Mental Health Legal Centre Women's Only Psychatric Wards forum 2004

MHLC TRANSCRIPT OF 'WOMEN'S ONLY' FORUM

In 2004 the Mental Health Legal Centre held a forum on women only wards

Fran O'Brien - Senior Counsel specializing in employment law and speaking on issue as discrimination

Mental Health Legal Centre ;-

The Mental Health Legal Centre is concerned that women are not safe in psychiatric units in general hospitals in Victoria, We believe that it is a violation of women's rights to be placed at risk of violence and sexual assault when they are inpatients in psychiatric facilities.
A free public forum regarding these issues was held on Tuesday 5th October 2004 at Swanston Hall, Melbourne Town Hall
in Swanston street Melbourne, Australia.
Women Only Psychiatric Wards
Transcript of speeches delivered at the "Women Only Wards Forum" held on 5th October 2004:

- Chair - Renata Alexander
- Carolyn Graham - author of Certified Truths study
- Cath Roper - consumer activist and consumer academic at Centre for Psychiatric Nursing Research and Practice on Consumer Experience
- Fran O'Brien - Senior Counsel specializing in employment law and speaking on issue as discrimination
- Barbara Shalit -Mental Health Legal Centre Lawyer, sum up

TRANSCRIPT OF 'WOMEN'S ONLY' FORUM

Date: 5/10/ 2004

Renata

Welcome to this public forum on women's safety and psychiatric settings. My role as chair is to give introductions to the speakers and to give you some information about the program. I will thank the speakers and you, the participants, and the organisers in advance and there will be some thanks at the end.

First, I need to express that we respect - as the organisers of the forum, we respect that we are standing on Wurundjuri peoples' land and we acknowledge the elders, past and present, of the Kulun nation. We also say thank you to Russell Kennedy, a firm of solicitors for their kind sponsorship and we also have a letter of support that I wish to read out from the Islamic Women's Welfare Council of Victoria. It's very short.

It's from the Manager of the Islamic Women's Welfare Council of Victoria, and she says, 'We would like to offer our support and endorsement for the campaign to offer women entering psychiatric units and settings the option of a single sex environment, of female only staff and consumers. There is long term evidence of many women being sexually harassed and assaulted in mixed sex environments. This is an urgent policy issue that needs to be addressed by our government and that may well form the basis for resolution that you may wish to pass at the end of the forum.'

Let me just give you an outline of the program - if you weren't bombarded by 'how to vote' pamphlets outside. The only one that I got was a Families First, I'm not sure why, I must look like that kind of person. None of the Greens or any of the other parties gave me any pamphlets. And if you don't want to do a post-graduate course, which is upstairs, for Monash University, then you've come to the right place.

The program is this, we have 4 speakers, each of whom will speak for up to 20 minutes and then there will be an opportunity for questions from the floor for approximately 4 or 5 minutes. We then plan to have afternoon tea around 3.30pm for about 20 minutes, again, and then the 4th speaker after that. In the last half hour we will break into small groups, depending on how the forum feels, and the numbers, groups for discussion and then reconvene as a whole to formulate and put forward any resolutions that you want to come from this forum. We plan to close the forum at approximately 5 o'clock. So I'm not sure if that's when we get kicked out, but that seems to be the opportune time to finish.

Finally, if any of you have any personal issues you wish to discuss, personal experiences, or any issues generally, there are people here available from the Mental Health Legal Centre who will be available

after the close of the forum and to Victoria Ellis is here from CASA, Centre Against Sexual Assault, and they're both available – those workers are available for you. So if you don't have time during the forum or during the workshop period to air your reviews or address some of your concerns then feel free to contact any of those workers after the forum.

I'm just going to speak for a couple of minutes - I'm not very good with technology, so I keep hitting that microphone. This is Community Safety Week. I wasn't aware of that, but that goes to show how much publicity we've had about it, and I guess then it's quite appropriate to talk about women's safety and psychiatric settings. And from many perspectives really, because women's safety is a community concern. Psychiatric settings are varied. You know from your experiences, and I know as a lawyer, and other people here in various professions, that psychiatric settings include a vast array of clinics, of mental health service providers, of doctors, of hospitals, of institutions, of therapists and other people in the service delivery area. And women's safety in those psychiatric settings is not just a feminist issue, it's an issue about human beings and human rights and it's about the abuse of and discrimination against women. It involves very similar human rights issues, issues of safety, of trust, of security, of self esteem and protection, and the provision and delivery of professional services at high standards to women who have special needs or disabilities.

There are lots of similarities between women who are being abused in hospitals and mental health settings and women being abused in the home in domestic settings, and that's my area of speciality, family violence. When I was thinking about the issue last night, and earlier, I realised there are very many comparisons between the topic of today's forum and my work in family violence. There are comparable issues to do with gender, gender dynamics, violation of human rights, power and balance, abuse by those in power and authority. There are also comparable issues and experiences of fear, of trauma, of helplessness, of powerlessness and victimisation.

It's fora like these – the plural of forums is fora – it's fora like these that allow people from all areas to air and address these concerns, to air and address their experiences and share their experiences, to listen to one another and to also look at the broader frameworks and the broader issues and hopefully together help in the process of

healing, of helping women in special settings, with special needs and disabilities, as well as a broader outlook on legal and institutional reforms. And that's what I'm looking forward to in the forum today.

So without further ado I'll introduce our first speaker. Our first speaker is Carolyn Graham. She's the author of a research project called 'Certified Truths' published in 1994 when she was then working at South East CASA. She's currently an evaluator, working as an evaluator for the Western Region Health Centre. So it's Caroline Graham.

Carolyn Graham

Thanks Renata, and so I don't forget at the end, I just want to thank Merinda who has volunteered to do the overheads for me.

Today I would like to talk about Certified Truths, a research study that I undertook in 1994. I will only be talking about part of it, because essentially the first section is about circumstances of sexual assault, whereas the second section is more about safety of women in psychiatric settings and responses from doctors etc.

You may think why the hell am I standing up here given that the research was done 10 years ago. And, yes, in some ways I do feel like a relic. Now I looked up what the word 'relic' means and I was rather upset by it. Some of the definitions are 'a memento', 'a souvenir', 'surviving trace or memorial or a custom, belief of people'. Now, I hope that by the end of this session that it won't continue to be a relic but become part of the movement to go forward.

The main reason why I'm talking about it is that, as I'll talk about later, virtually none of the recommendations that are in Certified Truths have been adopted, acted on or moved forward by the particular people it was identified would be appropriate to pick up those recommendations. Why, in 10 years, have we not had that happen?

Also when I revisited the research on the weekend I was reminded about the consistency of women's stories, the consistency of their interpretations of their experiences, and reminded about how, despite the pain and the trauma that it often causes for them to relive their story, by talking to me, they did it because they wanted to make

sure that in the future some other women didn't have to go through what they had to go through. What I would like to do again, as I've done in the past, is to honour those women and to recognise the respect that I have for them, for participating in this project.

So, on to Certified Truths. I'm just going to give a really brief overview. The research project was for one year and it was funded by the National Women's Health Program and the Stegley Foundation. Thirty-one women undertook in depth interviews and 30 of those interviews were actually analysed. As I said, I'm not going to be going through all the different sections of the report, but I would just like to show you the, the chapters within the book and what the findings are.

And as you can see, some are more pertaining to sexual assault per se, and others are more about violence and also the relationship between doctors' interpretations and women's experiences. One of the perspectives that I would like to look at is two women's stories about what they saw as the connection between sexual assault and mental illness.

The first slide.

> 'When I was in hospital, what was wrong was my memory of my past. These memories I feel actually put me into a psychosis because I was trying to be in non-reality. I didn't want to have any memory of my past and I didn't want to be the here and now because I couldn't cope with the here and now. The medication didn't block out any memories, it just made me more confused.'

And then the second quote there:

> 'It is always the past. Memories of sexual assault coming back to me and it sees me ending up in hospital'.

But then on a more positive note, a woman who had been in an institution for 15 years said;

> 'I'm getting control of my life back. It is linked to having sorted out some of the abuse stuff. This has been a combination of CASA counselling, counselling from a psych nursing hospital and the community psych nurse. I don't think there is any medication that could wipe that out, what I wanted to wipe out.'

Regardless of the setting, women wanted psych workers to listen, believe and understand the trauma associated with sexual assault and to provide somebody to talk to them about it. The following experience of a woman at her first psychiatric admission echoes the sentiments of virtually all women interviewed:

> 'The psychiatrist at the hospital was the first professional I ever disclosed sexual assault to. You always get the feeling that they really don't want to know that part of it. I said, hey this is what it is, the incest side of it that is worrying me, and you are not believing me.'

Throughout the interview she cried as she discussed her experience, stating, 'every time I mentioned it they didn't want to know about it'. As a result she was left with the impression that, 'oh, oh well, she's in here, she's depressed and we'll deal with that'.

Whereas the incest was pushed aside and not looked at:

> 'I would have found it useful for them to talk about and say 'hey, we know this happened to you. We will get you some help to deal with it so that you're able to live with it'. Since 1988 to now I still haven't had help for my incest. Help would just be counselling, someone to talk to about it and someone who understands what you're going through and someone who believes you and listens to what you are saying'.

On the other side there was a positive experience from one of the women that I spoke to and she talked about her disclosure of sexual assault within a community based health clinic:

> 'But this doctor that I have now I hope to stay with because he is really good. He said to me, 'no amount of

> psychotherapy will cure your chemical imbalance, but no amount of lithium will cure the fact you have been sexually assaulted''. So I thought that was really good. It was a way of merging a psychiatrist's model of genetic disease and the fact that I was sexually assaulted. It makes me feel that he sees me as a whole person. Not as something that needs lithium or something that needs psychotherapy, but rather as a human being with the right to be depressed for a start.'

And I must emphasise that was the stories that were coming through with most of the 30 women that were interviewed.

Moving on, the reality is that women are still being sexually assaulted in our psychiatric hospitals in Victoria. It's happened for a long time and it's still continuing and of the 30 women that I interviewed. Seven had been sexually assaulted or harassed while in hospital, of these 5 women had been sexually assaulted by other patients, one had been sexually assaulted by a staff member and one had been harassed. Furthermore, there were 6 women who reported that they observed women being sexually assaulted in hospital. Half of those spoke up and went to the staff and the staff basically told them to just go away. So even back in 1994 we had a problem.

In terms of the lack of safety, as I said, many women reported not feeling safe while a patient in a psychiatric hospital. Their concerns were that few institutional policies or practices to prevent the sexual assault of female patients existed, and that women's complaints of sexual assault mostly fell on deaf ears. Furthermore, they were rarely responded to. It can be seen that mixed wards and lack of choice of the gender of service providers often exacerbates a woman's unsafe feeling or in fact can result in women being sexually assaulted.

The lack of safety and the lack of support to women, and one could argue the lack of response to women who have been sexually assaulted while an inpatient in an psych ward is illustrated by following quote:

> 'I was concerned about a particular man because he was harassing me in the locked ward. I did tell the staff about it but they didn't really take any action. We were both transferred to the same open ward and he sexually

> assaulted and he raped me. The staff said about the harassment that they couldn't do anything about it until something had happened.'

The doctor's response to the sexual assault of this woman is also a concern. That's what it said in the book, but I have added 'outrageous' for today.

> 'I told my treating doctor eventually because I feared I might be pregnant. He did not pursue at all the nature of what happened, who was involved etc. The biggest insult was that he put me on the pill and wrote on my file that I was promiscuous and flirtatious.'

You have to wonder where these people are coming from when they do things like that. The above is supported by the other 6 women who were sexually assaulted by another patient. In none of the cases were the women or the male perpetrator removed from the ward. This only added to women's fear and distress.

Another woman who was sexually assaulted on the first night of her psychiatric admission, reported that when she told her psychiatrist he replied, 'don't worry too much about it, because this sort of thing does happen, we can't help it because we can't hear the screams being these thick walls.' Is that acceptable? I don't think so.

As noted earlier, a number of women witnessed other women being sexually assaulted. One woman described the situation this way:

> 'There was a little girl in my room and every morning the patients would take it in turns with her. I went to the head nurse and I said 'you know what is going on', she said, 'mind your own business'.'

And again, that was repeated over and over again by other women.

As illustrated above, women's feelings about the lack of safety within hospital were exacerbated by what they described as trivialising of both of their expression of fear of sexual assault while in hospital and their report of sexual assault to staff.

Furthermore, they felt powerless when the common reaction of psychiatrists to their wish to talk about feelings of having been sexually assaulting in hospital were more often than not responded to by an increase in medication, and we've already heard women saying that that's not going to help when there's other issues happening.

As one woman said,

> 'Of course it is the responsibility of psychiatric services to provide support to woman who have been sexually assaulted. None of them are interested. It is too hard. I'm sure of that. I wrote a letter to a community based health service about what happened, but there is no complaint process. It is like the chicken being asked to complain to the fox.'

Women shared feeling unsafe or freaked out having male patients in the bed next door in high dependency units. Equally, all but one woman interviewed felt unsafe and/or insecure having men sleeping in the same ward. Issues raised in relation to mixed wards were that particularly in the early stages after admission women felt particularly vulnerable and thus unsafe with men in the same ward, that previous experience of sexual assault most commonly results in women having a heightened distrust of men. Sharing wards with men exacerbates these fears and can trigger memories. Lack of choice in terms of mixed or single sex wards is another indication to women of the lack of understanding by psychiatric service providers of the impact of sexual assault on women and staff members generally and/or the number of staff present on the wards did not protect women from male patients.

With respect to that last point, those of us who have been in hospital know that what the women were talking about to me was so true about the staff so often being in their room, rather – or in the fishbowl, rather than actually being on the ward, being aware of what's happening.

Finally, I would like to just talk about some of the recommendations. The recommendations are listed under headings and I've just done a little summary of each of them.

The first heading is Education and Training under recommendations related to education and training and from the study there was ample evidence that within most psychiatric services there is an ignorance and fear about how to appropriately respond to women who disclose sexual assault. So the recommendations in this area revolved around developing training modules on sexual assault, appropriate responses etc to all sectors of the mental health system, both as pre-training and in service education. And I guess I ask, has this happened as far as I'm aware? No. Somebody here might be able to happily change my mind.

The second group of recommendations were around access to counselling and if a woman is within the mental health system and she discloses sexual assault she should be referred to a professional within the system, trained sexual assault counselling. If there is nobody within the system, then a referral to another specialist organisation such as the Centre Against Sexual Assault should be made. Again, is this happening? And those of you working in the field will know the answer to this – but I suspect that it is still not happening at any sort of acceptable level.

Thirdly, the involvement of women in diagnosis and treatment. Sexual assault is recognised as contributing to the emotional state and behaviours of women who require assistance from psychiatric services and that an appropriate treatment plan is formulated collaboratively with the woman in response to her needs. Counselling regarding a sexual assault will be a significant part of this. Anecdotal evidence suggests that many within psychiatry still maintain a belief that mental illness is only a biologically based disorder that can be stabilised with medication. Hopefully more psychiatrists are embracing a social view of health and can understand and respond to sexual assault by listening and believing women's experiences.

The final group of recommendations relate to safety from sexual assault within psychiatric services. They are policies and procedures, which should be developed to ensure the sexual and physical safety of female patients and prevent sexual assault occurring. These include the provision of choice of women only or mixed wards, all allegations of sexual assault and sexual harassment of a female client by a male client to result in the immediate removal of the offending client from the current ward, that any alleged male perpetrators be

placed in a male only ward, mandatory reporting of sexual assault and health and community service facilities to be replaced by a process that supports over time the woman in making informed choices as to the response she requires, including sexual assault counselling from a trained professional within the services, referral to CASA, reporting the offence to the police or legal representation.

My final comments are that we cannot allow women to continue to be vulnerable to sexual assault while being an inpatient in a psychiatric setting. We must challenge the distortion of women's experience of sexual assault that is so commonly made by the mental health workers, in particular psychiatrists and psych nurses. We must bond together to work towards the achievement of women only wards in psychiatric settings. I believe that we must maintain the rage around this area.

Question from Floor

Carolyn Graham

I think that from what I'm aware of, with these sorts of issues we have to get together. I mean the best thing would be an organisation picking it up as the advocacy issue for the year. But also getting together groups of people – groups of women that are – sorry, individuals who want to change the system and set up a whole process. I mean I don't think it can come through an arbitrary basis of me talking today and someone else talking today and next week someone else talking – there has to be the next step of us actually collaborating to see something move forward. But given I'm not in an organisation at the moment that is related to the issue who would pick that up I don't know. Maybe Isabel's going to say VMIC will!

Question from Floor – Any research re attitudes of mental health clinicians towards assaults?

Carolyn Graham

Back in '92, I think – I mean I know his work, but I'm trying to remember what was within it, but I'm pretty sure Paul Mullin did some work, did some work on that and I've got 3 references from him. It was interesting too, because, as many of you might know, he's

within forensic psychiatry, but he picked this up in New Zealand before he came over here, as an issue and did some research. Other than that, I don't know Isabel.

Renata

Caroline Quatrio in Sydney did a PHD in the field of looking – she's a psychiatrist who did her PHD looking at psychiatrists' attitudes to gender and sexual abuse victims and she was dismissed from University for trouble and so she completed her doctorate in private practice, but in terms of attitudes within the profession, she's the one - most recently the one who's tried to do that in a very – in a way that was difficult but very clear and it is disturbing.

Comment from Floor – Female Only Psychiatric Wards Group – see Website

Carolyn Graham

I just wanted to say that if anybody is interested in a copy of Certified Truths, I rang South East CASA last week and they've still got copies and they are free. Thank you.

Renata

Thank you to Carolyn. The next speaker is Cath Roper, she is a Consumer Academic at the Centre for Psychiatric Nursing Research and Practice.

Cath Roper

I'm going to apologise right up front as I'm going to be a bit disorganised in terms of working out which things to say in 20 minutes and which not. There are some questions I think about often, so I wanted to just put them out there. First, maybe just thinking about

What kind of safety we are imagining when we are hearing the different things that people are talking about?
What kind of unsafety are we talking about and thinking about today as well? It's not academic it's real for some of us here today, based on our actual experiences.

We will be thinking in different ways about these questions. One of the central things that I believe is that the medical model is unsafe. It's not just unsafe for women, it's unsafe for everyone and I think that's because it believes pathogen, not testimony. So that's a major difficulty that has to be understood.

For me, this is about psychic safety, emotional safety, physical safety and sexual safety. I wasn't going to do this, but I am going to do this now, I'm just going to talk about my own experience of being sexually assaulted while being an inpatient. I'm not quite sure how to do this in some ways because part of me is still responding to revisiting Certified Truths, thanks to Carolyn, which I've read a number of times and it speaks so powerfully even now and it's still true, it's still certified truths. So I am going to refer to my own experience, partly because it's a story with closure so it might be nice to do that. (Nice in some way).

The sexual assault that happened to me took place – it was actually from a charge nurse and took place when I was within a High Dependency locked space within a locked admissions unit in the old days of the stand alone hospitals. Who did I tell about this? I told a friend who was visiting me regularly and I also told my family. Subsequently I found out from my family that they had been told by staff that I was too sick to be visited. What happened was that this charge nurse took me into a laundry, because I had been saying for days I needed to have my – it was really awful because if you're in HD for several days and you've only got one pair of underpants, you really do want to go and wash them – or I did, and I'd been asking for days and couldn't get anyone to let me out just so that I could wash my knickers. So finally I was quite relieved when the charge nurse let me out to do that. The assault took place in the laundry where the door was closed and locked. I was not raped though: I need to say that.

So my friend believed me, my parents did not. I understand my friend also tried to speak to staff about that on my behalf. I then made a service plan upon discharge that under no circumstances was I to be brought back to the hospital where this had happened and subsequently, of course, I was sent back there.

While I was at the same hospital on the next admission I saw the same man while I was on a walk with a couple of friends - friends who were inpatients with me at the same time, women. I couldn't control my anger and anxiety, and I told them who he was and what had happened to me. And they were actually great, they really supported me to tell the staff what had happened on the previous admission, to say that I'd seen the guy again, These two women friends were very careful of me and knew how to support me.

And initially nothing happened, and then in the evening a student talked to me and promised that she would make enquiries, which you don't always trust, but then the next day she came back to me and said, 'Look, I've looked through your notes and your file and there does seem to be some oddity there'. And then some time later it was put to me did I want to do anything about this and I had the opportunity for the very first time to talk about what had happened. So it was the very first opportunity. And in the end I did, I did say that I wanted to follow up by making a complaint.

I think it was a few days after I had been discharged from hospital, that two burley cops appeared at my door and started talking asking me questions: was my name Cath Roper, had I made a serious complaint against a staff person from x hospital, did I know how serious that was, and, (I now assume), trying to sort out whether what I was saying had any validity from their point of view. Fortunately I had a family services worker there at the time who told them in no uncertain terms that if they wanted to talk to me they could do it, down at the station, with whomever I chose present at the interview. So an appointment was made to go to the Carlton CIB to give my statement. I went with my mum, who at that point said to me, 'Look, your story has been so consistent for such a long time that I really need to believe you,' so that position changed also. Nothing actually happened as a result of making that statement and because I never heard anything back afterwards, and I wasn't ever contacted about it, I gave up. And I didn't take it up any more.

Now, almost a year ago I was invited to speak at a conference in Sydney about women and trauma and psychiatry and safety and I mentioned how this event had been triggered again, from meeting up with a person during a mental health survey just weeks before the conference, who had worked in the same ward during the same era when the assault took place. I was describing at the conference what

a trigger event feels like and the physical/emotional reliving that takes place. A week after that Sydney conference, we had our work conference at Moonee Valley and I was about to chair a session and I went to get some water at break time before the session was due to start and I was reaching over my colleague to get to the jug of water and then I saw the man who had assaulted me and I froze. This was almost exactly one year ago from today.

And the odd thing is the physical response. I became immobilised, I couldn't breathe, I couldn't speak, I certainly couldn't chair the session. I had to be escorted by the colleague who knew that something was drastically wrong. I was escorted wailing out of the conference area and into a side room where I wept and wept and wept. By that stage I had 3 women colleagues (all psychiatric nurses) in the room with me who just let me do that. And they, of course, being nurses, had got tissues and water and everything - all my physical needs had been attended to beautifully in this moment And I was, I guess, enabled emotionally for the first time to feel what had never been able to be felt. To see this person ***so*** close up in such a strange context – he was a conference registrant to the conference put on by my workplace. And though the period of time when the assault took place was so long ago in terms of linear time, it somehow felt as if the past was suddenly superimposed over the present, immobilising me.

So we were in this little ante room. The rest of the conference was proceeding, and oddly enough, when we came out, who should be sitting on a little seat right away from the conference, by himself, but this same man. So we came out and I realised who it was and my first instinct was to put my head down in shame and hope to God that he didn't see me and walk right past him. And my colleagues were all protectively trying to get their tempo, in terms of how fast to walk, from me. And at the last minute, and I truly was not thinking, I went, 'bugger it, this is my one opportunity that I fantasised about my whole life'. My heart was just going like this (pounding in my ears) and I – I walked directly back to him. He was seated and I was standing, and I looked at him and I said, 'Hi, I remember you from blah blah blah – (name of hospital)'. And he said, 'Oh, good or bad?' And I said, 'Bad, very bad, sexual assault'. And he said, 'Oh, I wouldn't know anything about that'. And I said, 'That's okay, I just want you to know that I know'. And then I sort of walked off, quite

proudly I thought, sort of still - you know how your knees sort of collapse when you're quite – you just can't – (language fails). And there's my 3 colleagues, by beautiful 3 strong women with me, you know, kind of carrying me (symbolically) and we headed straight outside for a fag on the outside grandstand section of the Moonee Valley Racecourse which is where the conference was being held.

I think it's important to mention that for me, that was the kind of closure that I could only ever have fantasised about. And to this day I can't think how the hell I could do it because it doesn't feel like something Cath Roper would do. *She's not like that.* I only managed it only because of the quality of the help my colleagues gave me. If I was ever going to get that opportunity in life, let alone take it up, it couldn't have happened in ***any other way*** than it did. Fate can be a marvellous thing…

There are lots of things that I'm sure you can see: it's the thing of not being believed. Even at a forum that I was at recently, someone talked about their daughter as having experienced a 'delusion' that she had been sexually assaulted. I felt it was very necessary for me to say, look it may not be a delusion, and even if it is, there's obviously something going on. I think it's definitely something that's present in people's minds -this lack of being able to give authority to someone's testimony.

I'm not sure what time I started so – we've got 5 minutes? Okay.

Just very briefly then, what do we know about women's psychiatric diagnoses? As has been already said, underlying problems may not be addressed. Those underlying problems may actually be the *reason* why the woman is coming into contact with psych services in the first instance. So often the diagnosis is treated while those initial issues remain unaddressed.

We know that women are 3 times more likely than men to receive a diagnosis of personality disorder. We know that that's significant because of the vitriol that exists in the system around that diagnosis. We know that the prevalence of a background of sexual or physical abuse in female patients coming into contact with psych services is consistently at least 50% and in some studies, particularly American studies, it is as high as 80%. We know that there's debate

about what post-traumatic stress is and even whether it's really a disorder.

This is a great shame, because my feeling is that understanding trauma, and using this as a framework, could have enormous potential across a spectrum of responses to distress. It doesn't get used very much.

I definitely don't have answers for today, and I really feel like maybe – it may be useful, it may not be, to throw out some broad questions. But I think there is a need, talking about attitudes, I think there really is a need for rethinking about how you approach women. That knowledge that we have about the statistics (1 in every 2 women who present) means that this needs to be in the forefront of every clinician's mind - not the background - the forefront of every clinician's mind. So it does mean not just knowing how to refer out, but how to approach someone, how to let someone come to you. These are the opportunities for a woman to actually start to find ways of dealing with things, so it's the relationships between providers and consumers at that point that really deserve attention and we are by no means there.

Post traumatic stress syndrome was first included in the DSM in 1980.

I guess like a lot of women my bible is **Trauma and Recovery,** a book by Judith Lewis Herman. I'll just read a quote. Where the world has been experienced as very unsafe and unpredictable this is what happens around trauma for anyone. You're in a state of heightened apprehension and things are extremely volatile and dangerous. And the common denominator of psychological trauma is intense fear, a loss of control, and a threat of annihilation. And so here Judith Lewis Herman says:

> *'Psychological trauma is an affliction of the powerless. At the time of trauma the victim is rendered helpless by overwhelming force. When the force is that of nature, we speak of disasters. When the force is that of other human beings, we speak of atrocities. Traumatic events overwhelm the ordinary systems of care that give people a sense of control, connection and meaning.'*

These facts need to be grasped by people who come in contact with women. I just also want to make a link here between service use on top of any history of sexual assault a woman might have or whether she's been sexually assaulted by using services. There are so many forms of treatment that replicate trauma and abuse. And just starting with terror and safety, I don't think we do safety well at all, in say, acute services. Psychic safety – we don't have psychic privacy, we don't have privacy per se. We don't have physical or psychic or emotional privacy – we have to tell our stories to people that are strangers to us. It's very much like our insides are just splattered everywhere for any one to have a look at and basically it's very degrading. So there's that kind of less obvious humiliation that goes on.

But if the need for establishing individual safety were properly understood and regarded as the primary objective, for example in the way that care is delivered as well the physical layout of the building, then I think that could really change the way things are understood and change the way practice occurs – you know, if the central question was, what makes you terrified? I would need to know that as a clinician. If you are terrified, I need to know what I can do to make things less terrifying. And we don't ask those questions in an assessment, we say 'Are you hearing voices?' And terror is the one thing that often people present with. That's my perspective.

I think that terror is a state that is induced by detention and forced treatment as well, on top of any existing pain and terror experienced by a woman. And powerless is often a feature of that experience of treatment in mental health services. So statutory powerlessness is often the status of the psychiatric patient and so one can't help connect with the other. And it's the unspeakable experience of being unable to say no to detention and treatment that replicates trauma. It's fairly obvious when you spell it out. If you can't say no to quite invasive things, even if its oral medications, that's about your mouth, that's a very intimate thing – what do we expect? If it's an injection, that's also a very intimate thing. If it's forced then your whole will is taken away from you. What is that going to do to someone where they have been sexually assaulted? That is a true and absolute replication of loss of will. That is essential to every human being and that's not something you recover from. So we are actually replicating that in psych services as a "health treatment".

That's probably about all that I wanted to say today. I'm happy to stop there if that's okay and take questions or anything. Oh, except to say when I first started as a Consumer Consultant, I remember attending a CASA workshop because I was interested and they had a diagram about how to approach a woman who's had sexual assault in her background and it was something like: immediate needs, so, what do I need right now? And then, 'what's the next step to comfort?' And then 'what resources do I need to achieve that'? What support do I need to be comfortable and then moving out towards self determination and independence: what are the next things that I need? I've always loved that because I think that approach would work anywhere. But then I might be very simplistic. So yes, questions?

Question from Floor - People Diagnosed with Personality Disorder

Cath Roper

Yes, I was hoping that you would take that up, or someone would, because – yes, there's no doubt about that. Actually to just add a further comment, it is quite shocking if you haven't been around – if you are a consumer and you haven't actually been around nurses to hear the way that they speak about people who have been diagnosed with borderline personality disorder. It is really really shocking. And the fact that it's kind of acculturated – people get acculturated to it and they pick up the language. I can't even remember, fortunately, some of the expressions that I've heard students just give me as a brainstorm of the "cruel talk" (as it's been coined by a colleague of mine) as applied to people who've been labelled with a personality disorder - we have discussions about this cruel talk.

Renata

Our next speaker is Fran O'Brien. She's been a lawyer for 23 years, dare I say I've known her for that entire time. She's been a barrister for 17 and a QC or an SC, I'm sorry, since 2002, and she specialises in employment and discrimination law. Thank you.

Fran O'Brien

Thank you everybody. I must say I have been very interested and enlightened this afternoon from both the other speakers and the commentators from the floor - oh and the chair! One always feels good when one thinks one's prejudices are being confirmed. But when there's some objective assessment of those prejudices perhaps they're not prejudices after all.

My perspective of course is from a legal perspective and so you'll have to look at it in that context. There are very few reported cases of discrimination on the grounds of mental illness. We've had both the Disability Discrimination Act (Commonwealth), since 1992. We've had the Victorian Equal Opportunity Act which had a ground for mental illness since 1984. It's really quite astonishing to think that there has been so few cases on this ground. There are even fewer reports of an applicant with a mental illness actually being successful in a discrimination case but within the context of the provision of services to the mentally ill I could find no cases whatsoever. However I do know from my own experiences and this is what I thought perhaps were merely my prejudices, that the provision of psychiatric services to the mentally ill can be extremely discriminatory.

The particular case which, I have personal knowledge of came to me from Barbara Shalit via Howie Maher solicitors. It was a personal injuries case, not a discrimination case. And the gist of the action was an action by a former patient of one of our psychiatric services and the substance was a sexual assault that she had suffered by a nurse in that psychiatric institution. The action was in negligence, and the negligence action arose because the employer, the State of Victoria, was aware that this particular nurse had had previously a number of similar complaints made about him. This particular person, a nurse, had had at least 3 previous complaints of sexual assault of earlier female patients in that same hospital. One of those complainants had in fact committed suicide prior to her complaint being investigated and when our client, Barbara's client, came to us this evidence obviously proved to be fundamental to our case.

Now you might think that the other side might think it was fundamental too. You might also think that they might think that the evidence would be very damaging to their case. During the course of the negotiations to settle the matter it was necessary to persuade them about two things. I think these are two of the things that we've

discussed today. I notice that one of the commentators from the floor described it as pathologising sexual assault. There was a fundamental difficulty in the representatives of the State of Victoria actually accepting that what my client was saying was true. As far as they were concerned, she had a mental illness so she must be making it up. That was the first thing. Secondly, and this is the interesting part, in the alternative, because of the evidence of the previous incidences, they were prepared to accept it may have happened but were not prepared to accept it wasn't consensual. Now my client was an involuntary patient as I kept saying and ultimately we did settle, but they were the two critical responses from the State of Victoria to this action in damages. She probably made it up because she's mentally ill and if she didn't well she probably consented.

Now these two notions seem to be elements that have passed through discussions today in a more sophisticated way than I could ever do. It raises issues for me that as I say confirmed my prejudices but perhaps truly what is going on in our hospitals today. And that really leads me to the question of can our discrimination Acts or our personal injuries provisions for that matter, be a means by which we might be able to bring some public exposure to the way it appears female patients are treated in our psychiatric system, or more specifically in the context of this campaign as I understand it.

But the central issue now is, how can we protect our female patients, that is, how do we move the policy debate and the practical implementation of women only wards in the Mental Health system? Now from the point of view of the lawyers, this would not be easy. There are difficult substantive and procedural issues on any view, however I don't think it's impossible. Both the Human Rights Equal Opportunity Commission Act which is the procedural provisions for the bringing of a complaint under Commonwealth Discrimination Acts and the Equal Opportunity Act have what I think are properly described as representative provisions. They do allow joint complaints to be made. But it is my view, and there are some constraints on how that is done unlike the bringing of an individual action, however it is my view that by sensitive and capable legal support it is possible to bring a successful action by an individual complainant where there may have been or currently is a mental illness and I have certainly done that myself, not just in personal injuries matters, but in the Discrimination Tribunal.

There have been actions by mentally ill persons and I have been involved in them with wonderfully competent, sensitive and intelligent solicitors. However, there are substantive issues in how to approach such an action, so if we wanted to raise the question of the failure of the hospital services to provide women only wards in our Mental Health system, we might need to look at the question of whether we would approach that on an indirect discrimination or a direct discrimination basis. And it's my view that probably the best way to approach it would be on the basis that the requirement that a mentally ill female or a mentally ill woman be required to share a mixed ward is a requirement that she cannot meet, because of the potential ramifications to her mental health and that it is a requirement that is unreasonable in all circumstances. And they're the essential tests. I mean there some other technical elements to the test, but I'm not going to bore you with those, but they're the essential elements that have to be got over.

The direct discrimination approach is not helpful and that's essentially because of the way the High Court has recently approached the question in *Purvis*. I do not think it would be possible to establish that the placing of men and women in mixed wards would be something that we could say was unfavourable and not something that would happen to men and women in hospitals without a mental illness. So I don't think that's the way to proceed. However, I think with careful examination of where the law stands at the moment it has got real potential. This of course would require our consumer advocates, our gorilla nurses and I put that in the context of the nurses who are prepared to stick their necks out and perhaps supply some information to our Mental Health Services so we could track down some complainants, who are prepared to provide us with some complainants who we could get together and support to bring an action of this nature. The discrimination system, our Discrimination Acts and our Discrimination Tribunal provides a wonderful means of public exposure and it also in the remedies that are available, particularly under the Equal Opportunity Act Victoria it has a wide capacity to provide real policy remedies that might go to some way to addressing some of these issues. They're not the kinds of remedies or public exposure that you would get the personal injuries system in the Common Law personal injuries system. And the public exposure of course as I'm sure you all know, is one of the reasons why there's virtually no sexual harassment cases in the system anymore, because they're always settled no matter what on a

confidential basis because of the ramifications publicly are so horrendous.

So they're just my thoughts and in summary, I think it's proper to say that, and having heard from the floor some comments about how our nurses are managing their professional lives and our psychiatric services and how our psychiatrists are, I think perhaps something does need to be done.

But I want to say something else about just a couple of comments about the provision of services. I work in employment law and we have erected a vast structure of means to ensuring safe and harassment free workplaces. I'm not saying it's a perfect structure, I'm not saying the workplace is perfect, I'm just saying we have erected a very substantial legal structure where individuals, unions, groups, employers, can effect very substantial change in the way their workplaces operate in the cause of ensuring the workplace is safe and harassment free. Why can't we provide exactly the same in places where services are provided? Why shouldn't we have a Health and S