springboard for a new and more positive chapter in my life.

In a way this was the beginning of my pathway back to relative sanity and social inclusion. My experience as a consumer now had a more constructive value to it and a more meaningful life personally was to follow. I have now held executive roles in the Network since 2006, including Chairperson from 2011-2016. I still sit on our COM today holding the executive role of Secretary.

Working with and being supported by the WMHNV has allowed me to grow to the point of maintaining a permanent job as Senior Consumer Consultant at Forensicare.

After 30 years of non-employment and countless lost years in a psychotic wilderness, I have held my job with Forensicare since 2009.

I also achieved sector recognition with a career highlight in 2014 when I was the winner of the Minister's Award for Outstanding achievement by an Individual or Team in Mental Healthcare at the 10 year Anniversary Victorian Public Healthcare Awards.

In isolation severe mental illness can seem hopeless but with positive workers, support and perseverance anything is possible. Trauma does not need to equal negative life outcomes.

Anyway Moving On:
In summary, my experiences in acute settings over the years have included:

- Male patients walking naked into the day room from the shower.
- Female patients often enduring unwanted verbal aggression from male patients. Examples of this are in the form of:

    - Inappropriate sexual suggestions
    - Insulting homophobic comments to women

- Physical/sexual threats or demands in relation to female patients' bodies and private space

- Male patients walking uninvited into female patients' bedrooms.

- Witnessing male and female patients engaging in sexual activity/intercourse. This is not restricted to the open areas. I have also been witness to patients having sex in HD at night when unsupervised.

- When visiting friends in hospital, I have had to endure male patients exposing themselves or making lurid comments as I have left the premises.

- I no longer feel comfortable even visiting someone in hospital, let alone voluntarily putting myself in as an inpatient to a public psychiatric facility.

- In my own case I have been sexually assaulted whilst an involuntary patient. Due to my confused and

delusional thinking I thought that by complying with the sexual demands of the male who assaulted me I would be released from hospital.

- Even though I was severely distressed I did not inform staff. Due to my paranoia I thought they had instigated the encounter on purpose, to test my sexuality.

These situations are not rare and can affect female patients' mental health long after they have left hospital.
I had two friends who were sexually assaulted while in hospital. One friend suicided and the other became pregnant as a result of the assault.

All of these things have happened over the years, many of which are ongoing as illustrated by my last hospital stay.

On the up side some change is evident. However talking to fellow consumers with more recent hospital experience, many of these issues still arise.

Consumers and staff need to work together to bring about change at staff, financial and structural levels.

For example, the first night I was in HD the nurse threw me a pair of ward pyjamas and said "one size fits all". They were old, faded, the top was too small and missing a button so that my breasts were partially exposed – and I literally had to hold the pants up with my hand.
Later in my stay when I got to know this nurse he was very reasonable and approachable.
However at the time I felt vulnerable, powerless and intimidated. I thought to myself which is worse, the hell in my mind or the hell in the surroundings I was forced into?

Another common problem that was still evident concerned one male patient hitting on vulnerable and confused female patients.
So at one point I told him not to take advantage of them.
His response was to call me a fat pig with men's balls.

When I asked him to move away he called me a slut and many other unmentionable words, and then threatened to knock my block off.

At this time other female patients became concerned and moved over towards me. When the altercation was over the other female patients talked to me, hugged me and gave me a shoulder massage to try to relax and reassure me.

All this happened with a male staff member watching on. He only intervened when it looked definite I was about to be physically assaulted, but the nurse did not reprimand the male patient. Later, when the offender was out of earshot, the staff member congratulated me for sticking up for myself.

What message is this sending to male patients who act inappropriately and in an aggressive manner, and to female patients that they should have to tolerate such behavior?

The staff had been told numerous times what was going on but in my opinion the other female patients did more to protect and support each other than the staff did.
On the staff side, resources were tight and HD was full, but does this justify females being so exposed to such abusive men?

Disrespectful behaviors should not occur in any part of society. Do not allow this to be an excuse of mental illness. This is one more reason why we need gender sensitive wards and staff.

In situations like the above, a Code of Conduct would be useful, for both patients and staff alike. There was a strong response from political candidates in our Victorian 2014 pre-election survey in favour of this measure. So stay tuned.

By clearly outlining appropriate and acceptable behavior, a standard of what will be tolerated can be set, so as to reassure vulnerable consumers that they are in a decent and secure environment

Without strong leadership and clear policies staff can also feel unsupported and intimidated, resulting in inaction.

I think change is possible and staff can be responsive to women's special needs and gender rights. More increases in funding and resources would certainly help but does not preclude making changes within existing parameters.

For example: In the hospital situation…
After raising the pyjama problem with the unit manager she agreed to try buying separate pyjamas just for the HDU and washing them in the hospital laundry instead of putting then in the general linen service.

Unfortunately often such possibilities can be limited by how flexible or accommodating to patient dignity key staff members are.
At another time I was in a meeting where this same pyjama problem was raised. However that particular NUM's thoughts were it was more important to spare night staff the indignity of washing pyjamas on the unit and not to have the possible expense of clothing items going missing. Yet quite often kindly nurses in HD would wash and dry patients' clothes on the night shift.

Often it is too easy to see problems than put the effort into solutions. Many times when reasonable suggestions are made the system is so rigid that we forget how to be human. It is people who change this situation.

I also experienced basic hygiene problems when sharing bathroom facilities in LD. Some male patients were urinating, defecating, and taking drugs in the bathroom and spreading these substances all over the toilet seat and floor where I had to shower.

This has been addressed in some units on a structural level by having female only corridors, and gender dedicated bathroom facilities.

In the last decade 'women only corridors' have increased from existing in just 2 hospitals to now being in every public psychiatric inpatient unit in the state. Though this improvement is repeatedly compromised by men being admitted to these dedicated corridors when bed-shortages arise.

Nurses are not horrible people. But the system as a whole can be very demeaning for female patients. Training in dealing with sexual and abuse issues would be a good start.

Many times when an incident arises staff may be reluctant to tackle the fall out with affected patient s. When disclosing my history of past abuse I have been met with a range of responses varying from ridicule to straight out silence. Like I was invisible and had said nothing of significance at all.

Distressed consumers need support and compassion, not disbelief.

Although such scars are rarely addressed during a hospital admission, insensitive trauma handling can result in it being compounded rather than reduced.
Nurses cannot be expected to solve all of a patient's pre-existing problems, especially in such short term environments.

However showing some basic compassion can go a long way to making a vulnerable patient feel more secure and heard.

In the face of such conditions in mixed wards, mutual support and bonds between female patients can develop. This process is enhanced by the separate female only spaces in mixed wards. Such spaces allow for more free and supportive conversation between females to deal with the challenging circumstances that frequently occur.

A common case in point is young females new to the system being targeted by some predatory male patients. The constant exposure to very sick male patients can be very frightening, creating tension and an unsafe atmosphere on the ward.

After all, the female patients are not there for a holiday. They also are very unwell.
It only takes one disinhibited or sexually aggressive male patient to change women's sense of the ward from being protective to threatening.

By talking to other women about my personal hospital horror stories at the beginning of our Listening Events (which led to the publication of the 'Nowhere to be Safe" Report) I think that women attending felt more able to open up about what had happened to them in hospital.

A number of positive things arose from this process of expression and empowerment such as:

- Being able to meet and bond with other women
- Sharing a refreshing and inspiring catharsis from such honest, upfront and passionate discourse,
- Witnessing the amazing courage of women to talk about issues they had not felt supported or safe to discuss up to that point, and
- Working with women in their local areas to raise awareness and improve services.

We need to keep raising the issues of women's experiences. It is not enough to hope for change – you have to believe it can happen and work collaboratively to make it happen.

If you feel too intimidated by entrenched staff to directly challenge insensitive attitudes then at least lead by your own personal example when engaging with consumers.

Being involved in the WMHNV has shown me how outrage can be changed into positive determination for a better outcome for women psychiatric patients. Thus the title of my comic book publication on women's issues being distributed today.

Hospitals should be about refuge and recovery from mental trauma.

What consumers and staff need is a supportive framework that encourages and enhances the development of skills and expertise in identifying, acknowledging and addressing safety and trauma issues.

So for staff, please take your own steps as individuals and as a team to help empower consumers with the respect and self worth they deserve.

I know doing these talks changes the way I perceive and relate to staff.

I hope they change how you perceive and engage with consumers.

Thank you for listening.

Julie Dempsey

07/03/2017