

Productivity Commission Inquiry

***The Social and Economic Benefits of
Improving Mental Health***

Public Submission

from

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Contents

Part I: Overview

- Productivity Commission Inquiry
- Personal Objectives
- Practical Cost-Effective Suggestions
- Methodology
- Changing Behaviour and Culture: The Power of Storytelling and Leadership
- Public vs Private Submission
- Sources and Verification

Part II: A Personal Case Study

- The Lived Experience: A Personal Journey of Comorbid Physical and Mental Health Challenges

(A) Physical Health Challenges

- (i) Intestinal Deformity and Disease
- (ii) Perforation, Intestinal Haemorrhage, Septic Shock and Organ Failure
- (iii) Intestinal Disease Prognosis
- (iv) Chronic Kidney Disease
- (v) Metabolic Bone Disease

(B) Mental Health Challenges

- (i) Depression and Generalised Anxiety
- (ii) Suicidal Ideation

- (iii) Obsessive Compulsive Disorder (OCD)
- (iv) Eating Disorder – Anorexia
- (v) Borderline Personality Disorder (BPD)

(C) Comorbid Physical and Mental Health Crisis: A Case Study of Workplace Aggravation

(D) The Mental Health System: Personal Experiences

- (i) Hospital Inpatient
- (ii) Mental Health Practitioners
- (iii) Rehabilitation Experience: Mental Treatment Programs
- (iv) Rehabilitation Experience: Workers Compensation Schemes
- (v) Rehabilitation Experience: Cost Barriers

Part III: Recommendations / Possible Improvements

(A) Prevention and Early Intervention

- (i) Mandatory ‘Interactive’ Mental Health Strategies
- (ii) Responsible Utilisation of Performance Management Systems
- (iii) ‘Incentivising’ Good Mental Health through Performance Management Systems
- (iv) Full Disclosure Statements of Duties and Responsibilities
- (v) ‘Invested’ Organisational Management and Leadership
- (vi) Responsible Human Resource Management: Sustainable Accountability
- (vii) Executive Remuneration and Mental Health
- (viii) Management Training and Recruitment: Emotional Intelligence and Output Maximisation

- (ix) Mental Health Referrals: Proactive Medical Practitioners
- (x) Mutual Obligation and Personal Responsibility

(B) Treatment and Rehabilitation

- (i) Accessing Cost Effective Therapies: A Possible Mental Health Contributions Scheme (MHCS)
- (ii) Accessing Mental Health Services: Refining the Public Messaging
- (iii) Accessing Sustainable Therapy: GP Proactivity
- (iv) Improving Therapy Effectiveness: Client Input and Consultation
- (v) Rehabilitation and Recovery: Non-Discriminatory Workplace Schemes

Part IV: Conclusion

PART I: Overview

The terms ‘crisis’ and ‘tragedy’ are seemingly used with increasing frequency and varying degrees of sensationalism in the public discourse these days with respect to various social and public policy issues, almost to the point where the gravity and import of their meaning – and the issues themselves – are being devalued.

Yet when it comes to the seemingly poor mental health of significant segments of the Australian population, with a suicide taking place roughly every 3 hours of every day - and with thousands more every year trying, but failing, to attain the permanent release from torment that only death can seemingly deliver - it is not an exaggeration or in any way sensationalist to claim that Australia has a mental health crisis and that with every single case there resides a genuine human tragedy – often of profound proportions and of unimaginable suffering.

That it is also possible for such a wealthy nation with a fundamentally decent and caring population to record multiple child suicides in just a few short weeks - and to then allow the issue to fade with little serious discussion and follow-up – is not only reflective of a genuine crisis but represents a grave national failing in every respect.

Yet despite these appalling realities, it is highly likely that the potential mental health challenges facing the broader community dwarf existing challenges.

The irrefutable reality is that the Australian people – who are amongst the most highly personally indebted in the world - are extremely vulnerable to major structural economic changes and external shocks that no Government can hope to prevent.

While every generation seems to face its own unique set of economic and social challenges, the changes that are currently occurring in the world of work, personal relationships, family dynamics and individual freedoms have the potential to accelerate and aggravate social and psychological distress. This is perhaps most starkly evident in the changing nature of the labour market as thousands of jobs and current skill sets are eliminated to be replaced by robotics and artificial intelligence possessing hitherto unprecedented capabilities.

In such a climate, it is imperative that the policy framework and operational factors relating to the effectiveness and efficiency of the Australian mental health system are reviewed, refined and reinforced on an ongoing basis to minimise the sheer waste and human misery of mental ill health.

Despite the significant public policy attention and expenditure mental health has received in recent years, the sad reality is that we are still seemingly unable to devise effective whole of Government and adequately resourced policy responses that cater to the needs of the vulnerable and the unwell – as whole individuals - supported by practical measures within our workplaces, families and schools - to make significant and lasting headway on what ought not be an intractable problem.

Although a good case can be made that in 2019 we are far more understanding as a community of the insidious and prevalent nature of mental illness than we were 20 years ago, it is pure folly to think that the everyday stigma and discrimination experienced by those

trying to manage a mental illness is somehow less of a barrier to rehabilitation and recovery today than it ever was.

Productivity Commission Inquiry

Despite the large number of recent reviews and inquiries relating to mental illness and issues of relevance to the Australian mental health system – including a current Royal Commission in Victoria – this inquiry by the Productivity Commission is timely as it has the potential to make an important contribution by seeking to address issues from a ‘participation and contribution perspective’ while striving to compliment the work of other recent inquiries.

This is especially important because it is through ‘participation and contribution’ – be it in the world of work, local communities, families and other social networks – that we are able to derive a sense of purpose, meaning and true value as human beings and it is what gives us the chance of realising some of our potential.

It is also through meaningful ‘participation and contribution’ that we can hope to break down the barriers of discrimination, stigma and the inherent dehumanisation that is experienced routinely by those living with or trying to recover from mental illness.

While the Productivity Commission can be relied on to undertake a thorough analysis and to produce a report with useful recommendations, the real challenge will be for Australian Government’s – at all levels – to take the findings seriously and to follow through, including through the Council of Australian Government’s (COAG) where relevant.

The Productivity Commission has produced many high quality and insightful reports into diverse economic and social issues over the years – only to have their work ignored.

It is to be hoped that this Inquiry will not go the same way.

Personal Objectives

As someone who has long lived with, and continues to live with, a complex array of physical and mental health challenges which commenced at birth and intensified significantly over the years and proved almost fatal on multiple occasions, I see merit in making a very personal submission which seeks to shed light on some of the many issues of relevance to the Inquiry – as well as demonstrating why some of the existing approaches and public messaging do not work – or cannot hope to work in various scenarios.

I am also someone who has experienced high level and relentless public and private ridicule, mockery, character assassination, invalidation and devaluation as a human being over a long period, including by high profile public figures and am very aware of the stigma and inherent discrimination that one confronts when seeking to reengage - thereby seriously compounding the mental health challenges as well as compromising the prospects for effective rehabilitation.

In light of my experiences, I am also keen to provide some insights, albeit from a sample of one, on why those struggling with mental illness over many years not only go to great lengths

to hide their torment - but are highly unlikely to ever seek treatment until it is either too late or only when their hand is forced – often at very significant cost.

As I believe strongly that employers – large and small, public and private – hold the key to facilitating early intervention and providing the overall environment for effective treatment, rehabilitation and recovery – I am especially keen to explore some important issues relating to mental illness in the workplace whilst also identifying some possible practical solutions that could help in reducing the incidence, severity and overall costs of mental illness to the material benefit of all.

I am also seeking to draw from my extensive experiences with the Australian health system – both physical and mental – to make some suggestions for more effective treatment. There is a very important overlap between physical and mental health treatment which from my experience, is deficient and needs attention.

Having now spent a decade in the mental health system - including a 6 month stint as an inpatient in a mental health facility and as a consumer of numerous mental treatment programmes and as a ‘client’ of 18 different mental health practitioners of varying quality and integrity - I believe that my experiences allow me to offer some insights which may be useful to the work of the Inquiry.

I also believe that my varied experiences have relevance for Government, especially in the context of rehabilitation and recovery involving workers compensation schemes as well as in the regulation and funding of selected mental health services, particularly with respect to being able to access competent and responsive clinical psychologists over a long-term basis and in the affordability of proven therapies for recognised mental disorders.

Practical Cost-Effective Suggestions

This Inquiry will almost certainly receive a large number of well researched and argued submissions from various experts and interest groups setting out compelling reasons as to why the Commonwealth needs to make significant additional injections of public funding to the mental health system.

It is to be hoped that the Commission and the Australian Government will consider any such proposals fully and in good faith.

As a sole contributor drawing primarily from my lived experiences, my objective is to identify relatively practical and cost-effective options designed to improve the effectiveness of the Australian mental health system, including in the critical area of prevention and early intervention, which need not involve any significant injection of new funds.

At a time when the pressures on the public purse are increasing and will continue to increase through demographics alone even in the absence of poor policy choices, it is important that we explore ways in which tangible improvements to national mental health can be made without necessarily adding significantly to overall budgetary costs.

Methodology

My submission to this Inquiry draws heavily from my personal experience – i.e. my lived experience.

The Inquiry will undoubtedly receive expert input from various sources that is supported by extensive empirical research and sound analysis.

As important as that is in the consideration of inherently complex issues of public and social policy, I believe that it can still be valuable for policy makers to be exposed to the ‘lived experience’ of real people - something which may well be foreign to key decision makers, especially on issues relating to mental health.

In drawing on my experiences, I have opted to provide as much detail as possible, including on matters that are deeply personal and painful.

I believe this is necessary in my case for the following reasons:

- (i) As I have been subjected to significant and persistent character assassination and ridicule, much of it in public and much of it motivated by powerful and privileged individuals with a self-serving agenda, I feel that I need to be far more explicit about my long-term issues than I otherwise would be if my views are to be considered equally and fairly along with those of other contributors.
- (ii) Related to point (i) above, a number of my former superiors have wilfully invalidated and completely dismissed the serious mental health challenges I have faced – many of which go back at least to my early teenage years.

One of my former senior supervisors for example, testified to the AAT that my mental health challenges are, at best, only a recent phenomenon and were non-existent prior to 2009. This is not only very hurtful because it demonstrates a callous disregard and ignorance of my experiences, but it highlights the challenges that exist in workplaces if managers, who generally have zero medical or psychological training, are arrogantly prepared to completely dismiss the expert views of mental health professionals to support an agenda or their own narrative.

Therefore, in light of the extensive invalidation I have encountered, I feel I have little practical choice but to divulge far more personal detail than I otherwise would do so as to have my views considered equally with those of others.

- (iii) Drawing from points (i) and (ii) above, if we are to have any real prospect of improving understanding and breaking down the barriers to facilitate a ‘participation and contribution’ framework – I believe there is a need for people to tell their stories – in as much detail as possible.
- (iv) I stated above that one of my objectives in this Submission is to shed light on why those suffering from a mental illness are highly reluctant to own up to it and seek

help. I believe that rather than talking in generalities, I am best able to shed light on this critical issue by going into significant detail about my experiences. This is especially relevant in my case given the complex interplay of my physical and mental health conditions.

Changing Behaviour and Culture: The Power of Story Telling and Leadership

I believe very strongly that if we are to make any significant and lasting improvement to the mental health challenges we face, many of which evolve or are exacerbated through our experiences at work, it is imperative that there be strong, committed and determined leadership in every workplace – public or private, large and small – that involves visible and genuine ‘buy in’ from those at the very top.

Simply talking the talk and parroting the latest management or virtue signalling fads will not cut it when it comes to encouraging troubled employees to address their issues and seek help.

Attaining an organisational culture whereby employees feel genuinely valued and sufficiently ‘safe’ to reach out, needs strong leaders who are prepared to make a personal and professional commitment to the wellbeing of their staff. This requires managers and leaders to put ‘skin in the game’.

I believe that one of the most effective ways this can be done is for leaders to demonstrate courage and conviction and to be willing to ‘share’ their own personal ‘stories’ – particularly with respect to the fears, loss, mental struggles and failings they have endured - and how as a consequence they are understanding and appreciative of deep personal suffering.

As a community, we are fortunate that we have some strong, courageous and high-profile Australians who are willing and able to advocate on mental health issues – with the likes of the Hon Jeff Kennett, the Hon Julia Gillard, Professor Allan Fels and Ms Jennifer Westacott the most prominent.

However, it is going that extra step and opening yourself up that is the hardest thing to do – but potentially the most rewarding for those you lead.

The current CEO of Beyond Blue, Ms Georgie Harman, is one such leader who has demonstrated the courage to openly discuss some of the challenges she has faced – all of which I expect help equip her perfectly for her role.

The Hon Andrew Robb was also very strong in discussing the mental health challenges he faced – many of which seemingly went back to his schoolboy days. The fact that he was able to become a highly effective Trade Minister – *after* he made his revelations - is a positive reflection not just on him, but on all of us.

Although his situation is different, the senior NSW public servant Michael Coutts-Trotter is one of the very few public service leaders who has had the strength and courage to openly discuss the challenges and demons he faced as a younger man and how he overcame them.

This type of leadership not only builds and reinforces trust but generates deep loyalty and a sense of belonging – all of which I believe is critical to minimising the costs of mental illness and supporting a ‘participation and contribution’ framework.

But we need to be brutally honest and look at *ourselves* if we are to find the answer as to why there are so few leaders who are prepared to actually lead on these issues.

How would colleagues, the media and other stakeholders react – not to mention the destructive open sewer that is most social media - if the CEO of a major company or public service department opened up about his or her mental health issues – even if it could be demonstrated that the issues are very manageable and the prognosis positive?

Until we get to the situation where we can be confident that any such person will get a fair go and not be torn down, we will struggle to make significant and lasting improvement.

Public vs Private Submission

While I understand it is possible for contributors to make private or confidential submissions, I think it is important in the context of a public Inquiry that material be provided openly so as to allow the Commission to maximise its potential usefulness while also allowing members of the public and overall taxpayers to hopefully derive some benefit from it.

Sources and Verification

All of the disclosures I make in this submission can be verified from my extensive medical and mental health records as well from witness statements submitted by various individuals to tribunals such as the AAT.

Many of the events I set out in my submission involved witnesses as either participants or observers, almost all of whom are still living.

I am willing to make available all of my medical and mental health records to the Commission as well as to provide it with copies of relevant witness statements, particularly on those matters relating to my experiences in the Department of Prime Minister and Cabinet in the critical period from August 2006 to mid-2008 under the Howard and Rudd Government's, if deemed necessary and explicitly requested by the Chair of the Inquiry.

References to Selected Individuals

In order to comply with the Productivity Commission's submission guidelines and directives, it has been necessary for me to publicly suppress the identities and formal positions of various individuals, particularly those relating to current or former Commonwealth officials whose conduct or actions had an unintended detrimental mental and physical impact on me, particularly while I served in the Department of Prime Minister and Cabinet under the Howard Government.

PART II: A Personal Case Study

The Lived Experience: A Personal Journey of Comorbid Physical and Mental Health Challenges

It seems quite well accepted in the medical and mental health sector that a correlation exists between poor physical health and poor mental health with one leading to or aggravating the other.

As someone with no medical or mental health qualifications, I can only make observations from my own lived experience – as well as drawing on basic common sense and logical reasoning.

In my case, the correlation between poor physical health and poor mental health is a critical life-long reality. At times it has been hard to isolate the causal dynamic between the physical and the mental, but in order to understand the mental health challenges I have faced and continue to face, it is necessary to understand the physical handicaps I have lived with since birth.

(A) Physical Health Challenges

(i) Intestinal Deformity and Disease

I have struggled with a relatively large number of physical and mental health challenges for my entire life having been born with a severe deformity of my large and small bowel which included a malrotation of both my colon and small intestine and long segment Hirschsprung's disease.

At age 10 days I started demonstrating symptoms of a colonic mid gut volvulus – which is quite typical for the 1 in 6,000 children born with a malrotation of the gut in Australia. However, my volvulus was apparently slow to progress and was only diagnosed correctly at age 5 weeks.

After some treatment at the then Fairfield Infectious Diseases Hospital in Melbourne - (which closed in the mid 1990's) – I was transferred to the Royal Children's Hospital for emergency surgery at age 5 weeks by which time I was very ill.

The administration of my Last Rites was apparently offered but rejected by my parents as I had not yet been baptised and because my Father thought it futile.

Although the midgut volvulus was corrected using the standard Ladd procedure, which amongst other interventions also involves an appendectomy, the irreversible impacts of Hirschsprung's and the inevitable post-surgery development of extensive adhesions, resulted

in serious problems with intestinal motility as well as a vulnerability to further obstructions through adolescence and adulthood, especially from my late 20's.

Hirschsprung's disease is a rare motor disorder that essentially means that the nerves lining the bowel wall which receive signals from the brain to facilitate motility or movement – are either poorly developed, inadequate in number or practically absent.

In 80 per cent of cases only a relatively small segment of colon is affected – which is known as small segment Hirschsprung's – and can be surgically improved by resecting that part of the colon. However, this becomes more problematic in the 20 per cent of cases with long segment Hirschsprung's where much, if not all, of the colon is affected.

My condition was further complicated because the motility disorder also affected – and continues to effect - my entire small intestine necessitating the consumption of very high daily dosages of medication to facilitate basic motility. The unfortunate paradox is that the heavy consumption of stimulants for prolonged periods has the effect of further compromising natural motility necessitating even stronger dosages of stimulants and the almost inevitable damage to the intestinal lining.

Although I struggled with very poor motility throughout my childhood, the disability didn't really bother me as my situation seemed 'normal'.

Critically, I also demonstrated no compromised capacity for nutritional absorption, particularly as my high fat food diet resulted in me being very overweight if not obese from around the age of 4 until age 15.

My overall motility issues deteriorated significantly from my early 20's so that by my late 20's, I needed strong stimulants to have at least one movement a week.

By my early 30's I was consuming very high daily dosages of stimulants – under medical supervision – which at the time involved 20 Dulcolax tablets late at night; a full box of 24 chocolate Senna Laxettes throughout the day; a Nulax bar at breakfast and at lunch and from March 2001, 2 satchels of the bowel cleanser Pico Prep in the early evening.

Pico Prep is a powerful drug containing sodium picosulfate and magnesium oxide usually taken in preparation for a colonoscopy or bowel surgery.

The combination of these stimulants worked effectively for only a few months before it became necessary to continue increasing the dosages – particularly of the Dulcolax and the Laxettes – to have the same effect.

This regime also became very expensive costing me roughly \$700 per month. In order to minimise my costs, I reached an arrangement some time later with the gastroenterologist I had in Canberra who supplied me with Pico Prep in bulk at wholesale prices.

In May 2002, I became very concerned following a significant bleeding episode. I underwent a colonoscopy that revealed significant abnormalities in the structure of my colon and staining associated with the heavy use of stimulants.

I was encouraged to try alternative approaches – including Epsom salts and fibre based bulk fillers – which only served to create very uncomfortable bloating, severe distension and zero movement.

In the circumstances, it was agreed that I should continue with the Pico Prep and the Dulcolax at the higher dose of 30 tablets per day – but cutting out the Senna based Laxettes and the Nulax.

This was ‘effective’ on some days and not others – for no obvious reason. When things became too uncomfortable, I would still consume the Laxettes.

By early 2003, it was very clear that my situation was deteriorating and that it was untenable for someone in their mid-30’s to continue to consume such high dosages of stimulants – and which didn’t always work.

My gastroenterologist referred me to a Canberra bowel surgeon who was very experienced and had an excellent ‘bedside’ manner. I liked and trusted him immediately and felt safe with him.

Following further colonoscopies and a Colonic Transit Study in June 2003, I was strongly advised to have a total colectomy.

A Colonic Transit Study is a 5-day test whereby they give you some radioactive tracer in milk on day 1 of the test - (radiopharmaceutical) - that is then tracked at the same time each day by a gamma camera to assess colonic motility.

Having stopped all stimulants for the test, by day five I was very uncomfortable and knew that the results would be at the extreme end of the distribution curve as I had zero movement.

The results revealed practically non-existent motility with the tracer still in my colon after 5 days – with any movement perhaps reflecting only the forces of gravity.

In light of these results and my history, my surgeon felt it prudent to have a total colectomy to minimise the likelihood of a serious obstruction while also hoping to improve overall intestinal motility by removing what was clearly a non-functioning colon.

At the time, the extent of my motility disorders within the small intestine were not known although it was known that I had a malrotation.

It was hoped that by removing my colon I would be able to significantly reduce, if not eliminate, the need for stimulants.

I agreed to the surgery on the strict condition that I would not end up with a colostomy bag. My surgeon expressed confidence that a total colectomy could be performed without me needing a colostomy bag, but he could not be sure until he operated.

As I was scheduled to commence a new role within the Department of Prime Minister and Cabinet on the very morning my surgeon advised I needed a total colectomy – Tuesday 10 June 2003 – I wanted to delay the surgery for as long as possible.

I was strongly advised not to delay for more than three months and so I proceeded to have an open total colectomy in early September 2003.

Although my surgeon succeeded in allowing me to avoid a colostomy bag, the surgery was at best only partially successful – through no fault of my surgeon.

A significant proportion of the 4-hour surgery was spent cutting through adhesions that had formed from my childhood surgery.

My recovery was slow and uncomfortable.

What was supposed to be a 10-day hospital admission dragged out to more than 3 weeks with no effective motility post-surgery and no capacity to consume solids or fluids.

I received nutrition by way of Total Parenteral Nutrition (TPN) intraveneously through a PICC in my neck. TPN – which looks like milk - is an effective way of administering critical nutrition when the patient is effectively nil by mouth over a prolonged period.

It became apparent within 3 weeks of discharge that I still needed stimulants, albeit at lower dosages. So, from this perspective, the surgery failed.

Throughout 2004 I was able to work intensely within the Department of Prime Minister and Cabinet with a routine 80-hour week on a limited diet – but which still required 2 satchels of Pico Prep daily and around 20 Dulcolax tablets at night.

Serious complications set in from March 2005, some 18 months after surgery.

It is thought that the complications followed the onset of new fibrous adhesions in my abdominal cavity following my September 2003 surgery, the continued deterioration of my intestinal motility as well the small bowel gradually assuming the functionality of the colon – which is not uncommon in those instances where a colon has been removed.

In early March 2005, I developed the first of 9 small bowel obstructions to date - (with my most recent episode taking place in March 2018) - and what is known as Chronic Intestinal Pseudo Obstruction (CIPO) disease.

CIPO is a rare disease that involves the development of a pseudo obstruction of the small intestine as distinct from a mechanical obstruction. It also occurs rarely in the colon – Ogilvie syndrome – but this is irrelevant for someone who has had a total colectomy.

The symptoms and the clinical presentation in a pseudo obstruction are very similar as with a mechanical obstruction – but with a pseudo obstruction surgery can be avoided if the obstruction is able to resolve after about 3 or 4 days or before intestinal ischemia sets in.

Small bowel obstructions are very painful, involve uncomfortable and highly intrusive medical interventions and represent a potentially serious threat to life.

They are also a serious mental health challenge – especially given the unpredictability and frequency of an attack and when repeat major episodes result in life-long impacts and trauma.

My first pseudo small bowel obstruction involved a very uncomfortable 10-day hospital admission in Canberra and raised many concerns for me, particularly as I was aware that removing a significant proportion of the small bowel was not practical.

My episode in March 2005 was quickly followed by a second obstruction in June 2005, a third in March 2006, a fourth in November 2006, a fifth in November 2007, a sixth in December 2007, a seventh in February 2009, an eighth in December 2017 and a ninth in March 2018.

Symptoms and Clinical Presentation

The typical experience of a pseudo small bowel obstruction involves the seemingly random onset of a slight pain in the abdomen and a noticeable pulling sensation.

This can happen at any time of day or night with no obvious triggers or prior symptoms.

The initial onset of pain, its severity and speed of progression is partly influenced by where in the small intestine the obstruction has occurred.

The lower in the intestine an obstruction occurs, the less severe the initial pain and the longer it takes for the vomiting of bile to occur.

Of my nine obstructions to date, seven have been low in the abdomen. My most severe obstruction in late 2006 which almost proved fatal, commenced very low in the abdomen with the initial pain and pulling sensations occurring almost within the groin region.

Within roughly an hour of the onset of a low intestinal obstruction, the pain will have intensified significantly with cramping being felt in waves with the timing between waves becoming increasingly shorter.

It is imperative that all consumption of food and drink cease as the additional pressures could present serious dangers.

A low intestinal obstruction results in immediate and severe constipation with zero capacity for any movement.

It is possible to actually have a movement with a higher intestinal obstruction. This usually involves the emptying of that part of the small bowel below the point of obstruction. It will be the final movement until the obstruction is resolved.

A movement associated with a high-level obstruction can be potentially dangerous if such an action serves to encourage unjustified complacency and an under estimation of the serious threats an obstruction presents and a consequent delay in seeking emergency treatment.

After about 2 hours of a low intestinal obstruction, the cramping pain is severe and constant.

The abdomen by now is usually severely distended and very hard. Dehydration has almost certainly set in and will rapidly intensify.

At this point, only the vomiting of bile can deliver temporary respite in the absence of high dosage opiates – preferably morphine.

However, the lower in the intestine an obstruction occurs – the longer it usually takes to orally expel bile – which normally presents as a dark green fluid with black specks.

My usual routine is to wait until I orally expel bile before seeking treatment as I believe it is only at this point that I can be certain that the obstruction will not resolve itself and that I can justify Emergency Department assistance.

However, I do not recommend this approach to others, particularly as the risk of severe dehydration increases rapidly after the first 2 hours of an obstruction.

Once present at a hospital Emergency Department, the usual routine is for catheters to be inserted and IV saline administered along with morphine for pain relief. As morphine makes me very nauseous, a complimentary drug is administered with the morphine to counteract the nausea.

Blood pressure is normally very low and catheters hard to insert due to the difficulty of locating suitable veins.

CT and MRI scans using contrast are undertaken which will always show a severely distended segment or segments of small bowel confirming an obstruction – much like the presentation for a mechanical obstruction.

Once a mechanical obstruction is ruled out, the primary treatment is to stabilise the patient and try to facilitate resolution by providing complete gut rest involving depressurisation and nil consumption of any food or fluids.

Broad spectrum antibiotics are also usually administered intraveneously to reduce the possibility of severe infection such as sepsis and septic shock.

With the exception of the physical pain of the obstruction, which by now multiple dosages of opiate have hopefully alleviated, the most uncomfortable and dreaded intervention is the insertion of a gastro nasal tube – or nasogastric intubation.

Nasogastric intubation involves the insertion of a plastic tube – similar in appearance to the plastic tubes used in fish tank filters – through the nose, the throat and into the stomach.

This is done while fully conscious.

The patient is given a small amount of water to drink while the tube is being inserted – the idea being that the contractions in the throat will help pull the tube into the stomach.

From my experience, most ED nursing staff and doctors lack the skills necessary to efficiently undertake NG intubation.

Every attempt that I experienced in Canberra resulted in nose bleeds and significant distress.

The usual protocol appears to be that any one nurse or doctor can only make two attempts at NG intubation before handing to someone else.

Once the intubation has been undertaken, chest x-rays are made to ensure that the tube has been inserted correctly and has not damaged the lungs.

A plastic bag is then attached to that part of the tube exiting the nose.

Almost immediately, green/black bile is extracted from the stomach and out through the nose into the bag.

This is a critical intervention as it allows depressurisation, pain relief and provides the basis for complete gut rest.

The tube will remain in place until it needs to be changed or the obstruction has resolved. From my experience, the shortest time I had a NG tube was three days, while the longest was about 3 weeks.

Once all of the interventions and drugs have been administered, you have to wait – hoping that the complete gut rest allows for resolution.

If there has been no resolution or significant improvement after about three days, or if ischemia has commenced, surgery is necessary to prevent loss of bowel.

There is significant anxiety and psychological distress with every obstruction – especially as you wait hoping for a resolution without permanent loss of bowel, perforation, infection and the organ failure that can follow.

As much of the bacteria residing in the gut is highly toxic, if it enters the bloodstream it is absolutely critical that any infection is identified quickly and accurately to minimise the possibility of death or permanent organ damage.

(ii) Perforation, Intestinal Haemorrhage, Septic Shock and Organ Failure

Late on the evening of Saturday 11 November 2006, I developed what was then my 4th small bowel obstruction in under 2 years.

What started out as a ‘routine’ obstruction very low in my intestine, became a pivotal episode that not only very nearly killed me, but which seriously destabilised me psychologically particularly given the multiple stressors that I was dealing with at the time and in the months and years that followed.

As I address the mental health dimension in the next section, I will limit my comments here to the physical aspects of the experience.

Although the obstruction that started late on the evening of 11 November 2006 involved rapid onset of severe abdominal pain and cramping, vomiting did not occur until more than 15 hours after the onset of the obstruction.

Although conscious and responsive in the ambulance as I made my way to the Canberra Hospital, I was severely dehydrated, in severe pain and very weak.

The pressures on the intestine were so severe that I perforated the small bowel and developed a major intestinal haemorrhage that bled for five days necessitating multiple blood transfusions.

After about day 2, I developed gram negative septicaemia, septic shock, acute kidney failure, pulmonary oedema, a heart murmur, severe general oedema that involved more than 14 kilograms of weight gain in 5 days and an infected bladder.

Sepsis is a terrible condition that affects you in so many different ways. Of all of the impacts, what sticks with me most is my complete lack of strength and inability to walk – even after the first two weeks – and that most of the skin on my torso, hands and feet literally peeled off in large pieces and much of my hair fell out.

Although I survived despite family being advised that I was unlikely to do so, I suffered permanent kidney damage and psychological trauma, particularly with respect to the longer-term prognosis which emphasised a sense of futility, hopelessness and inevitability.

The episode involved an almost four-week stay in hospital, including in the ICU and multiple complex interventions along with haemodialysis.

Sepsis and septic shock are terrible illnesses that

(iii) Intestinal Disorder: Prognosis

Having consulted various physicians which include some of the most senior gastroenterologists and bowel surgeons in Melbourne as well as in the ACT, my prognosis with respect to my intestinal disorder is at best guarded and not at all optimistic.

The expectation is that I will continue to develop small bowel obstructions of varying severity. When and how often they develop is unknown and beyond my control.

With each obstruction, there is the risk of further perforation, haemorrhage, sepsis and organ failure leading to death.

It has been made very clear to me that surgery will only be undertaken in my case if it became a matter of life and death in part because of the inevitable post-operative complications I would experience through compromised nutritional absorptive capacity and the onset of further adhesions.

There is also no cure for my very poor intestinal motility with the expectation that to the extent I retain any natural motility, it will continue to diminish.

All current available drugs – including Resotrans – have been trialled with no positive effect.

At present, I am consuming 60 Dulcolax tablets a night – under medical supervision – with the occasional need to increase the dosage to 80 pills in a 24-hour period.

This equates to at least 420 pills a week and a little under 22,000 a year.

I have discussed the dangers and logical unsustainability of such a high dosage of stimulants with a top-level gastroenterologist working from the Epworth and Royal Melbourne Hospitals who I trust absolutely – and the general view is that I should continue with what works for the time being and not to think too far ahead.

This has been, and very much remains, a significant mental health challenge for me as a source of anxiety and depression.

(iv) Chronic Kidney Disease

In the weeks leading up to my episode of acute renal failure in late 2006, blood tests revealed that my renal function was already down to about 70 per cent.

Although it has never been determined as to why this was occurring, it is possible that my long-term heavy use of Pico Prep was having an adverse impact as were the effects of my various intestinal issues, poor diet and the long term struggles I had been having with an eating disorder.

My episode of acute renal failure was severe in that I had zero renal function with the kidney's shutting down completely.

My creatinine levels exceeded 700 milligrams. A normal creatinine level for a healthy male is between 60 to 120 milligrams. Creatinine is a waste product in the blood that is normally cleared by the kidneys.

Although my acute renal failure resolved after a period of haemodialysis and recovery from sepsis, a renal biopsy in March 2007 confirmed some permanent renal damage at around 20 per cent lost capacity.

Depending on the formula used – my renal function has fluctuated between the moderate to mild Chronic Kidney Disease (CKD) at Stage 2 and 3 over the past decade.

It has been made clear to me that I will be at high risk of serious permanent impairment with a further episode of acute renal failure.

(v) **Metabolic Bone Disease**

In mid-2008, my then Canberra nephrologist commissioned some tests which confirmed the existence of metabolic bone disease, including rather severe osteoporosis.

I was told that this was not unexpected given my prolonged intestinal issues and the consequent impact on diet and nutrition as well as the serious eating disorder I had long struggled with.

I was told that without significant intervention, it was likely that I would sustain rib fractures at any time and fractures of the lower back and hips within 10-15 years with serious consequences for my mobility and quality of life. I was 41 at the time.

I was strongly advised to commence a course of intravenous pamidronate infusions.

Pamidronate is a powerful drug that is often administered with chemotherapy to treat bone damage caused by multiple myeloma and in the treatment of diseases causing weak bones such as Paget's disease.

The possible side effects are not insignificant with one of the most serious being osteonecrosis of the jaw – which essentially means that the jaw bones die through loss of blood supply, then fracture and in some cases, break through the face.

Although such risks are rare – they were pointed out to me and I was instructed to undertake all necessary dental work before the commencement of treatment.

The other major side effects are whole of body skeletal pain, severe headache and nausea.

I commenced what was supposed to be a 12-round programme of pamidronate infusions in mid-2008 with an infusion every 4 or 5 months.

The first infusion resulted in severe skeletal pain and breathing difficulties that resolved within 48 hours. The second and third infusions in late 2008 and mid 2009 resulted in localised infections and severe swelling of the arm.

In light of the side effects and the discomfort – I terminated the treatment after the third infusion.

I have had multiple rib fractures and a fracture to my sternum since 2010. My most recent rib fracture occurred in mid-2018 following prolonged coughing associated with a simple cold. Such fractures are painful but can only be resolved on their own over time.

Recent bone density tests in early 2019 reveal significant progression of my osteoporosis to the high fracture risk category particularly in my spine and hip.

I have been referred to an endocrinologist to consider possible treatment options which I expect will include the administration of bisphosphonates in some form over a prolonged period.

(B) **Mental Health Challenges**

In Part I of this submission I set out some of my reasons why I am willing to openly disclose and discuss some deeply personal matters.

Despite the strength, validity and honourable intent of my rationale – I remain apprehensive because I expect that my honesty will be used against me – be it through labelling, entrenched discrimination and character assassination on the one hand – and cruel mockery, vilification and caricature on the other.

In our modern world of social media - where it is so *easy* to hurt someone through trolling, bullying and vile defamatory distortions - seemingly with impunity – it is very risky for anyone with a history of mental health issues to be genuinely transparent and honest.

Yet as bad as the vermin lurking on every social media platform are – what's worse from my experience are those people who extend their hand in faux friendship with insincere promises of help and support - seemingly content to play you along treating you with contempt.

The motivations are inevitably varied and complex – but often it is fear and ignorance that fuels discrimination and loathing.

There can certainly be some risk in embracing those who have lost their way, who are struggling and who may not be as valuable to you today as they once were – but every person is of value and everyone deserves a chance – perhaps even a few chances.

I also believe strongly that every human being is vulnerable and has a breaking point.

While some are much more resilient than others – every single person can be broken in the ‘right’ circumstances - so no-one has permanent immunity from mental breakdown and mental illness.

Diagnosed Mental Health Conditions

Over the past decade, I have been formally diagnosed with a number of mental health conditions, some of which I had long been aware of and attempted to manage secretly on my own over many years, while others came as a surprise, at least initially, in part because I had never heard of them or understood them.

Specifically, I have formally been diagnosed with various depressive conditions including clinical or major depression, suicidal ideation, dysphoria, post- traumatic stress disorder (PTSD), generalised anxiety and various anxiety related disorders including obsessive compulsive disorder (OCD), an eating disorder (anorexia) as well as the complex, but treatable, condition known as borderline personality disorder (BPD).

All of these conditions are inter-related and seem to feed off each other in ways that at times I seriously struggle to understand – which is perhaps not surprising given that I trained in the social sciences not in medicine, psychiatry or psychology.

Although I cannot deny that at times the burden just seems too heavy – particularly when my physical challenges surface and my reservoir of resilience has been exhausted – I make the following key points:

- Despite the complexity and debilitating nature of my conditions – the mental health experts are adamant that they are all treatable and manageable but require time, discipline and a commitment to long term therapy;
- I have applied myself completely to the painful and testing task of rehabilitation over almost a decade by working with relevant mental health experts in multiple settings – despite some upsetting and unsettling personal experiences with the mental health system; and
- Rehabilitation and recovery – or at least productive stabilisation – cannot be achieved on my own and requires a partnership involving productive engagement with a supportive employer. This is consistent with the Commission's 'participation and contribution' framework and underlies the critical role employers have in facilitating improved mental health outcomes in the world of work and the broader community.

Consistent with the underlying philosophy and purpose with this Submission, below I set out some of my experiences with respect to a number of my diagnosed conditions noting that it is personally challenging to do so.

(i) Depression and Generalised Anxiety

I have struggled with depression, depressive tendencies, dysphoria and anxiety of varying intensity – for as long as I can remember – certainly from very early childhood.

From the age of 14 and at various times in adulthood, multiple stressors and a convergence of events have resulted in bouts of clinical or major depression which have represented a threat to my life.

A number of my most serious episodes of clinical depression were triggered - or at least were demonstrably aggravated - by events in the workplace – some of which were undoubtedly compounded by my own weaknesses and inadequacies, while others reflected the mistreatment and mismanagement of my superiors through no fault of my own.

Having said that, my objective here is not to cast blame on any individual as that is unhelpful, unproductive and possibly unfair – but it must be acknowledged that poor outcomes are rarely the product of a single individual, even if the single individual ends up carrying a disproportionate share of the burden.

My first serious breakdown in the workplace took place on 25 February 1998 having just turned 31.

I was a Unit Manager in the Australian Treasury within what was then the International Economy Division. I was responsible for the Unit that managed our relations with the International Monetary Fund, the World Bank, the Asian Development Bank and other international financial institutions, the annual aid program, our bilateral financial relations with PNG which at the time included some significant loans and various pacific island countries.

The trigger for my breakdown in February 1998 was sheer exhaustion having worked 16 and 17 hour days with no respite – including Christmas Day 1997 and New Year's Day 1998 - since the previous August when the Asian Financial Crisis commenced.

Despite being a junior Unit Manager – I had no Branch Head from August 1997 as the occupant had taken up a role in Washington and his former role had been left vacant for a long time.

The load was simply too much and there was no end in sight. Something had to give – and it was me.

I was loathe to complain, in part because I knew how hard my most senior superiors were working and the issues were of genuine national importance.

I also felt a very strong sense of loyalty to two of my superiors – my then Division Head (Neil Hyden) and the then Secretary to the Treasury, Ted Evans. These were both no nonsense men who were very determined and set high standards.

I absolutely adored Ted Evans and would do anything for him. This in part reflects other

issues which are too complex to unpack here but go back to my childhood and my futile search for paternal mentoring and nourishment.

As I set out below, the BPD I have been diagnosed and treated for is at the more emotional end of the spectrum which can result in fierce loyalty irrespective of personal cost and a willingness to push yourself to the absolute limits to please the person you care about or are afraid of being cut off from.

On 25 February 1998, I told Ted Evans that I wanted to resign as I could take no more and that he was better off getting someone else.

He asked that I take some time off but that he valued me and wanted me to stay.

I took a few days off during which my work load was reduced – what I had carried in one section for almost a year was now spread across three sections - and a Branch Head was allocated.

I was medicated by my local GP for depression who advised I seek professional mental health treatment. I didn't take up his advice.

I moved to another role in Treasury about three months later with a much more 'normal' work load and the crisis passed.

But my underlying structural vulnerabilities remained as they had not been thoroughly identified or treated.

As my physical health started to noticeable decline shortly after this event, I became increasingly susceptible to major depressive episodes.

I had further episodes of varying intensity in August 1999, May 2002, June 2003, March 2005, August 2006, November 2006, March 2007, May 2008, January-February 2009, April 2009, June-December 2009 and for significant periods despite intensive treatment in 2010 to 2018 with some deep episodes in September 2015, April-May 2016, December 2017 and July 2018.

Other than the February 1998 event that involved consultations with my then GP, all of my episodes prior to June 2009 were officially undiagnosed and untreated.

Of all of these episodes, the most pivotal were those commencing from late August 2006 following some highly distressing events while I worked as a Branch Head in the Department of Prime Minister and Cabinet under the Howard Government - (this is explained further in Section C of this submission).

This was the point where many of my underlying anxiety and personality disorders in combination with my physical deterioration and workplace issues - converged to put me on a path that almost proved fatal in November 2006 and again in the second half of 2009 - and

has remained a significant threat since despite my efforts at rehabilitation and recovery.

I detail some of these events below as they provide a real life case study of the potentially fatal combination of mental and physical illness with workplace triggers – and the challenges that exist in having employees heed the public messaging to reach out and get help.

A key benefit of treatment and therapy is that it becomes easier to understand and accept why certain things happen. Greater self-awareness and acceptance are very important in maximising the impact of treatment and in the attainment of lasting rehabilitation.

I have had to confront some difficult issues from my childhood and adolescence which have cast a dark psychological shadow over me for many years and although they may never be completely resolved, a better understanding and acceptance allows for forgiveness and some inner peace.

My depressive tendencies and anxiety disorders are directly related to my childhood experiences.

My siblings and I – an older sister and a younger brother - were born to Maltese parents who migrated to work in the factories of Melbourne’s western suburbs in the mid 1950’s when they were still very young. My father – who was completely illiterate – was only 21 when he arrived. He would never again visit Malta or see his parents and most of his siblings. This was his choice.

My mother was also 21 when she made the voyage to Melbourne some two years after my father.

They married by proxy shortly before my mother left Malta with my paternal grandfather representing my father who was in Melbourne.

Although they would remain married for 60 years until my father’s death in June 2018, they had a turbulent and unhappy marriage that was often physically violent necessitating frequent police intervention during my youth with much emotional abuse.

There were many reasons for this, including the fact that both had experienced significant trauma and near starvation as young children during the Second World War with the intense bombing of Malta by the Luftwaffe and Italian forces in 1940-42 which also involved the frequent sinking of supply convoys to the small island nation as the Allies fought desperately to hold what was a critical post in the Mediterranean theatre of the war.

But the more significant issue for my parents was that they were not especially compatible, with my mother being very family orientated who wanted children and everything that went with it – with my father not wanting any children seemingly content with the very basics of life.

The fact that my father ended up with three children that he didn’t plan for and didn’t want,

was a significant factor behind his unhappiness and frequent violent outbursts as was the perpetual pestering from my mother to provide.

I am also certain that my father was deeply frustrated by his illiteracy and the constraints this imposed particularly as he was a highly intelligent man who was very creative and had a gift for learning by seeing. But his lack of education resulted in him working in menial jobs and for people who were often of lesser ability to him.

In later life, I would often tell him that he was actually very fortunate because it was possible for him to come to a new country as a healthy young man and despite his handicaps, there was plenty of work, housing was very affordable and the opportunities immense. It was a golden period that will never come again.

Although my father didn't drink – at least not until his 60's – he was a very heavy smoker and had a volcanic temper. He was also physically strong in his prime years.

He had few friends and didn't enjoy socialising.

His volatility, temper and unpredictability were a constant cause of anxiety for my siblings and me.

Home was anything but secure and stable – and certainly not happy.

He was also emotionally absent and never showed affection.

I do not recall my father ever hugging or embracing me. I seriously struggled to physically touch him – even as he lay dying on his death bed in the Footscray Hospital in June 2018.

As a family, we never went on a single vacation or outing other than occasionally visiting the home of my paternal uncle who lived around 6 kilometres from where we lived – trips which often resulted in my parents embarrassingly fighting - with my father impulsively driving off on his own leaving my uncle to drive my mother, brother, sister and I home.

My parents would argue and abuse each other verbally at least weekly until my late teens. Physical confrontation of varying intensity would take place monthly in my most formative years and less frequently in my later teenage years.

The most brutal physical confrontations involved actual assault with my father hitting my mother and the literal destruction of entire rooms and furniture.

On one occasion, in a complete rage my father literally ripped the kitchen cupboards off the wall and smashed every piece of crockery he could find - and while holding a dining chair from its back, smashed everything in his path.

As a child I saw my father straddling my mother on the kitchen floor with his hands firmly around her throat. She was gasping for air with her feet both kicking upwards inwardly inverted.

No child should have to process something like that – and no child forgets it.

All I could do was scream as I ran out the front door onto Millers Road in Altona North in Melbourne’s western suburbs where we lived.

Millers Road in the late 1970’s and early 1980’s was a busy road as it remains. We would flag down a passing motorist to fetch the police – who at the time seemed to have a rather hands-off approach when dealing with domestic violence. Other than having a quiet chat with my father – the police never did anything.

As bad as the physical blow-ups were, the emotional torment was in many respects harder, because it could come at any moment with seemingly innocuous triggers. Although my siblings and I became skilled in guarding our comments, mindful that a perfectly innocent or jovial remark could be misinterpreted and provoke a violent outburst – it was not always possible to do so.

To give one example, we were having dinner one Saturday night in the mid 1980’s. I was in a good mood because my AFL club the Western Bulldogs - (who in those days played as Footscray in the Victorian Football League) – had scored a dramatic win against Collingwood in the dying moments at the Western Oval (now the Whitten Oval) - when our then full forward, Simon Beasley, intercepted a misdirected pass from the Collingwood back man - Graeme Allan - to goal and win the game.

Although I was in good spirits, my father clearly wasn’t.

While I was excitedly recounting the dramatic final moments of the game to my brother, my father – for no apparent reason – said that it was his intention to kill us all eventually and bury us in the backyard.

In an instant, what had been a rare pleasing afternoon with the promise of an enjoyable evening watching the VFL replay – was ruined as we just sat there in silence not knowing if he was just trying to upset us, or if he had definite plans.

There were many such episodes throughout my entire childhood and adolescence, all of which leave their mark irrespective of the passing of time and how hard you try to rationalise the behaviour.

As upsetting as the fighting – and inevitability of fighting was – what deeply rattled me as a child and seriously impaired my relationship with my father and my emotional development – was the brutal realisation that he never wanted me.

The first time I became aware of this was during an argument that my parents were having when I was about 11. Although much bile would routinely emerge in their exchanges, on this occasion my mother referred to the pressure my father placed on her to terminate her pregnancy when she was carrying me.

Apparently, my father was not overly pleased when my mother told him she was expecting a second child and he demanded she terminate.

Safe abortions on demand were almost non-existent in Melbourne in the late 1960's, although I understand securing the services of a 'backyard butcher' was relatively easy.

While my mother refused to go along that path, she claims that to appease my father she would exert herself by repeatedly lifting an old singer sewing machine she owned in a vain attempt to induce a miscarriage.

Whether or not this actually happened – I simply do not know – but this is what was said and it put me in a difficult place.

As my parents routinely played emotional ping pong with my siblings and I during their fights – whereby they would ask in anger which parent us children most liked – I couldn't discount the possibility – even at the tender age of 11, that what my mother had told me about the attempt to terminate wasn't true.

However, in late 1978 shortly before my 12th birthday, my father demonstrated from his own actions that what my mother had claimed was most probably true.

On Tuesday 28 November 1978, I injured a testicle as I attempted to dismount from an oversized bike.

Although the pain was bearable initially, it intensified significantly over the next three days to the point where I could not move and was in significant distress.

My father refused to take me to the local medical clinic so my mother arranged a home visit from a GP who failed to diagnose the torsion I had suffered and the seriousness of my condition.

On the morning of Friday 1 December 1978 – which I recall was a stunning sunny day for the start of summer – I was in so much pain that I was pleading with my mother to take me to hospital.

My father was unemployed at the time and in bed.

He refused my mother's request to drive us to the Royal Children's Hospital which was only about 20 kilometres from where we lived.

As my mother didn't drive – and she was very frugal – she decided that rather than calling a taxi, we would first catch the bus from our home in Altona North to Footscray and then get a taxi to the RCH in Parkville. This was her way of saving on a full taxi fare.

Although the bus stop was only about 100 meters from where we lived – that walk seemed

like 10 kilometres. The pain was so intense that I couldn't walk as such – but straddle like an overweight duck.

The public busses in those days did not cater for those with disabilities. There were three steep steps that you had to climb to get on board. I couldn't do it – I just couldn't bear the pain. The driver got out of his seat and yanked me up.

I finally got to see a doctor about three hours after arriving at the Royal Children's.

The doctor inspected me and quickly called in a colleague who also inspected my injury and the immense discomfort I was displaying each time they touched me.

They told my mother that I needed emergency surgery and was at risk of losing a testicle.

Whether it was the protocol of the day I do not know, but they wanted my father to come to the hospital to authorise the surgery.

A short time later, a nurse told my mother that she had telephoned and spoken to my father and explained the situation. He told the nurse that he was on his way. My spirits lifted.

Approximately two hours later when it became clear that my father was not coming – the surgeons could wait no longer and they operated.

As I was significantly overweight at the time, I believe I was given too heavy a dose of anaesthetic and recall being slapped about the face by the medical staff long after I was supposed to wake up.

The surgery was successful but I hallucinated badly that night convinced that the boy opposite me in my hospital ward was my brother and so I repeatedly called out to him to the boy's amusement and that of the nursing staff which only made me feel more inadequate.

My father didn't turn up – not before the surgery or at any time after.

When I was discharged, an orderly put me in a wheelchair and pushed me out to the taxi rank where I slid onto the back seat of a taxi with my mother for the drive home.

When I arrived home around noon, my father was sitting at the kitchen table smoking. He completely ignored me and didn't once ask how I felt.

This certainly upset me but paradoxically, I wasn't angry at him – I blamed myself and somehow felt that I had let him down.

Later that afternoon, I sat in bed talking to my older sister and my mother. My sister was with my father when the nurse from the RCH had called him explaining the emergency I faced and the importance of him getting to the hospital.

What my sister said rattled me then and continued to affect me for many years later – perhaps it still does.

My sister said that when my father had finished speaking to the nurse, he swore and said that I had been nothing but a burden for him and that he hoped that this time I would not survive.

This was a reference to the life-saving surgery I had to correct a volvulus in my colon a few weeks after birth.

With that, my father went to bed before getting up very late to watch TV.

Meanwhile, I waited for him to come – and dealt with the aftereffects of surgery before eventually having to get a taxi ride home.

Although there were many other episodes, that one cut deep because my father had a clear choice and his actions spoke for themselves.

It is not really surprising from these experiences that as a child and as an adolescent, not only did I fear my father and fail to connect with him – but I developed a number of survival behaviours that caused problems in adulthood.

Paradoxically, these included a deep distrust on the one hand – despite a craving for paternal mentoring on the other – as well as a fierce determination to keep things to myself, despite wanting – and needing – emotional embrace.

Being very unhappy at home and constantly on edge had implications for school which became an additional source of anxiety and depression particularly from Year 9 in 1981 when I transferred from the local high school – which at the time was known as Altona North High School – and went to the local Catholic boy’s school - St Paul’s College also in Altona North - (these days St Paul’s is known as the Altona North Campus of a much bigger school called Emmanuel College which is located in the rapidly growing suburb of Point Cook in Melbourne’s south west).

When I was at the school, St Paul’s College was run by an American religious order called the Marianists – as distinct from the more commonly known Marists. St Paul’s College at the time largely catered to the sons of poorly educated first generation European migrants, who like my parents worked in the factories and industrial sites of Melbourne’s western suburbs.

The sisters of the boys that went to St Paul’s were usually sent to Mount St. Joseph’s Girl’s College in Altona which was located about 8 kilometres away.

Many of the children that went to these modest Catholic schools carried the heavy expectations of their parents – and many, like me, didn’t want to let them down.

Despite his illiteracy, my father appreciated the importance of a formal education and often impressed upon my brother and I – albeit in very crude language – why it was important to finish school.

I regard this as my father's greatest gift noting that it was still common in the early to mid-1980's for children to leave school in Year 10 or Year 11 and that Year 12 completion rates were not much higher than 30 percent.

The early to mid-1980's was also a time of significant economic and global political turbulence with very high levels of unemployment and inflation, especially following the 1981-82 recession.

The Cold War – which for many migrants from Europe had a personal edge - was a constant and the seemingly never ending threat of nuclear war played on young minds.

Youth unemployment was well above 20 per cent and those who left school after Year 10 or 11 faced prolonged unemployment with very poor prospects.

My father was often unemployed and it was common for him to be off work for 12 months at a time.

This put major strains on the family which relied on my mother who was working a full-time afternoon shift at the local dog food factory – ‘Luv’ - in West Footscray. The factory these days houses the ‘Pampas’ facility.

While my mother's job was critical and kept us afloat – it created further tensions between my parents as my proud father was in effect economically dependent on my mother.

I therefore arrived at St Paul's with heavy emotional baggage and with the weight of expectations.

I was also significantly overweight at the time and lacked self-confidence and the social graces. I was never one of the boy's and would always be amongst the last 2 or 3 picked for sporting teams in PE classes.

It was a little ironic because I had a genuine love of Aussie Rules football and followed the Footscray Bulldogs passionately and I loved cricket and watched it religiously in the summer.

Although I applied myself intensely – I had inefficient study skills and found homework stressful and draining.

I had no-one outside of school to guide me – the concept of an external tutor was completely foreign and I didn't have an older sibling who could help me with school issues.

Although my sister was four years older than me – she left school at Year 10 and went to secretarial college. She ended up a very good PA with a fast typing rate and could do short-hand. But she couldn't help me.

At the end of my first year at St Paul's, one of the very few boy's that I got to know and like – Peter Blackett – was killed in an accident a few days before Christmas.

Peter was everything I wasn't – tall, handsome, very athletic – a good footballer and cricketer – with natural leadership ability. He was an all-round good kid.

About two weeks before his death, the teachers organised an end of year cricket match and Peter was appointed Captain of one of the teams.

For some reason not only did he pick me to join his side – and well before many better players - but he also asked me to bowl some early overs.

Although slow medium pace at best, I was a much better bowler than most of the boy's expected because I would concentrate on line and length. I tried to model my bowling action on that of Greg Chappell. Although Chappell was primarily a top order batsman of genuine class – he was also a handy slow to medium pace bowler who was deceptively hard to play because he concentrated on a good line and length.

That afternoon in late December 1981, I was bowling to a very cocky boy who was a little older than me, very strong and a genuinely good player. He thought he could pick me off at will. As I was bowling full and very straight, he couldn't play his shots and became frustrated.

On the third or fourth ball of my very first over – he lashed out and skyed the ball gifting Peter a simple catch in gully.

I was ecstatic – as was Peter. It was a great moment.

Two weeks later he was dead.

Exactly 12 months later – to the day – another boy I got close to throughout Years 9 and 10 at St Paul's, Melvin Cassar – was horribly incinerated along with his father in a gruesome accident in Mason Street, Newport which was only a short distance from my home.

Melvin and his dad were driving home having just completed some shopping in the final few days before Christmas.

Like me, Melvin was the child of Maltese migrants and although cheeky at times who would clown around and get into some mischief, he was a good boy who was anxious to please his parents.

These deaths deeply upset me – they still do.

On the night of Melvin's death, I said a prayer for him and for Peter – and have been doing so ever since on the anniversary of their death.

It's the only time I pray.

Although I generally got on well with my teachers and I respected them, I only grew close to one – Brother Bernard Hartman.

Hartman taught me in Years 10, 11 and 12.

Brother Hartman was from Pittsburgh in the United States which is where the Marianists are based.

He was friendly and seemed to care about me. He was openly warm and liked to embrace – which was novel for me.

I trusted him and although he was much older than me, I looked up to him and viewed him more as an older brother rather than as a teacher per se.

He was officially my ‘mentor’, careers counsellor and home room co-ordinator, as well as my subject teacher for biology in Years 10 and 11 and biblical studies in Year 12.

At times he did make me uncomfortable by giving me what I call a ‘reverse bear hug’ – where he would come up from behind me and place his arms around my chest with his chest and chin leaning against my back with his groin leaning against my rear.

I didn’t like it and felt trapped by the action as I couldn’t see him coming and adjust my position – but I never complained and probably wouldn’t even today.

Many years later, I was deeply upset to learn that Brother Hartman – my trusted mentor – was at the time an active paedophile with an interest in both boys and girls, some my age while others younger.

He was extradited from the United States in 2013, tried and convicted of historical child sex offences. He served a term of imprisonment in Victoria before being released and deported in 2017.

These and many other experiences conspired to produce a highly anxious, insecure and persistently unhappy adolescent and young man who by early adulthood was not only vulnerable, but lacking the skills to manage many of the psychological conditions which had already been established.

During university and then as a public servant, I was always insecure and anxious believing I wasn’t quite as good or worthy as my peers.

My time at the University of Melbourne in the second half of the 1980’s was profoundly lonely and I felt completely alien, particularly as the overwhelming majority of the students I was with were the children of the affluent who went to some of the best private schools in the state.

I felt different than them – because I was different.

Although I became very self-reliant and fiercely determined to prove myself – this was ultimately unhelpful as it served to fuel anger, resentment and further alienation.

I pushed myself and worked exceedingly hard not because of some deep passion or altruistic agenda – but because of fear and chronic insecurity.

Ultimately, it was a fear of failure – and of rejection and abandonment.

In effect, I used my very painful experiences as a fuel – as a ‘propellant’ to keep pushing myself forward.

This was effective up to a point – but the brutal reality is that it is exceedingly exhausting – and corrosive - to keep pushing yourself on anger and fear.

It is a recipe for a miserable existence of perpetual sadness and premature death.

The only thing that gave me sustenance and a sense of personal worth – was my work – particularly when I reached the position of Branch Head in the Department of Prime Minister and Cabinet from mid-2003 and realised that I had the confidence and respect of the then serving Prime Minister and his staff.

This was quite an achievement given my life long struggles and the cess pit of misery from where I had come.

But it was short lived as my physical health failed – further compounding my psychological vulnerabilities – and I encountered the viciousness and callousness of cruel office politics which again delivered the rejection I had strived my entire life to avert.

(ii) Suicidal Ideation

I have struggled with suicidal thoughts and ruminations since my early teenage years. I am not in any way ashamed of that and most certainly don’t see it as a sign of weakness.

Paradoxically, there have been many times when I have derived strength and resilience by knowing that suicide is an option.

Do I recommend this? Most certainly not.

When there is a choice between life and death – the best option must always be life.

But I think as a society we are too reactive and overly judgemental when it comes to discussing the complex and painful issues surrounding suicide.

I do not want to say very much in the context of a public submission, mindful that vulnerable individuals may selectively and inaccurately make unhelpful inferences.

However, I will briefly share two episodes – one from my youth, while the other from the last 12 months.

I have only made one clumsy and very naive attempt to end my life.

It took place in August of 1981 when I was 14 and struggling in Year 9 at St Paul's College.

I took two of my mother's Serepax (oxazepam) pills and 4 Panadol with a glass of milk late on a Friday night thinking that the combination would send me to sleep forever.

To my surprise – but not my disappointment – I got up late the next morning with minimal side effects.

Despite my clumsy and ineffective attempt – the episode was pivotal as it actually gave me strength because I proved to myself that I had the inner resolve to pull the metaphorical trigger if need be.

This has acted as a psychological drag in later life as some of my ruminations and suffering intensified significantly. It takes great discipline and an inner resolve to believe that there is a shining sun beyond the fog and clouds.

So why did I pull the trigger as a 14 year old schoolboy?

On the evening of Tuesday 18 August 1981, my mother was at home recovering from surgery to remove some very ugly varicose veins from her legs.

I was studying for a Social Studies test in my room for the next day when my mother – wearing a pale blue nylon dressing gown – limped out to the garage with a mug of tea for my father.

It was around 8.30pm. I had a clear line of vision from the window in my room to the garage at the back.

I still don't know what set my father off – but after what only seemed a minute – he started shouting and cursing my mother and threw the mug at her.

I could see her struggling to run from the garage with one heavily bandaged leg – back to the house – with my father following her seemingly possessed.

My mother was very distressed, crying and covered in hot tea. She and my sister ran out the front door and onto Millers Road. They flagged a passing motorist who went to the local Altona North Police Station to get help.

In the interim, my father in a wild rage set about literally smashing the kitchen – and the only

TV we had. He made an almighty mess.

I was trapped in my room but made a dash to my sister's bedroom which was at the front of the house – running over broken glass along the way.

My brother came with me.

About 5 minutes later, the police turned up and knocked on the front door. I opened and the officer flashed his torch in my face. I said nothing and just stepped aside.

The officers just asked my father what the problem was and whether he was OK. He said he was.

I remember one of the officers asking about the very large goldfish I kept in a tank near the kitchen.

My mother, crying, told the officers she felt in danger and wanted him removed. They simply put the onus on my father to behave.

They also asked my mother if she and the kids had anywhere else to go for the night. She said no because we had nowhere else to go.

The police left and shortly afterwards my father went to bed – leaving my mother, siblings and I to clean up the mess.

The next day, I didn't go to school and I didn't sit the social studies test.

When I did go to school on the Thursday (20 August) – my social studies teacher – a short, red headed American fellow who didn't think much of my abilities – asked why I missed the test and whether I had a note to explain my absence.

I told him that I had been ill and that I didn't have a note.

He failed me and gave me a detention on the spot whereby I had to sit the test after school with my grade still being recorded as an 'F'.

I had never failed a test or a subject before and felt humiliated.

There was absolutely no way that I would tell him why I missed the test – and he probably wouldn't have believed me anyway.

I was very upset and felt completely caged. My situation seemed futile. This is how some teenagers think.

Time also seems to go much slower when you are a child – so thinking one or two years ahead is completely alien – at least it was to me.

That night and during the Friday at school – the last day of Term 2 - I devised my plan to exit.

I wasn't at all afraid and not once did I hesitate.

I was sure I had found the way out.

I kept this experience to myself over many years and subsequently thought about it often, particularly in periods of very high stress.

However, I have always been mindful of the significant 'externalities' that would inevitably materialise from any decision to exit, even if that seems to 'unfairly trap' you in a world of perpetual suffering to protect others.

My father died on 28 June 2018 and was buried at the Altona Memorial Park on 4 July 2018.

It fell to me to organise the funeral and to handle the relevant logistics.

I visit his grave often to keep it tidy and to reflect.

About 10 meters from my father's grave is a grave of a 14 year old boy named Gavin.

Gavin died on 14 June 2018 – exactly two weeks before my father.

The photograph at his gravesite is of a very handsome bespectacled boy with a delightful smile and a love of sport – especially the Geelong Football Club.

Approximately 3 weeks after we buried my father, I was at his gravesite removing large clumps of soil and debris that the grave diggers left behind. (The graves in the cemetery are dug into reclaimed landfill and have been elevated above the water table using soil and building rubble, some of which is brought to the surface when a new grave is dug).

As I quietly cleaned up my father's gravesite, I noticed a woman roughly my age literally laying on top of Gavin's grave – trying to sing – in between sobs.

She was obviously grieving intensely.

I went over to her slowly and despite the awkward moment – I asked if she needed help.

It was Gavin's mother.

She looked up at me with a swollen face and said that she visits the grave every day and sings Gavin's favourite songs - convinced that her boy can hear her in his coffin below.

What happened to Gavin? A terrible accident or terminal illness perhaps?

No.

Suicide.

He took his own life and his mother remains at a complete loss to explain why.

I said nothing – there are no words that can provide any real comfort in such circumstances.

I just left her alone - lying in the dirt on his grave. A mother and her son.

The brutal truth is that Gavin is gone and he is never coming back.

If there is a better place – he had better have found it.

But his mother – still a relatively young woman – and all of his siblings – will have to carry the pain of his departure in their hearts for the rest of their mortal lives.

It is critical, however, that we must never judge.

It would be grossly hypocritical to do so – especially as we are all vulnerable and there is just so much that we don't know or understand.

But we can reflect and cherish the joyful memories – even if they are very few in number - while we can and strive not to take anything or anyone for granted.

I routinely visit Gavin's grave when I tend to my father's plot.

I recently left him a Geelong Football Club flag to commemorate the start of the new season and the hope that normally holds for every supporter.

It is the first new season that Gavin has missed.

(iii) Obsessive Compulsive Disorder (OCD)

Of all of the mental health challenges I have faced over the years, my obsessive-compulsive disorder (OCD) and OCD tendencies – have been by far the most frustrating and often the most exhausting.

OCD is an anxiety disorder that ensnares you in a cruel web whereby you feel compelled to undertake one or more strict routines and rituals that can become very exhausting – but which only provide a mirage of temporary relief that never address the real cause of the problem.

What is incredibly frustrating with OCD, is that the absurdity and outward irrationality of the rituals and routines you feel compelled to follow – are often very apparent to you, but you

still feel completely helpless to stop them.

In my case, OCD was never a constraint on my work performance – other than perhaps contributing to my utter exhaustion at times.

In some respects, my OCD tendencies, especially a rigid perfectionism, helped in the maintenance of quality control as I was very vigilant in proof reading briefing papers and other documents which meant that what I sent out to my Ministerial and departmental clients was almost always error free.

The other paradox in my case was that the anxieties that fuelled my OCD rituals - resolved or seemingly evaporated as soon as I physically left my home and went to work.

Physically being at work provided an antidote for my OCD issues.

However, there was an undeniable direct correlation between my overall levels of work stress and the intensity of my OCD issues.

The more stressed and threatened I felt at work – the more intense and laborious the OCD rituals at home became.

Although I cannot pin point the definitive cause or starting point for my OCD and OCD tendencies, I suspect that there are genetic forces at work in addition to the impacts of socialisation on childhood emotional development.

My father had definite OCD tendencies and was a perfectionist. He would become very frustrated – and angry - when something he was working on or creating wasn't 'right'. He was also a hoarder of junk who felt compelled to keep things and store them with warehouse precision – for no obvious purpose.

My earliest recollection of my OCD tendencies was in the latter stages of primary school.

I would get home from school always anxious about what I would find once I opened the door.

As my mother worked afternoon shift and my father was frequently unemployed, they spent quite a lot of time together during the school week. This provided ample opportunity for trouble.

While it was often obvious when they had been fighting even if there was no broken furniture or household items because the place would be dark with the blinds closed, dishes left unwashed, beds unmade, no food left out for dinner and there would be a putrid smell of stale tobacco from the stubbed cigarettes my chain smoking father would leave around the house – other times it wasn't so obvious.

As I felt I needed to know, I would ask my father a series of questions about my mother that

all had the same answer.

What I was looking for was not the answer per se – but the way he said it.

If in response he said ‘your Mother’ or ideally ‘your Mum’ – that suggested they hadn’t been fighting. If on the other hand he used some profanity to describe my mother – the chances were they had been fighting.

The problem was I got to a point whereby I felt I had to keep asking the questions even when I knew the answers – because an inner voice would tell me that if I didn’t – they would fight the next day and it would be my fault.

This was cruel because I was on a hiding to nothing.

For reasons that I still don’t understand, my OCD tendencies diminished significantly in my teenage years and early adolescence – although I was always a perfectionist with respect to essay writing and was a creature of habit.

However, my OCD tendencies flared up unexpectedly and quite intensely shortly after I moved to Canberra in my early 20’s and started living on my own.

They stayed with me throughout my entire period in Canberra and got much worse following the near fatal small bowel obstruction I had in late 2006 which also coincided with some very stressful workplace bullying I was subjected to while a Branch Head in the Department of Prime Minister and Cabinet under the Howard Government.

The rituals and routines all revolved around home security, safety and order.

I could not get in the house unless I was certain that it was secure. I would check every door and window, side gate, backyard shed – even the box housing the electricity meter – to make sure they were ‘right’.

I would also check the roofline with a torch fearing that someone may have gained entry by displacing the roof tiles.

I also detested leaf litter on the front drive-way – the rear yard was fine – but I had to ensure that the front was in proper order before I could go inside.

This was not only time consuming and outwardly absurd – but when you arrive home past midnight after a 12 to 14 hour day – the last thing you feel like doing is to pick up the leaf litter from the front driveway!

But you feel compelled to do so – or something ‘bad’ will happen.

As debilitating as something like this is, it is treatable – although I did not receive any treatment for my long standing OCD issues until the second half of 2009 – and even then,

treatment was initially patchy.

Anxiety medication helps – but the best approach is to embark on specialised therapy.

There are various therapies for OCD of which aversion therapy is I think especially helpful – but this requires ongoing vigilance and application.

As with many mental health conditions, I think that a genuinely loving environment whereby you are made to feel truly valued and wanted – and ‘safe’ – is the most critical ingredient for sustainable rehabilitation.

Things are so much harder when you are fighting on your own.

(iv) Eating Disorder – Anorexia

I have struggled with an eating disorder since the age of 16.

It is ironic that I was only formally diagnosed with anorexia in May 2018 after consulting a psychiatrist specialising in eating disorders at the request of the doctors who treated me for a small bowel obstruction at the Royal Melbourne Hospital in April that year.

Eating disorders are incredibly complex, debilitating and as has often been publicly reported – fatal.

As with many mental health conditions, there are many misconceptions about eating disorders and who they affect and why.

My eating disorder is significantly complicated because of the way it interacts with the physical bowel deformities I was born with.

For example – commencing in March 2007 and up until February 2009, I regularly practised bulimia in the toilets of the Department of Prime Minister and Cabinet and Treasury late at night not because of a concern about weight gain or body image – but because of a desperate attempt to avoid further small bowel obstructions. My thinking was that the less food my gut had to process – the less likely it was to obstruct or contort as it struggled to do what was naturally impossible.

My anorexia was not the product of teenage vanity – but a complex by-product of shame and humiliation from being significantly overweight – as well as a desperate attempt to have some ‘control’ when everything seemed chaotic.

There are two rather distinct phases to my eating disorder – that relating to my teenage years up to my late 20’s; and a second stage from my early 30’s that coincided with the rapid deterioration of my intestinal motility, the loss of my colon and the onset of multiple small bowel obstructions.

I was significantly overweight from around the age of 5 until the age of 16. I was always the fattest or second fattest child in class in primary school and early high school.

Childhood obesity in the 1970's and early to mid-1980's wasn't as prevalent as it is today – so overweight children stood out.

There was no secret as to why I was overweight.

I simply ate too much and of the wrong foods.

I grew up on high fat junk food and I derived comfort from eating.

With my mother working afternoon shifts, even at a young age I had to prepare my own meals which often simply involved heating pies, pasties, chicko rolls and the like in the oven.

I would routinely drink 2 or more litres a day of full strength Coke.

These were the days before sugar free or low joule soft drinks.

The only low joule soft drink I recall at the time was a cola drink called 'Tab' which I intensely disliked.

While I derived comfort from eating junk food and sweets, I was conscious of my weight and often felt ashamed.

Two episodes in my childhood stood out both of which took place when I was aged 10 in 1977.

In late January, a few days before the start of the school year, my mother took my brother and I to the local shopping centre to buy new pants for school.

When we arrived home, my brother and I went in our room to try them on.

I still don't know what triggered the row, but my parents had a major fight that was very physical.

My siblings and I ran out of the house and were joined shortly afterwards by our mother who was bloodied.

We ran to the end of the street to a house owned by an elderly Greek woman called 'Pat'. Pat was well aware of the domestic tensions in our home and she took a genuine maternal interest in my mother.

Pat would always give us refuge and she would let us use her phone to call the police.

This is what we did again on this occasion.

The problem for my brother and I – although more so for me – was that when my parents started physically fighting in the kitchen just outside our bedroom door, we had not had time to get dressed.

We were both in our underwear in the process of trying on the new school pants. So, when we ran down the street – we did so only in our underpants and singlet.

When the police arrived at Pat's place, they looked at me – and both laughed. It was spontaneous. There was no apology.

Although it was probably amusing to see a fat kid in his underpants and singlet sitting on the loungeroom floor blubbering – the humiliation I felt at that moment was profound and very long lasting, particularly as I had looked up to the police and fantasised as many young children do of becoming a police officer.

Later that same year, a slightly older boy at school started giving me torment in the playground whereby he would not only call me names but physically prod my gut with his fingers.

Although I did my best to avoid him, one day after school he caught up with me as I was walking home with my brother.

I simply tried to ignore his taunts as I walked as fast as I could.

My tormentor noticed an old shoe that had been discarded on the ground and picked it up.

He stood in front of me on the footpath and demanded I chew on the shoe.

I refused and tried to get away from him.

He was becoming quite agitated and slapped my face with the heel of the shoe. It hurt.

Miraculously, as I looked up, I saw my father coming towards my brother and me.

This was incredible because he never came to meet us or to collect us from school.

I immediately pointed out my father to my tormentor. His demeanour changed immediately.

When my father reached us, I told him what my tormentor was doing – clearly expecting my father to defend me.

Rather than defending me – he burst out laughing – thinking it hilarious to force someone – your own child – to chew on a discarded shoe.

My tormentor, clearly relieved, also laughed. They were both laughing.

At that moment, my humiliation was complete.

Although it would be another 5 or 6 years before I seriously committed myself to the task of losing weight – I recall the absolute determination I had once I made the decision to finally look ‘normal’.

The actual task wasn’t that difficult – I knew that weight gain and loss was a relatively simple equation involving the difference between the energy consumed and the energy used.

As I was not especially keen to become overly active – I simply cut back on the daily energy I consumed.

I went completely cold turkey on the soft drink cutting out all the Coke and drinking just mineral water.

I cut out all junk food and consumed mostly bread and crisp bread with vegemite and canned tuna.

It took a little while to see results – but when the weight started coming off, I felt a sense of great satisfaction and accomplishment.

For the first time in my life, I could see that I had control – over my own body.

This gave me joy and confidence.

The problems started when I felt I had lost enough weight.

How do you stabilise – without putting the weight back on?

I had become accustomed to rigorously counting my daily kilojoule intake – (I set a limit of 3,500 kilojoules a day which can deliver weight loss of 1kg a week) – and was very reluctant to increase it.

Although I eventually managed to find a rough equilibrium – I became very sensitive to even very minor weight gain and would weigh myself religiously every morning and night.

Any upward movement would trigger significant anxiety and the fear of getting fat again.

This is a battle I have essentially continued to fight ever since – even if the key motivations have changed.

When my intestinal motility noticeably deteriorated from my late 20’s and early 30’s necessitating very high dosages of stimulants, I became conscious of the convergence between two significant problems.

This did not upset or destabilise me – in fact I took some comfort from the fact that the one

‘treatment’ – i.e. a heavy use of laxatives and stimulants – was helping me deal with two problems at once.

As the severity and life impacting effects of my intestinal disorders intensified, my overall concern was – and remains - to manage my intestinal issues – not the management of my weight per se.

My intestinal disorders have required not only a heavy reliance on stimulants – but also a very limited diet.

This has ‘helped’ in keeping my weight down.

I do not deny that I remain very sensitive to weight gain – in part because I feel that this would represent a betrayal of the undertaking I made to myself when I was 16 – as well as threatening my sense of control.

Over the past year, I have applied myself vigorously to the task of trying to better understand and manage these issues under the care of an experienced psychiatrist who specialises in the area.

Although it is a very difficult task – and it will take time - I remain hopeful of finding a more sustainable balance between the need to consume adequate nutrition while managing the complexities of my intestinal disorder.

(v) **Borderline Personality Disorder (BPD)**

I was formally diagnosed with borderline personality disorder (BPD) in mid- 2014.

Although I had been told as early as 2010 that I exhibited definite BPD tendencies and that I likely met the diagnostic criteria for BPD, I was still surprised and upset when the staff at the Melbourne Clinic diagnosed me with the condition in 2014.

BPD is a highly complex and widely misunderstood mental condition that comes in many forms. There are well over 200 different manifestations of the illness across a broad spectrum of criteria and in varying severity.

It seems to affect about 2 percent of the population and generally emerges in adolescence and early adulthood. There is no definitive cause – but it seems widely accepted that environmental factors, especially in the critical formative years, are important causal factors.

Children who experienced persistent emotional abuse, real or feared abandonment and persistent invalidation – are more susceptible.

In my case, I was told that my BPD was almost certainly the consequence of prolonged childhood emotional abuse and trauma, especially the tangible experiences of rejection I

experienced from my father and others.

Some sufferers resort to self-mutilation such as ‘cutting’ – including for pain relief, while others succumb and commit suicide, abuse drugs, engage in risky sexual practices, spend money impulsively way beyond their means and generally take risks that place them in real danger - while others do none of these things.

Although BPD was deemed very difficult to treat for many years, BPD is treatable and those who suffer from it are able to lead highly productive lives and contribute fully.

But as with practically all mental health conditions – recovery and stabilisation takes time and requires a genuine commitment to treatment and support.

Noting the limitations of generalisation, especially with an illness with many varied presentations – those suffering from BPD – especially those who are at the more emotionally sensitive end of the spectrum – as I am – tend to seek out acceptance and validation from superiors and peers.

They will do everything they possibly can to please their superiors or the person that is important to them and will be fiercely loyal.

Emotional pain is felt more acutely and for longer periods and can often feel chronic and never ending.

The BPD sufferer craves acceptance and embrace – and is very fearful of rejection and abandonment.

Real or perceived rejection – especially when it cannot be rationalised or justified - can have severe consequences and seriously destabilise the sufferer.

The BPD sufferer is also prone to ‘splitting’ – whereby you are very quick to see the good in someone while ignoring or downplaying the bad – or vice versa if it is someone you don’t necessarily like.

Anger can be a real problem for some sufferers – and once triggered, defusing or calming down can take longer than for a non BPD sufferer.

In the workplace, BPD sufferers who are at the more emotionally sensitive end of the distribution – tend to be very hard working and will carry disproportionate workloads – and they very rarely complain.

If they have a problem or are unwell – they will try to hide it and resolve it themselves fearing the consequences if they fess up.

They will try to be what the employer wants them to be or who they think the employer wants them to be – and in the process risk losing themselves.

They are amongst the best employees as they always deliver with a minimum of fuss.

This reflects the desire to please and to be accepted – and the converse fear of being rejected if they don't perform or if they complain.

As the BPD sufferer craves acceptance – he or she will seek positive feedback as validation and as a tangible sign of acceptance.

Constructive or even negative feedback is actually welcomed – as long as it is clearly justified and can be rationalised.

Consequently, such employees are more vulnerable to exploitation and being taken advantage of.

They are also poorly equipped emotionally to deal with the sheer bastardry, double-standards and inter-personal toxicity that passes for modern workplace politics.

The BPD employee will essentially give you his or her all and will ask for little – they simply expect to be treated fairly and with respect and with the occasional display of appreciation or warmth.

If the BPD sufferer is treated unfairly or is double-crossed and rejected – the consequences can be significant and possibly life threatening.

The links with childhood trauma, particularly emotional abuse and neglect are quite obvious.

Treatment

There are various treatments for BPD that usually involve a combination of medication and intensive therapy.

The widely accepted therapy is Dialectical Behaviour Therapy (DBT) that was developed by Professor Marsha Lineham at the University of Washington in Seattle. Professor Linehan is a very interesting woman and is living proof of the scope for BPD sufferers not only to succeed but to excel.

Linehan suffered with BPD as a young woman and was institutionalised by her family. She went on to become one of the most respected psychologists that the US has produced – and is still teaching.

DBT involves a mix of teachings that seek to give you the skills and tools to better regulate your emotions and to more effectively deal with the triggers of distress as well as allowing you to better manage the frustrations and injustices of daily living. It involves a significant amount of mindfulness teaching and acceptance therapy.

DBT involves a serious commitment of time and emotional effort and usually features a one on one 50 minute therapy session each week with a clinical psychologist as well as a 4 or 5 hour weekly group therapy session with private ‘homework’.

I undertook the DBT program at the Melbourne Clinic in Richmond, Victoria in 2015 and the early months of 2016.

While DBT is not rocket science and involves many concepts and ideas that seem rooted in common sense, its effectiveness comes from the relative ease with which its teachings can be absorbed and implemented in daily living – and helping sufferers defuse stressful situations in part by putting them in the present moment.

But as with all therapy – its effectiveness depends critically on the sufferer making a long term commitment and remaining vigilant and genuinely ‘invested’ in his or her recovery and rehabilitation.

Recovery and rehabilitation are undoubtedly aided if there is a broadly supportive and embracing environment that values the sufferer.

While families and loved ones are critical in this – employers are just as important because it is often through productive and meaningful employment that BPD sufferers receive validation, a sense of belonging, positive reinforcement and a sense of worth.

I have made a significant and intensive commitment through therapy over a long period to better understand my BPD and to develop the basic skills to manage it.

While I need to remain vigilant – there is not much more that I can do on my own.

(C) Comorbid Physical and Mental Health Crisis: A Case Study of Workplace Aggravation

The almost universal response to an unexpected suicide, suicide attempt or even a violent crime that results in the loss of life or serious injury to innocent victims is ‘why’?

Why did XY do it? He or she seemed fine. They didn’t complain or say anything. Why didn’t they reach out and seek help? What could possibly have made them do it?

Although there are many instances of tragedy resulting from an impulsive act - perhaps influenced by intoxicating substances, it is often the case that a complete breakdown in mental health that results in suicide or attempted suicide or worse, is the tragic conclusion of a set of cascading events and multiple triggers – at least some of which were – or should have been - visible to third parties.

Although I can only comment with confidence and candour with respect to the situation I faced, I think it is possible to draw some lessons from my case, especially given the role that workplace triggers played – and continue to play - in my struggles.

While there have been many triggers and events that have almost proved fatal on at least three occasions in the period since late 2006, the major trigger took place on 24 August 2006 – which also happened to be my mother’s 70th birthday.

At the time I was a Branch Head or Senior Executive Service Band 1 officer – responsible for the Industry Policy Branch of the Department of Prime Minister and Cabinet (PM&C).

I had been in the position since June 2003 having transferred into the role from Treasury after having been approached by the then Deputy Secretary of PM&C – David Borthwick.

I had known and worked with Borthwick from my earliest days in Treasury and I naturally warmed to him – as most did. Borthwick was rare as a senior bureaucrat in that he had excellent people skills and was genuinely decent. He also had a great sense of humour and didn’t take himself too seriously.

Although I had been in Treasury for almost 14 years after starting as a young graduate before moving to PM&C, the role I had in PM&C was my ‘dream’ job and my overwhelming objective was to do it well and to earn the respect of my colleagues and the Prime Minister of the day.

Unlike many of my peers, I did not have aspirations to keep getting promoted because in part I appreciated my limitations. However, I felt that I had the capacity and ability to serve at least as a Division Head if not in PM&C then in some other agency down the track.

What was critical was that I be treated fairly and be assessed on merit reflecting my actual work performance and to be treated on the same terms as my peers.

Work for me was absolutely critical on almost every dimension.

Work was my only source of economic security, especially coming from a genuinely dysfunctional migrant working-class family. I had no family wealth or connections to fall back on.

Work was also what gave me a sense of self-worth, an identity and a sense of belonging.

While this is quite common, it was paramount for me given my background and some of the long-standing psychological issues and trauma I was struggling with.

This is especially significant in the context of my BPD and my craving for acceptance, validation and deep held fears of rejection.

While I was not aware at the time that I suffered from BPD, I was certainly aware of my BPD symptoms and behaviours that influenced my everyday life and interpersonal interactions.

Although I hadn’t completely given up on the idea of finding a partner, I had always been hesitant to seriously commit in light of my lifelong experiences and I became especially hesitant once my physical health started to rapidly deteriorate.

It has always been my view that a serious loving relationship must involve honest

communication and a willingness to give yourself completely.

I just cannot ‘lean’ on a prospective partner or someone I genuinely care about unless I am confident that I will not impose a burden or unless I am sure that they can lean on me in equal measure.

So when I moved to PM&C in June 2003, I was not only absolutely determined to do my very best, but I was also prepared to devote myself completely to the role, fully expecting – and accepting – that my work-life balance would be very poor.

The Branch in PM&C I assumed responsibility for only had a staff compliment of 9 – including myself – which were split across three sections.

The Branch covered a very wide range of industry and economic policy issues that included manufacturing, the car industry, energy policy, competition and consumer policy, customs, the pharmaceutical industry, tourism, the Council of Australian Government’s (COAG) and sports policy.

COAG was a major stress on the Branch because we were responsible for servicing the COAG Secretariat and co-ordinating the Prime Minister’s briefing for the entire COAG agenda and for managing the physical logistics for meetings held in Canberra.

For most of my time in the Branch, we had to co-ordinate and prepare for 4 or 5 COAG meetings a year, occasionally more.

The work load was immense for all staff members and as PM&C operated under a traditional hierarchical structure at the time – all briefings and Cabinet related material that went to the Prime Minister or the Prime Minister’s Office (PMO) had to be personally cleared and signed off by the Branch Head – and by the relevant Deputy Secretary or the Secretary in the case of Cabinet briefings.

As most of my Branch colleagues were either married or in relationships and had family responsibilities, I was very conscious of minimising the need for any staff member to work excessive hours.

I was also conscious that the surest way to lose good young staff is to ‘burn’ them or encroach so heavily on their private and social time that they choose to leave.

I therefore did everything I could to ensure that by 7.00pm they could all go home.

But as Branch Head, my day often only really started after 7.00pm once the phones had stopped ringing and the ‘crisis’ of the day had been resolved.

It was then that I would start clearing the briefing papers and ministerial responses that while not urgent earlier in the day – would be urgent the next day if not actioned.

Although the staff I had were all very capable and worked hard, the quality of drafting, especially from the more junior staff, was patchy and occasionally poor.

This would result in me having to substantially redraft the relevant briefing to get it to the

standards expected. However, this had to be done mindfully and with care so as not to demoralise a staff member who may well have spent much of his or her day working on the document in question.

The mentoring responsibilities of supervision are very important and I took them very seriously.

I also took a genuine interest in the wellbeing of my Branch members and I cared about them as people and was conscious that they were often stressed and not invincible.

I also used every opportunity I could to help them secure promotion or to progress their careers – even if that meant losing good staff.

My efforts with respect to my staff were rewarded in that they were loyal, did their very best and when I got sick, they willingly and very effectively carried a bigger load. I also had some of the lowest staff turnover of any policy Branch in PM&C over the 5 years I served in the Department.

To be effective as a Branch Head or SES officer in the Department of the Prime Minister and Cabinet or any Government agency, it is critical that you network effectively and have the confidence and respect of your key clients. In the case of PM&C, this is the Prime Minister of the day and his or her key staff who you must interact and deal with daily.

I had worked very hard to develop and maintain a strong professional and respectful relationship with the Prime Minister of the day, the Hon. John Howard and his key staff.

By mid-2006 although my physical health was clearly failing and had been for some time with the loss of my colon three years earlier and the onset of multiple small bowel obstructions from March 2005 – I was still a highly performing Branch Head that had the confidence of my key clients and the strong support of my staff.

I always delivered and never missed a deadline.

Of literally the hundreds of briefing notes, strategy papers and pieces of correspondence my Branch produced and submitted to the Prime Minister and the PMO while I was the Branch Head – not one was deficient or failed to meet the standards of the Department or the Prime Minister. Not one.

I was working a routine 80-90 hour week that included the obligatory Sunday afternoon and evening preparing or clearing material.

My formal performance assessments were outstanding as was the informal feedback I was getting in day to day activities.

As I had expected from the very start, my work-life balance was very poor and I kept the mental health issues I was struggling with to myself.

These principally included my OCD, eating disorder, dysphoria with the occasional bout of depression and the increasing anxiety about my physical health, especially the inevitability of further small bowel obstructions and what that meant – as well as overall despondency from

the realisation that I would probably always be alone.

I was also constantly exhausted and rarely slept more than 4 hours a night – which was always interrupted as a result of the medication I was taking for my intestinal issues. I also just couldn’t switch off and would worry obsessively.

On Thursday 24 August 2006, I met with my immediate supervisor, Mr ‘X’, for my annual performance assessment for the year ending 30 June 2006.

I had a generally sound relationship with ‘X’ and I liked him. He was able and rarely interfered in my work which I took as a very good sign because it suggested that he had confidence in my ability to undertake my responsibilities.

I knew that the upward feedback from my staff was excellent as was the feedback from my key clients.

I was anxious that my small bowel obstructions and hospitalisations may adversely impact my reliability, but up to then, it wasn’t an issue and at no stage had my superiors raised it as a concern.

After a few minutes of small talk, ‘X’ told me how well my subordinates thought of me and how much the Prime Minister and the PMO valued my work.

He then paused, avoided eye contact and said that despite this – ‘*they*’ didn’t want me in the Department and that if I didn’t leave voluntarily - ‘*they*’ would engineer a transfer to get me into another agency.

It was literally that blunt and it came with absolutely no warning.

It was also completely at odds with all of my feedback – formal and informal.

‘X’ then offered to facilitate a transfer for me to the Environment Department.

I was completely floored by this. I couldn’t believe it.

What was happening? What had I done to have my position effectively terminated?

‘X’ said that it was the view of a senior Departmental official - ‘Y’, and some of my peers from within the Department - (all of whom were in direct competition with me for promotion) – that I was not a ‘team player’ and that I was ‘too accommodating’ of the then Prime Minister and the PMO.

I pressed him on what this meant – because it was both without foundation and a serious slur.

‘X’ could not offer one example or any evidence to support his claim.

I asked him if I was being accused of misconduct and if so by whom.

He said that I was most certainly not being accused of any professional misconduct.

I had long been routinely very transparent in my dealings in the Department – and would always copy in my SES colleagues on all communications I had with the PMO that was of relevance to them – a courtesy not always returned.

So how could I possibly be accused of not being a ‘team player’ – and what was that exactly?

Critically – and in demonstration of the utter cowardice and contempt for natural justice and fair play – what ‘X’ was raising with me had never been raised with me before.

Furthermore, my modus operandi within the Department and with respect to my dealings with the Prime Minister and the PMO had not changed one iota in the 3 years that I had been in the Department up to that point.

This was the ultimate rejection that I had worked so hard to avoid given the chronic rejection of my youth and adolescence.

It was also manifestly unjust – because I had done absolutely nothing wrong and could not justifiably be accused of doing anything wrong!

I had literally left my guts on the table for the Department and the Commonwealth – often under great duress - and this is what I get!

While my peers – most of whom were no better or more effective than me – were either getting promoted or being groomed for advancement – I was getting shafted!

How do you think I felt?

How do you think I still feel about this?

Although I expect that any ‘normal’ person would be rattled by this – someone at the emotional end of the BPD spectrum and with the psychological history and trauma I experienced over many years – would find it very destabilising and a serious violation of their whole being.

I was very upset, angry and my thoughts turned very dark, very quickly.

The following morning - Friday 25 August 2006 - I went to see senior officer ‘Y’ hoping to clarify and rationalise what Mr ‘X’ had told me the previous afternoon.

Senior officer ‘Y’ was clearly nervous and simply reiterated what Mr ‘X’ had told me.

Again, ‘Y’ could give no examples to support the slurs.

‘Y’ added that I had no support among the senior echelon of the Department and that it would be futile for me to resist.

‘Y’ offered to arrange a transfer for me back to Treasury.

I told ‘Y’ that if I wanted to return to Treasury, I would arrange it myself.

With that, I left the office of 'Y' and went for a walk to the Kingston shops which are about 2km away from the Department of Prime Minister and Cabinet in the Canberra suburb of Barton.

I felt completely lost, deeply upset and humiliated.

A fundamental golden rule of performance assessments is that there should be no surprises - certainly not on the downside.

In many respects, this was a classic case of workplace bullying - but I had no effective means for dealing with it.

If the arguments of 'X' and 'Y' had substance - why were they not raised with me earlier, perhaps informally and with evidence?

And if they had substance - why wasn't the remedial processes within the Performance Management System utilised to deal with the issues to give me at least one opportunity of correcting any perceived deficiency - after all, I was effectively being dismissed?

But what could I do? The powers against me were too strong.

Although I doubted their resolve to actually engineer a transfer themselves – that night I decided to leave and return to Treasury knowing that if I attempted to stay, I could never position myself for promotion and I simply could no longer trust my superiors.

I moved quickly and through the then Secretary to the Treasury, Dr Ken Henry, I arranged a transfer to the Foreign Investment Division.

Although this was a good role, I was very bitter, angry and upset.

BPD sufferers *ruminate* much more than a 'normal' person.

This is one of the reasons why impacts are felt deeper and longer and why seemingly even minor issues – let alone serious issues involving significant violation and injustice - can have more profound implications.

Before I went home that night, I sent a short e mail to the PMO letting them know that I was leaving and why. I heard nothing.

I didn't say anything else to anyone - certainly not to my Branch members or to any other Departmental colleagues.

I went through the motions on the Monday waiting to sort out a time with Treasury for when I could commence in the new role.

My plan was to commence in mid-October and to leave PM&C immediately by taking personal leave for the 5 or 6 weeks before starting in Treasury.

Shortly after 7.00pm on the following Tuesday night, i.e. 29 August 2006, I got a call from the PA to senior officer 'Z' asking me to see 'Z' immediately.

I found ‘Z’ frustrating to deal with because although I genuinely liked him and had much respect for his abilities and work ethic, I never felt he embraced me or liked me despite my complete loyalty to him and the Department.

When I saw him that night, he was quite animated. He had just returned from a meeting with the Prime Minister.

He told me bluntly that he was annoyed that the Prime Minister had asked to speak to him about me.

He said that the Prime Minister was somehow of the impression that I was being forced out of the Department for no just reason and that the Prime Minister had told him that he did not want me to leave.

It was apparent that ‘Z’ was annoyed thinking that I had gone behind his back to lobby the Prime Minister or the PMO for my role.

I had done no such thing.

All I did was to simply inform the 5 or 6 staffers in the PMO I dealt with on a daily basis that I was leaving and why.

I did not seek, and I did not expect – nor frankly did I want - them to intervene.

‘Z’ literally grabbed me by the arm - in a reassuring manner - and implored me to stay saying that I had his full support.

What do I do?

These were the most senior elected and unelected officials in the country. I felt that if I said no, it would be to my detriment.

Yet I knew that ‘X’ and ‘Y’ would not move against me without ‘Z’s’ support or knowledge. So how could I trust him?

I was placed in a very difficult position through no fault of my own - without justification - and not for the last time.

If I stayed in PM&C, I knew that irrespective of how hard I worked or how effective I was - I could never position myself for promotion because you cannot get ahead without the support and advocacy of your superiors.

Yet if I went back to Treasury, I would be going back very bitter and hurt and defeated. This would churn and eat away at me.

I told ‘Z’ that I would stay.

I informed Ken Henry the following day that due to some unexpected developments, I would have to stay in PM&C, but I expressed my genuine appreciation for the offer he made.

This was just the start of my troubles.

‘Y’ largely ignored me – and I thought it best to just avoid her as much as possible.

‘X’ had left for a long bike riding holiday in France on 25 August - so I didn’t have to deal with him again

But his replacement – ‘R’ - was very loyal to ‘Y’ and had long been positioning for promotion with the active support of ‘X’ and ‘Y’ – so I couldn’t trust her either.

So, from early September 2006, my overall anxiety levels and fatalistic mood increased significantly.

All of my mental health issues intensified while some were seriously aggravated.

I was now working very hard and putting in extraordinary hours not out of a sense of loyalty and service – but in order to survive - fearing that if I made one small error, it would be used against me.

My overall anxiety levels increased significantly, my OCD rituals and routines at home became more elaborate, my mood and overall outlook was very low and I was utterly exhausted.

I also became hyper vigilant with respect to the absolute necessity of avoiding a further bowel obstruction convinced – rationally or not - that my bosses would use any hospitalisation to move me aside.

Yet I knew that it was all futile and that it was just a matter of time before I developed another obstruction as I was averaging about 2 a year.

I significantly increased the dosage of the drugs I was taking for my bowel condition and further refined my diet. I became more adept at emptying my gut by inducing vomiting in the PM&C toilets late at night.

I believe that this would destabilise a 'normal' person - but it is especially destabilising for the emotional BPD sufferer - especially one lacking the basic skills to manage the destructive emotions and impulses that emerge from such an experience.

No-one should have to live like this - and to go through this - to earn a living!

As set out above, a little over 2 months later - on 11 November 2006 - I developed my most serious obstruction up to that point and which very nearly killed me.

I delayed seeking medical help that day because I was hoping against hope that the obstruction would clear itself.

This no doubt made things worse as my overall state of dehydration reached very dangerous levels and the pressure build up in my gut probably contributed to the perforation and subsequent sepsis.

On Friday 10 November 2006, I was a member of a recruitment panel that had been convened to fill various positions in PM&C. I spent the whole day interviewing and much of that night catching up with my paper work.

The panel was chaired by Angus Campbell who was then the Division Head responsible for the National Security Division of PM&C. Campbell has since re-joined the Australian Army and is now the Chief of the ADF.

I genuinely liked Campbell – and especially his immediate supervisor at the time, Duncan Lewis. Lewis was the Deputy Secretary in PM&C responsible for the national security apparatus and was previously in the SAS. He is currently running ASIO.

There was nothing pretentious about either Lewis or Campbell and they were natural leaders.

However, I was very concerned on the afternoon of Sunday 12 November as I lay on my couch in severe abdominal pain and with a grotesquely distended gut from what was then my fourth obstruction in under 2 years.

I didn't want to let Campbell down thinking that if I didn't turn up on the Monday for the next batch of interviews – I would upset him and this would gift 'Y' and my direct bosses a perfect excuse to move against me.

But it got to the point late that afternoon where I had no choice but to get to hospital.

I lacked the strength to do so on my own and ended up collapsing on the front steps of a neighbour who called an ambulance which took me to the Canberra Hospital.

I remember little of that first week in hospital as I drifted in and out of consciousness in ICU, developed sepsis and septic shock, multiple organ failure and a major haemorrhage.

This event was a significant 'game changer' for me in every respect.

I was now not simply dealing with the inevitability of 'routine' obstructions – but the real possibility that any single one could kill me.

How do you think I felt? How would you feel?

When I returned to work in March 2007, I was very unwell, physically and psychologically. I was fragile and very vulnerable.

Yet I had no-one to seriously engage with and I trusted absolutely no-one.

Following the change of Government in November 2007, 'Z' went on leave and never came back.

'Y' replaced 'Z' on a temporary basis.

I felt completely spent. I honestly saw no blue sky, no hope.

Around this time, my long-term GP gave me copies of official doctor to doctor communication between my nephrologist, gastroenterologist, surgeon and a cardiologist I also had to see.

The doctor to doctor correspondence seriously rattled me because the language used was very pessimistic.

My gastroenterologist was saying that my outlook was 'grim' and incredibly, my nephrologist was saying that I should pray!

I followed this up with him when I next saw him, and he said that I was 'sailing very close to the wind'.

Knowing that I would develop more obstructions, it was very challenging for me to deal with what I was being told.

I was now in the 'perfect storm' involving the convergence of my physical and psychological ailments fuelled by the disintegration of the only pillar that gave me structure and purpose – my work and vocation.

I had another two small bowel obstructions in late 2007 and spent Christmas of 2007 in the renal ward of the Canberra Hospital fully expecting to develop sepsis for the second time and to go into renal failure.

Mr 'T' replaced 'Y' in April 2008.

Although I had limited prior dealings with Mr 'T', I genuinely liked him and felt comfortable with him - but by this stage I was very wary of everyone.

Immediately upon commencing, Mr 'T' commissioned a review of the PM&C SES and various functions.

The person tasked with undertaking the review was assisted by 'Y' and another senior officer. To have 'Y' directly involved in this review was pure poison for me.

Of all of the SES positions in PM&C - the review in effect recommended the abolition of only one line role - my role!!

How do you think I felt?

I was offered a 'strategy' role that was poorly defined and involved no staff.

I had zero confidence that I would not simply be 'parked' before being moved off as 'Y' and her acolytes had attempted roughly 2 years earlier.

I made it very clear to 'Y' and other review staff that I wanted a normal Branch Head role.

I was told it was either the strategy role or no role.

So, I arranged, again through Ken Henry, to return to Treasury.

But this time I was only offered a 'Strategic Adviser' role within the Corporate Law Division whereby the Division Head or General Manager - was effectively the same rank as me (SES Band 1).

The role also involved me having no staff.

I was completely demoralised and quite lost.

But I had to get out of PM&C - so I took the role in Treasury.

Within a couple of months, the GFC started and my workload exploded.

I had no staff - although a competent APS 5 or 6 was seconded to help me out - it wasn't enough.

As many of the projects I was working on were important and time sensitive - I was desperate to deliver, fearing that if I went down with another blockage, I would be pushed out, but this time from Treasury.

My senior supervisor in Treasury at the time – Mr 'J' - was rather eccentric and many found him hard to work for - but I genuinely liked him.

However, he was quick to remind me that they were doing me a favour by placing me in Markets Group and that as an SES officer - I was expected to deliver.

I resorted to my bulimic practices – but this time late at night in the Treasury toilets. However, I stopped doing it for good on 1 February 2009 when I developed another obstruction (my 7th to that point).

The obstruction I had on Sunday 1 February 2009 was a multiple obstruction, i.e. the small intestine kinked in three places which I had never had before.

I returned to work only 12 days later and at least 10 days too early. I was still very distended, sore and tender. It can take 4-6 weeks for the distended gut to resume its 'normal' shape after a severe obstruction.

Within 4 days of returning to work my political masters within the Rudd Government asked that I assist some distressed car dealers who were experiencing difficulty securing floorplan financing as a result of the GFC.

Despite the extremely limited options I had – and the very significant pressures I faced to deliver – some of which were significantly compounded by my longstanding psychological issues - everything I did to help those people was cleared beforehand by my superiors at both a Departmental and political level.

One of the dealers I was asked to assist would literally call me 6 or 7 times a day in tears pleading that I save her business while threatening self-harm.

One evening her elderly mother called me saying that if I didn't save her daughter's business,

the elderly woman would suicide so that the daughter could cash out the life policy to save the business.

This was manifestly difficult for me – especially given the psychological issues I was dealing with on a daily basis.

I lacked the skills to deal with it – although I did report the representations to my superiors.

No public servant or any employee should be placed under such duress.

It is ironical that my successful efforts to help that woman were later used against me.

It is in this overall environment and sense of futility, anger, bitterness and despondency, that I came into the orbit of various powerful and highly privileged individuals who had zero concern for my wellbeing and who were content to exploit my vulnerabilities for their own benefit.

But to be clear – I do not blame anyone.

There is no productive purpose in apportioning blame or continuing to inhale the toxic fumes of lingering anger.

The sad reality is that if I couldn't rely on my own father when I needed him most – it was utterly delusional of me to expect better of others who have never been invested in my wellbeing.

Although it is easy to assert that I should have ‘reached out’, got help or just walked away – I hope that it is possible to see why that was not a realistic avenue for me.

(D) The Mental Health System: Personal Experiences

Over the past decade I have had extensive interaction with the mental health system, including as an in-patient in a public mental health facility, as a ‘client’ of numerous mental health practitioners of varying description as well as a consumer of various intensive programs designed to treat the complex anxiety and personality disorders I have been diagnosed with.

I wish I could say that my experiences have been overwhelmingly positive and helpful, but that would be wrong and misleading.

While some of my interactions with the mental health system have been undoubtedly beneficial, some have had a regressive impact and have in fact resulted in further humiliation, invalidation and breaches of trust which at times have pushed me to the edge.

It is certainly the case that some of my negative experiences have been a direct consequence of me having to confront painful issues and trauma, as well as the personal difficulties I have encountered ‘connecting’ with many therapists.

However, a number of the challenges I have faced reflect system deficiencies, excessive cost barriers and weaknesses that should at least be acknowledged - because they can be encountered by others and possibly act as a deterrent to treatment.

This is important because despite some of the upsetting experiences I have faced, I remain convinced that the only plausible pathway for rehabilitation and a sustainable recovery – is to apply yourself fully to professional therapy and the supports that the system offers.

The experiences I set out below are therefore intended not to discourage – but rather to strongly encourage *perseverance* as well as to identify some things that could perhaps be done better.

(i) **Hospital Inpatient**

In June 2009, I was admitted to the public mental health facility at the Calvary Hospital in Canberra. Although I was formally admitted as a ‘voluntary’ patient, I only agreed to attend the hospital under threat of certification and being held within the secure mental facility at the Canberra Hospital - which is like a prison that accommodates at times seriously unstable individuals struggling with psychosis and related conditions.

I was kept at the Calvary facility for 6 months before being discharged in December 2009.

I was placed under the care of a senior experienced psychiatrist who was assisted by a registrar and a small team of mental health nurses.

At the time, the ward could accommodate approximately 22 beds which seemed mostly occupied by women of varying ages.

Although I undoubtedly benefited from undertaking various assessments and diagnosis that helped with immediate stabilisation, some of my experiences were detrimental and undermined the effectiveness of treatment and complicated my attempts at rehabilitation.

The senior psychiatrist who was treating me relied on daily therapy and medication.

I was initially placed on the drug Pristiq which had zero effect.

My psychiatrist was also concerned about my fragile physical state, including the possible onset of a further small bowel obstruction and renal failure. I was also haemorrhaging which led to an urgent sigmoidoscopy which was inconclusive.

Patients within the facility were weighed as a matter of routine on a Thursday morning.

By early August 2009, my weight was down to 43.4kg – which was about 6 kg less than at the time of my admission.

This didn't overly bother me – but it seemed to bother my psychiatrist.

I was strongly encouraged to take the drug Avanza to help stabilise clinical depression and anxiety.

I asked repeatedly about possible side effects especially with respect to gut motility and weight gain.

I was firmly reassured that the drug would not lead to weight gain and that it would not adversely impact gut function and on that basis, I agreed to take it.

Although the drug had zero positive effect on my mental state, it did impact my metabolism and body function in ways that I do not understand – but which led to rather rapid and significant weight gain – despite there being no changes in the composition or volume of my diet.

For someone with an eating disorder, this is deeply destabilising as it triggers multiple anxieties and a feeling of utter hopelessness as you lose control over your own body.

But it also destroys the trust and confidence that is absolutely critical in any relationship between therapist and patient.

Given the serious issues of trust I was dealing with, the actions of the psychiatrist – even if they were well intentioned – were highly damaging as I felt I had been deliberately misled.

I shut down and became very selective in what I told him and ignored his recommendations. I also ceased taking the medication and set about ‘reclaiming’ control over my body.

This is definitely not the pathway to rehabilitation.

It is absolutely critical that those tasked with the responsibility of treating vulnerable and at risk individuals are honest in their assessments and in the provision of treatment - and that they appreciate the potential consequences of misleading the person under their care.

My situation wasn't helped by one of the mental health nurses assigned to look after me who I believe was simply unfit for the role.

A mature aged woman who claimed to have many years of experience, the nurse was routinely dismissive and sarcastic towards me.

This upset me because her animosity was obvious and I couldn't rationalise it which made it impossible for me to adjust my conduct which was always courteous despite the challenges I faced.

In fact I had shown her kindness including by gifting her some gardening magazines a former colleague from the Department of Prime Minister and Cabinet had given me.

Although hard to believe, roughly half way through my admission, she told me that suicide was a plausible option for those who couldn't be helped or who didn't want to be helped.

This comment struck me as very odd as it was unprovoked and I had never discussed my history of suicidal ideation with her.

She also seemed to delight in bringing to my attention reports and articles that were cruel and critical of me.

On one occasion, a report appeared that quoted a senior economist with a high public profile who at the time was working as an adviser on climate change – referring to me as a ‘Goblin’ – an ugly deformed creature that is definitely subhuman’.

That someone with a high public profile would think it proper to make such a remark about someone whom they have never met, conversed with or who they simply do not know – is perhaps indicative of the character of the person making the comment – but for a mental health nurse tasked with caring for a vulnerable patient to seemingly go out of her way to bring such hateful bile to my attention – was a gross dereliction of duty that only served to undermine my trust and confidence not just in her – but to all of those who worked with her.

(ii) Mental Health Practitioners

The routine public messaging for anyone struggling with a mental illness or is at risk - is to reach out and seek help - which for most people is likely to involve consulting a professional therapist even if only for a brief period.

Although this is sound advice, it overlooks the fact that the seemingly straightforward task of finding a therapist may be much harder in practice for some people – especially for those who have experienced significant trauma and serious breaches of personal trust.

The transaction costs of ‘therapist shopping’ are high not just financially – but emotionally - and often result in significant frustration, disillusionment, feelings of rejection and an even greater sense of hopelessness.

At its worst, vulnerable individuals who are most in need of therapy – simply choose to give up and turn away from the mental health system all together - which severely compromises any realistic hope for rehabilitation and recovery paving the way for a potentially fatal conclusion.

It should not be so hard – particularly as the qualities of what makes a good therapist are rather obvious.

A good therapist should clearly have a sound clinical knowledge of their specialty – but critically needs to be willing and able to engage with a client on a *human* level and not just as a talking clinical textbook.

The best therapists are those that are sufficiently confident and experienced to be willing to 'share' some of their own experiences and perhaps some of their own failings and vulnerabilities.

While there can be some 'risk' in doing so – albeit a calculated risk requiring judgement – a therapist who is willing to share demonstrates trust which is the key ingredient for effective therapy.

I am well aware of these issues as I have seriously struggled over the past decade to find a therapist who I can 'connect' with, truly trust and open up to without fearing being judged, mocked or ridiculed.

Since 2009, I have been a 'client' of at least 18 mental health practitioners of various specialties and experience.

This has included two of the most senior forensic psychiatrists in Sydney, a number of psychiatrists in Melbourne and Canberra and a raft of clinical psychologists.

Although I genuinely respected the professional competence of all of the therapists I dealt with – I only felt comfortable with two – a very worldly and highly intelligent clinical psychologist in Canberra who was old enough to be my father and who I know genuinely cares about me – and a young female clinical psychologist in Melbourne who despite her relative youth, was warm, wise and non-judgemental towards me – and who knew more about AFL football than me!

Moving back to Melbourne made it impractical for me to continue consulting the Canberra psychologist – and as I was seeing the Melbourne psychologist through a program at the Melbourne Clinic – I was effectively barred from seeing her once the program concluded.

Indeed, my efforts to do so were strongly rebuked which only served to compound my feelings of rejection which directly resulted in my disengagement from the mental health system completely from mid-2016.

As for all of the other therapists I engaged with – I immediately distrusted those who I was referred to by third parties - while others made observations in therapy that struck me as very odd and which simply fuelled distrust.

One of the psychiatrists I consulted in Canberra for example, once told me that as I derive a sense of self-worth through public and community service rather than through the accumulation of material wealth - I should travel to the slums of India, Pakistan or Bangladesh and do voluntary work.

When I raised my concerns about the implications of such an environment for my physical health, especially the risks of developing an intestinal obstruction in a third world country, she said that as I was unlikely to survive to old age anyway, I might as well do something useful even if it leads to my premature death.

She was that blunt.

Although I could rationalise her thinking and it made sense – it wasn’t exactly the path to sustainable rehabilitation I was seeking.

I did consult a senior and very able psychiatrist in Melbourne for a number of years. Although I liked him and respected him, I never felt truly comfortable with him and often felt like I was visiting the headmaster. I stopped seeing him in 2016.

In May 2018, I recommenced consultations with a psychiatrist – largely at the request of my doctors at the Royal Melbourne Hospital who were concerned after I suffered my 9th small bowel obstruction.

The psychiatrist I am seeing is clearly able and experienced with a specialisation in eating disorders. I continue consultations with him.

The key point from all this is that it can be far more challenging to find a compatible and helpful therapist than it may seem – and the public messaging fails to adequately reflect this.

But most importantly, despite the challenges of finding a genuinely good therapist – it is critical to persevere because by giving up, you are in effect giving up on yourself.

(iii) Rehabilitation Experience: Mental Treatment Programs

For many people, individual therapy with a compatible therapist, medication and the support of a proactive GP complimented by a caring social network - proves sufficient for rehabilitation and recovery.

But for others, especially those dealing with complex anxiety and personality disorders involving multiple triggers and trauma – some of which may perhaps go back many years – treatment often involves designated structured programs and interventions that are of longer term duration.

These are mostly offered through various mental health clinics of which there are some good ones in Australia.

The Melbourne Clinic in Richmond, Victoria - is one of the largest in the southern hemisphere and offers a large array of programs through a busy Day Programs Unit and inpatient care through a rather large hospital.

Over the past decade, I have participated in a number of specialised treatment programs at the Melbourne Clinic relating to both generalised anxiety and OCD as well as Borderline Personality Disorder (BPD).

The programs generally involve a mix of group therapy sessions once or twice a week of up to 5 hours duration - complimented by a one on one session with a designated therapist.

These programs require a genuine commitment of time and effort as they tend to run over a number of weeks and months. They also require self-discipline and a willingness to apply the learned techniques in the ‘real world’.

Group therapy sessions – typically involving up to 14 patients of varying age and social backgrounds and often with a strong female majority – are humbling and rewarding as long as you invest emotionally and are truly respectful of fellow participants and the facilitators.

My experience with the group therapy sessions at the Melbourne Clinic has been positive and I always was made to feel accepted.

I did feel uncomfortable and out of place at times – especially when placed in a group where I was the only male in a group of 12 or 13.

I offered to leave after the first session, conscious that some women may have been struggling with issues relating to sexual or physical assault and may have felt more at ease in the absence of men.

My offer, however, was rejected.

Many of the teachings are not rocket science and rely heavily on mindfulness and being more in touch with the present.

The real challenge is to actually apply the basics in real world settings which is often much harder than it seems.

From my experience, the effectiveness of intensive programs depend critically on the competence and experience of the facilitators and the overall maturity of the participants.

Such programs are undoubtedly an important component to rehabilitation and recovery for those that need them - and as such any scope which exists to improve their effectiveness and efficiency need to be considered in the context of a ‘participation and contribution’ framework.

(iv) Rehabilitation Experience: Workers Compensation Schemes

Flexible, equitable and non-discriminatory workers compensation schemes are indispensable for the effective rehabilitation of injured or unwell members - and as such they are absolutely critical in the development of an effective participation and contribution framework.

The Commonwealth Government’s workers compensation scheme – Comcare – of which I am a member - seems to provide a more effective rehabilitation and recovery pathway for

some members as compared to others.

Comcare clients who have their claims for liability accepted whilst still serving as Commonwealth employee's - have a clear pathway for redeployment and reengagement once deemed fit to do so and therefore the prospects for sustainable rehabilitation are real.

However, Comcare clients who have their claims for liability accepted for an injury incurred while employed by the Commonwealth – but who were no longer employed when the actual claim was made – are not provided with the opportunity of re-engagement in a Commonwealth role that is broadly commensurate with their skills and experience.

This apparent discrimination seriously compromises the rehabilitation prospects of affected members - and risks placing them in a perpetual ‘anxiety trap’ - that serves to place such members at much greater risk of aggravation and relapse.

At the very least, there should be greater flexibility taking into account *why* an employee ceased Commonwealth employment after incurring or aggravating an injury which is retrospectively accepted.

In my case, I only resigned from the Commonwealth in September 2009 after being placed under significant – and I believe manifestly unreasonable and possibly illegal – duress.

Despite being an inpatient in a public mental health facility in Canberra for 3 months up to that point – and despite still having months of unused sick leave credits as well as the fact that I had/have never been charged or found guilty of any offence – I was denied access to my sick leave credits and therefore a salary.

With significant financial debts to service and bills to pay, I had no option but to resign so that I could access my unused long service leave benefits, my recreation leave and the personal contributions of my superannuation benefit. This provided me with enough income for a few months while I sold the few assets that I had left.

Given the very cruel experiences I had in the Commonwealth – especially within the Department of Prime Minister and Cabinet in the 3 or 4 years leading up to my resignation in September 2009 – and given the complex interplay of physical and psychological issues I endured – many of which were at least aggravated by the Commonwealth – to be so callously disadvantaged with absolutely no concern for my wellbeing represented an act of sheer bastardry that no employee should have to endure.

I believe that my experiences and the discrimination I continue to confront, bring into question the Commonwealth’s bona fides as an employer that is genuinely committed to the mental and physical well-being of its employees.

(v) **Rehabilitation Experience: Cost Barriers**

The cost of mental health treatment remains a very significant barrier which serves to seriously compromise rehabilitation and often cruelly ends any realistic prospects for lasting recovery.

The system is generally affordable for those dealing with acute episodes of mental illness that can be managed through GP administered medication and a short program of therapy.

Although a standard 50 minute session with an experienced psychologist can cost around \$180 – a Mental Health Plan prepared by a GP allows for up to 10 sessions to attract a Medicare rebate which significantly reduces the out of pocket expense.

However, those who are dealing with chronic or complex anxiety, personality disorders and major depression - perhaps compounded by trauma of varying intensity – face potentially life threatening cost barriers to effective treatment.

A standard 60 minute session with an experienced psychiatrist costs around \$350 – I am currently paying \$370. These normally attract a Medicare rebate – but the out of pocket expense still exceeds \$200.

Multiple sessions a month are usually required if therapy is to have any benefit – and in some cases, it is necessary to consult both a psychiatrist and a clinical psychologist. Monthly out of pocket expenses exceeding \$700 are common – not including medication.

Intensive therapy programs of the type provided by the Melbourne Clinic to treat various disorders are very expensive and can easily exceed \$20,000 per annum.

Private health insurance is often mandatory before being accepted in any program. Yet private health funds only seem to offer mental health cover after long waiting times and then only as part of their top hospital policies.

The annual premiums for such policies can exceed \$3,000 for a single adult. In 2016 I was forced to downgrade my private health cover because I could no longer afford an annual \$3,000 premium in addition to my other medical costs. By reducing my level of cover, I was effectively barred from accessing any intensive treatment programs – including a follow-up program for the Borderline Personality Disorder (BPD) I was diagnosed with in 2014.

As I continue to have only basic private hospital cover – I am not able to access any treatment programs for the eating disorder I was formally diagnosed with in May 2018.

Yet there are many others who are much worse off than me. Their prospects for any meaningful ‘participation and contribution’ are theoretically real - whilst they are alive – but practically and realistically non-existent as they suffer – most likely in silence and isolation.

PART III: Recommendations / Possible Improvements

In light of my varied experiences and challenges – of which I have discussed only some in this Submission - I would like to offer a number of ‘recommendations’ or suggestions that could perhaps be useful in the search for better ways to improve the overall mental health of the Australian people, particularly by allowing for healthier workplaces.

My suggestions principally focus on prevention, early intervention, acceptance as well as accessing better targeted treatment and rehabilitation services.

All of my ‘recommendations’ or suggested improvements reinforce or compliment the Commission’s ‘participation and contribution’ framework for this Inquiry.

(A) Prevention and Early Intervention

(i) Mandatory Development and Implementation of ‘Interactive’ Mental Health Strategies

All schools and workplaces should be required to develop and implement ‘interactive’ Mental Health Strategies that seek to inform employees and students about the symptoms, causes and suggested personal responses to mental illness, what constitutes bullying and harassment (and by definition, what doesn’t, particularly in the context of performance expectations), how to positively embrace unwell colleagues and examples of best practice with respect to maintaining a respectful workplace (or classroom).

A key objective of the Mental Health Strategies is to break down the barriers to seeking help not just by providing positive messages – but through organisational leaders actively seeking to change the internal dynamics by setting out their clear expectations that unwell or severely stressed colleagues must seek help and that failing to do so is contrary to management’s wishes and expectations.

The development of Mental Health Strategies will therefore require a clear statement of management expectations of staff with respect to the identification and treatment of stressors and related factors leading to poor mental health.

The strategies should involve much more than well intentioned and research backed messages on posters in staff/student common areas or the occasional HR message, but at least half yearly presentations to staff/students from the most senior organisational leaders assisted with external experts.

The external experts could involve the major mental health advocacy organisations, or the engagement of a senior mental health practitioner and/or a former sufferer who has been vetted to speak about his or her experiences.

Vetting could be provided by way of medical clearance through a certificate from a GP or relevant mental health practitioner with State Health Department's managing a registry or data base of available speakers or 'mentors'.

Interactive Mental Health Strategies and their effective implementation will allow organisational leaders to develop a supportive culture that is conducive to encouraging vulnerable or unwell employees or students to reach out and seek help – if not from within the organisation, then externally.

Strategies should be developed in close consultation with recognised external experts such as Beyond Blue, Lifeline and relevant Commonwealth and State Government agencies.

The development, implementation and administration of Mental Health Strategies will require some devoted resources within organisations to arrange sessions and to undertake the necessary consultations with relevant decision makers and stakeholders both within and outside the organisation as well as to oversight effectiveness and manage compliance obligations.

Small businesses as defined by Fair Work Australia that employ fewer than 15 people would not be compelled to develop and implement a Mental Health Strategy – but should be strongly encouraged to do so – perhaps by way of an annual tax incentive and the provision of free expert guidance, including through the availability of online templates and proformas, illustrations of best practice and interactive coaching through relevant Commonwealth and State Government agencies and organisations such as Beyond Blue who could perhaps be contracted on a fee for service basis by Government.

(ii) **Responsible Utilisation of Performance Management Systems**

It is imperative that Performance Management Systems and assessment processes are utilised by management as intended and consistent with all applicable workplace laws relating to workplace harassment and bullying.

While management has an undisputed right and an obligation to address sub optimal or poorly performing employees – staff must not be ambushed with unsubstantiated allegations or criticisms in formal performance assessments and must be accorded every opportunity – including through a formal documented process – to address any real or perceived performance issue.

The principle of 'constant feedback' should be the accepted operating standard whereby employees are coached, mentored and directed on a day to day basis with both positive and constructive corrective feedback provided as necessary.

Staff must never be placed in a situation whereby despite receiving consistently

positive feedback about their performance, they are told without warning in a formal performance assessment that their performance is sub optimal and inconsistent with organisational requirements to such an extent that they are effectively to be terminated.

The serious adverse impacts this can have on the relevant employee from a mental and physical health perspective is potentially profound – especially if there are pre-existing known or unknown conditions which may be seriously aggravated.

(iii) **'Incentivising' Good Mental Health through Performance Management Systems**

Formal Performance Management Systems and assessment processes could potentially be utilised to provide ‘positive incentives’ for staff to undertake regular mental health checks and/or to seek professional help for existing or developing mental health conditions.

This could involve staff being required to produce as part of their formal performance assessment, a mental health certificate on an annual basis from their consulting GP or a mental health practitioner declaring that the relevant staff member has consulted the practitioner for a mental health check.

The formal performance assessment cannot be finalised until a certificate is tendered by the employee.

The certificate will not provide the employer or supervisor with any specific information or details on what, if any, mental health issues have been identified consistent with patient confidentiality requirements.

The certificate will simply confirm that the employee has undertaken a mental health check. It will be up to the relevant employee to decide whether to make any specific disclosures to his or her supervisor.

As most performance assessment processes are routinely used to determine pay increases, annual bonus payments or the perpetuation of employment, requiring employees to produce a mental health check certificate could be an effective way of facilitating the identification and possible treatment of existing or emerging mental health issues.

The major possible strength of this approach is that it helps change the organisational dynamics with respect to mental health as even the most ‘resilient’ and macho of staff will be expected to undergo a mental health check.

Stressed or vulnerable employees who would otherwise hold back because of fear, shame or embarrassment – are potentially liberated from such constraints as they now have an ‘obligation’ as a dutiful employee to take the process seriously.

The potential positive impact of such an approach could be significant, even if some – perhaps many - employees choose not to seriously engage and treat the check up as an irritant.

The ability of a highly experienced, perceptive and well trained therapist to identify distress and possible stressors in a client – even in a single session – ought not be underestimated.

The costs incurred by the employee in the preparation of a Mental Health Statement should be met by the employee. An annual mental health check-up is not onerous and represents a personal investment in their own well-being while also being consistent with mutual obligation.

To the extent that the initial assessment reveals a need for further sessions, the employee can develop a Mental Health Plan with his or her GP allowing for the payment of a Medicare rebate for at least the first 10 sessions with a registered psychologist.

Subject to the wishes of the employee to disclose and the economic capacity of the employer, there may be scope for longer term treatment costs to be partially offset by the employer or for remuneration arrangements to be adjusted.

(iv) **Full Disclosure Statements of Duties and Responsibilities**

It is critical that prospective employees are fully aware of the demands, expectations and responsibilities of roles before they are engaged or accept offers of employment.

The transaction costs of poor recruitment decisions are often significant for all parties – but can be a source of major distress for employees, particularly as they desperately strive to make things work - perhaps for months - and in painful isolation.

Despite the modern temptation to do so, employers should not promote roles as being ‘family friendly’ with a ‘healthy work life balance’ if the role demands routine excessive hours, always being on call and the relegation of all other priorities to the work at hand.

The unavoidable reality is that in 2019, there are still many roles of varying seniority in a number of industries that demand excessive hours and an almost complete devotion to the organisation.

There are also some industries that seem to involve higher levels of internal competitive tension to maximise performance. This need not be a problem for the right person with the right temperament and overall skill set – but it can be very

damaging for the wrong fit.

When such roles are being filled – the employer should make the stresses and demands of the role very clear – including in writing.

It is far easier to commit and successfully perform a role that demands an 80-100 hour week with routine late night and weekend commitments and the constant electronic intrusion into your limited free time – if the demands and expectations of the role are clearly identified upfront.

(v) **'Invested' Organisational Management and Leadership**

The attainment of a respectful and ‘safe’ workplace that positively encourages all employees to reach out and seek assistance with issues that may be adversely impacting their mental health – requires genuine leadership and ‘buy in’ from the very top of an organisation.

While effective delegation is critical to maximise operational performance - there are some issues that demand top level ownership and visibility.

The most senior leaders of an organisation should be willing to make the time and the emotional investment necessary for real and lasting change.

While there are many ways in how this can be done, the willingness of the most senior leaders to place their vulnerabilities in the open by telling their stories, is potentially very powerful as a way of building trust and a respectful workplace – all of which is critical to improving overall mental health.

(vi) **Responsible Human Resource Management: Sustainability and Accountability**

Managers and supervisors must always take their duty of care responsibilities seriously in the management of all staff, particularly with respect to work loads and expectations.

It is very often the case that in team situations, workloads are uneven with the hardest working and most reliable employees carrying the higher load.

It is also often the case that such employees rarely complain and are loathe to push back which only compounds the problem.

Managers need to be proactive and alert to what is happening in the teams they manage – and must be prepared to intervene and reallocate tasks if the distribution of work is uneven, unfair and unsustainable.

It is, however, critical that managers seeking to reallocate tasks clearly explain and rationalise their actions so as not to send the wrong message to highly

performing and dedicated employees.

It is unfair, costly and a failure of management if under-performing staff or staff poorly suited to a particular role – are able to retain their positions by free loading on other team members.

(vii) **Executive Remuneration and Mental Health**

Facilitating cultural change in workplaces and organisations so that they are better able to deal with and minimise the incidence and severity of poor mental health, requires significant commitment by executive and management staff – and a willingness to operate beyond established comfort zones and/or long standing cultural prejudices.

Providing executive staff with financial incentives to drive necessary changes and to personally ‘invest’ in the task at hand – could help generate the necessary commitment and perseverance.

Executive remuneration schemes – particularly with the payment of bonuses or annual pay adjustments – could be formally linked to clearly defined mental health goals for the relevant organisation.

Such an approach could be applicable in almost all public sector organisations and any private sector entity that has an executive or managerial group that receive performance bonuses – or annual pay adjustments.

(viii) **Management Training and Recruitment: Emotional Intelligence and Output Maximisation**

The establishment of safe, respectful and collegiate workplaces that are best able to minimise the incidence and severity of poor mental health, requires experienced managers and supervisors who are well rounded as individuals.

Although technical proficiency, experience and high intelligence are very important characteristics of an effective manager, they are not enough when it comes to creating a genuinely collegiate and respectful environment where even the most junior and least experienced staff member – who may well come from a different cultural background or a community minority – feels valued and confident enough to speak up if troubled.

Creating such an environment – which is difficult, time consuming and demands constant endeavour – requires strong emotional intelligence, genuine empathy and a willingness to connect with colleagues as individuals - while obviously being respectful of professional boundaries.

It would be desirable if a greater emphasis was placed on emotional intelligence in

formal management training and in the recruitment of staff for supervisory positions.

Emotional intelligence could be tested through responses to various hypothetical scenarios and previous experience.

Those organisations who are able to recruit, develop and retain well rounded managers who have the strong emotional intelligence to complement their technical proficiency – are likely to experience a much healthier workforce with higher productivity and lower costs.

(ix) **Mental Health Referrals: Proactive Medical Practitioners**

Medical specialists and general practitioners who are treating a patient with serious acute or chronic physical illness and who may also have a challenging prognosis – should as a matter of routine and good clinical practice – enquire as to the overall mental health of the patient and strongly encourage the patient to consult a recognised mental health practitioner.

Medical practitioners should not underestimate the potential positive impact that their demonstration of concern and empathy can have on a struggling patient.

Most serious medical conditions involve a ‘team’ of various specialities and a general practitioner to perform ongoing treatment. Having a recognised mental health practitioner – most likely a clinical psychologist with expertise in depression, anxiety, grief and trauma – should be a standard feature of ‘whole of person’ treatment – and can help identify and treat mental health issues long after the immediate physical danger has receded.

(x) **Mutual Obligation and Personal Responsibility**

Mutual obligation and the willingness to accept personal responsibility is critical in almost every aspect of life if we are to have any hope of attaining an equitable, sustainable and reasonably harmonious society.

As challenging as it is, ultimately it is the individual – be it as an employee, colleague, private citizen, retiree or student – that holds the key to better mental health.

Despite the best endeavours of employers, the health profession, interest groups, loved ones and carers – it is the individual that must assume ultimate responsibility for confronting his or her demons.

This is incredibly difficult and for the most vulnerable and damaged, it is perhaps utterly impractical – but for those who are suffering in silence and who may have done so for months or years – they need to find the inner strength, desire and

willingness to reach out and commit to a more sustainable pathway.

This requires critical self-awareness and a willingness to take some risk – even if it means those around you think less of you or choose to abandon you.

While there are no guarantees and the likelihood of failure and perpetual despair is real, the alternative is worse and very finite.

The concept of Mutual Obligation is very important and should be explained clearly and simply in all workplaces and schools to reinforce the expectations of employees and students as part of a ‘partnership’ with employers, supervisors and relevant authorities in the development of respectful and supportive environments that are better placed to support good mental health.

Resilience training is also critical. The brutal reality is that life is hard, sometimes impossibly hard - with much suffering.

It is frequently unjust – even for those who are born into wealth and privilege and who are seemingly blessed with natural beauty and the social graces.

Many people are unnecessarily cruel with only a thin veneer of civility masking their unrefined brutality. While many others will happily do you in if doing so confers a small fleeting advantage.

This has always been the case and sadly always will be.

But there is still much good if we are prepared to look for it and embrace it.

As fragile and vulnerable individuals – we can either try to leverage the good to sustain us – or we can be crushed by the sheer weight of daily living.

It is certainly the case that while some never really get to choose or just tragically lose their way in the thick fog of struggle – most do get to choose.

Leaders, educators and especially parents, need to better prepare children for the realities of life and to equip them with the emotional toolbox they need not just to survive – but to prosper.

It is critical to allow children to be children with the freedom to grow and evolve without the suffocating and potentially corrupting expectations of others.

Learning to be kind, gracious, respectful and accepting of others and especially developing the capacity to truly love – even when it hurts – is a very good starting point and need not cost anything.

(B) Treatment and Rehabilitation

(i) Accessing Cost Effective Therapies: Consideration of New Funding Arrangements for Acute and Chronic Conditions – A Mental Health Contributions Scheme (MeCS)

The cost of accessing quality treatment for both acute and chronic mental health conditions remains a very significant obstacle which must be addressed if any real progress is to be made in the national mental health crisis.

With many psychiatrists charging upwards of \$200 per hour – after the Medicare rebate – and with experienced psychologists charging upwards of \$160 for a 50 minute session – the costs of seeing a mental health practitioner become prohibitive very quickly, particularly if a condition is chronic or multiple complex conditions are involved.

While Mental Health Plans prepared by a GP are definitely helpful in the treatment of a relatively uncomplicated acute episode by providing a Medicare rebate for 10 consultations with a registered psychologist – many more than 10 consultations are often required for many conditions.

The waiting periods for mental health cover from many health funds are prohibitively long – and seemingly growing longer - with many funds now also tightening the basis upon which clients can claim.

This is especially problematic in the treatment of chronic conditions such as complex anxiety and personality disorders which involve rather intensive therapy programs often requiring multiple mental health practitioners.

For example, a 12 month Dialectal Behaviour Therapy (DBT) program – which is the standard therapy treatment for Borderline Personality Disorder - undertaken at a major mental health facility in Melbourne, costs upwards of \$20,000 with clients also required to maintain regular consultations with an external psychiatrist at additional cost.

These programs are normally offered through a Day Programs Unit and involve multiple sessions a week.

Some private health funds – despite charging a single adult annual premium of around \$3,000 for a policy that supposedly includes mental health cover – now no longer fund such treatment programs, unless the client is an inpatient of a recognised hospital. This imposes a constraint that renders private health cover practically useless.

The existing pressures on public health budgets – which will only get worse in

light of our ageing population and unfavourable demographics – suggest that it may be necessary to explore some innovative options for alleviating the significant cost barriers to effective treatment that many Australians with mental health issues confront.

While there are many options that can be considered – including a general increase in the Medicare levy with the additional revenue raised hypothecated for mental health treatment - or the imposition of a separate Mental Health Levy on broadly the same basis as the existing Medicare levy but at a lower rate – I prefer an arrangement that avoids - as much as possible - the imposition of an overall additional tax burden on the working population.

One possible option could be a Mental Health Contributions Scheme (MeCS) that draws on some of the features of the HECS-Loans scheme that has largely provided support to Australian tertiary students for 30 years.

Rather than every taxpayer paying a MeCS – only those Australians needing mental health support in addition to what the public system already provides will pay it – once annual income exceeds a pre-determined level which can be indexed annually to AWOTE or the CPI.

The MeCS could be levied at around 2 per cent of gross income once gainfully employed with a salary exceeding \$30,000 per annum - (this is significantly less than with HECS which currently commences when income reaches around \$51,000 per annum).

Also unlike HECS, a MeCS could be structured so that it does not automatically extinguish at death – with the ATO having a legal claim against a deceased estate as with any other outstanding taxes. In the event that the deceased estate has insufficient or no assets, the MeCS is extinguished and is not transferred to others.

Those accessing a MeCS type benefit will be able to finance therapy sessions in addition to those provided under the existing Mental Health Plans – and critically, they will be able to get assistance to cover the payment of some or all of an annual private health insurance premium on policies that cover specified therapy programs to treat various psychological disorders offered by recognised mental health clinics.

All MeCS participants will be required to develop designated Mental Health Plans with their GP and a registered mental health practitioner such as a clinical psychologist or psychiatrist with the plan clearly specifying the condition or disorder to be treated and by what therapy or program.

Although it is possible that an additional tax type impost may act as a disincentive to those with mental health challenges from getting help – to the extent that any such scheme could serve to materially reduce the upfront cost barriers to effective

treatment – then such a scheme could serve to act as a positive incentive to get help.

While there is a degree of ‘transparency’ in a MeCS that some mental health sufferers may baulk at – the existence of a MeCS ‘account’ will be strictly a matter between the client and the ATO/Health Department and will be protected by existing privacy provisions.

Clients will also have the right to have any reference to a MeCS excluded from their ‘My Health Record’ if they wish – although full disclosure of a complete medical history is preferable for effective whole of patient treatment, especially if a mental health sufferer requires emergency medical treatment.

A MeCS type option will no doubt create challenges and may prove politically impractical – but we will not see any genuine improvement in mental health outcomes unless the real cost barrier to quality treatment is seriously addressed in innovative and sustainable ways.

(ii) **Accessing Mental Health Services: Refining the Public Messaging**

The general public messaging regarding mental health services, particularly messages encouraging those at risk to reach out - and by definition to place their trust in the system or with friends and colleagues – are inadequate and possibly unhelpful in some circumstances.

An individual who has experienced significant breaches of trust, trauma and humiliation in various settings – including through the mental health system itself - is highly unlikely to respond positively to such messages and may well regress further.

The public messaging needs to be more diverse and cater to a wider set of circumstances and scenarios – while still being easily digestible.

The public messaging should at least acknowledge that it may take time to find the right therapist – but that it is critical to persevere.

Messaging should point out that it may be necessary to talk to many different therapists - all of whom have different experiences, capabilities and personalities - before finding someone you can ‘connect’ with and feel comfortable with – and that the need to do so is not a failing on your part.

To the extent any such messaging already exists – it should feature more prominently.

This reassurance is very important because it is easy to become discouraged by negative experiences and the associated invalidation. This can prove to be the last

straw for a highly vulnerable and exhausted individual.

(iii) **Accessing Sustainable Therapy: GP Proactivity**

As the front line of the Australian health system – General Practitioners have a critical role to play in responding to and managing the national mental health challenge.

General Practitioners should be pro-active in the identification of mental illness in their patients and should be central in the development and implementation of relevant treatment programs.

They should regularly ask about the stress loads or any stressors that may be adversely impacting the mental health of patients.

GP's should strongly encourage patients to undertake regular Mental Health Checks – at least every six months – and should be prepared to make the decision and the therapy consultation as easy as possible for the patient.

While it is increasingly common for GP clinics in urban areas to accommodate a clinical psychologist – many do not – and even for those that do, many of the psychologists are not fully embedded in the practice but simply choose to rent out a room for a short period to conduct consultations.

Where it is not possible to embed psychologists within a clinic, GP's should be encouraged to develop a local network of experienced clinical psychologists from diverse backgrounds and specialties that will allow the GP to confidently recommend a particular psychologist to his or her patient.

This can be especially useful for men – who are generally much harder to motivate to get help – and members of certain cultural or ethnic communities as well as those with poor language or literacy skills who tend to face even greater hurdles in accessing treatment.

GP clinics should also carry a much wider range of mental health information which should be prominently displayed and feature multiple scenarios in varied cultural and ethnic settings.

(iv) **Improving Treatment Effectiveness: Client Input and Consultation**

The effectiveness of therapy and clinical treatment programs could perhaps be enhanced if program co-ordinators and service providers made a more determined effort to genuinely consult with patients or ‘clients’ to better match client needs or sensitivities with service options.

For example, programs involving group therapies with a significant gender

imbalance of 12 females to 1 male (or vice versa) – should be avoided or better managed to maximise the usefulness of group therapy and to avoid the situation where the sole male (or female) may feel disenfranchised.

Similarly, if programs involve regular one on one sessions with a clinical psychologist in addition to group therapy, clients should be afforded the choice of a psychologist that also operates a private practice to allow for a continuation or a tapering off of individual therapy post program as may be required.

Simply drawing a line on individual therapy at the conclusion of the treatment program and in some cases prematurely cutting a client loose because the therapist does not practice privately – can compromise the effectiveness of treatment.

These deficiencies can largely be avoided with better management.

As most, if not all of the private clinics offering mental treatment programs rely on at least some direct or indirect Government funding, including through private health insurance rebates, it would be useful if the relevant Commonwealth and State health authorities undertook a review with the clinical providers to identify options for better service delivery.

Any such review should draw on the invited input of current or recent consumers of treatment programs with the findings and recommendations published.

(v) **Rehabilitation and Recovery: Non-Discriminatory Workplace Schemes**

Flexible non-discriminatory workplace compensation and injury schemes are fundamental for the attainment of meaningful ‘participation and contribution’ frameworks and provide the pathway for rehabilitation, stabilisation and recovery.

Psychological or mental injury cases are undoubtedly challenging for workplaces and workplace injury schemes, in part because many psychological conditions take a very long time to resolve and the risk of relapse is real with potentially multiple and often unanticipated triggers.

The challenges are compounded when a seemingly well individual who appears to have ‘recovered’ – is not well at all.

If there is to be a genuine ‘participation and contribution’ approach to alleviating the incidence, cost and duration of mental illness, workplace injury schemes must not discriminate between eligible members by conferring more favourable re-engagement pathways and privileges to some members and not others.

For example, public sector workplace injury schemes that provide an assured pathway for employment commensurate with skills and experience for some injured members – while in effect ‘threatening’ other members with destitution by

terminating their benefits if deemed ‘fit’ – despite not having any realistic employment pathway – are not only inherently unfair but potentially fatal.

Such schemes also make it practically impossible for injured members to recover as such members are placed in a perpetual ‘anxiety trap’ which only serves to undermine and potentially aggravate the initial injury and related conditions.

The solution is relatively simple and involves ensuring that all members of any given scheme are treated equally.

Members or employees who are incapacitated through demonstrated and accepted psychological injury need to be provided with a clear pathway for productive employment in an appropriate agency or department once deemed sufficiently fit to do so - mindful that there remains a risk of relapse which may require the recommencement of treatment away from the workplace.

The relapse risk can be minimised through roles and responsibilities that are broadly commensurate with the member’s skills and experience and through the appointment of trusted and experienced mentors who are not involved in the daily supervision of the member, but who would be available to assist a returning member in his or her transition to the workplace.

The successful reengagement of such members will not only allow for lasting stabilisation and possible recovery, but will serve to minimise the overall costs and wastage of mental ill health in the workplace and the economy more broadly.

Part IV: Conclusion

In the few weeks that it has taken me to prepare this submission, more than 200 Australian men, women and children felt so overwhelmed by their pain and emotional torment that they chose death over life.

In the time that it will take to read and seriously reflect on this submission, more will have joined them.

All of these people, irrespective of their station in life, their inadequacies and likely failures – were uniquely precious human beings who had a role to play and a contribution to make.

Some will have died as they had lived – very much alone, afraid and unloved - and will be quickly forgotten thereby compounding the tragedy of their loss. While others will have left a world of suffering for loved ones who will forever struggle to comprehend the why.

Mental illness is truly a great leveller. It can affect anyone at any time and does not discriminate by age, gender, race, sexual orientation, physical beauty, class, political outlook or religious beliefs.

Every person is vulnerable in the ‘right circumstances’ - even if some are inherently more vulnerable than others through the lottery of genetics and by the sheer misfortune of ending up in an environment of abuse and neglect from the earliest age.

Those who persist in dismissing or downplaying the severity of the issues – or worse who belittle and invalidate the suffering of others – do so through ignorance, not comprehending what may well be occurring in their workplace, within their own home and in their own bed.

That there is a mental health crisis in Australia is an irrefutable reality and a national emergency. As critical as it is for our leaders, policy makers and mental health practitioners to ensure that our mental health system is resourced adequately, I believe that we can only make lasting improvements if we are able to restore a sense of dignity and self-worth to the mentally ill.

For the overwhelming majority of people, this can only happen through active participation and genuine engagement in the world of work and community service.

The ‘buy in’ of employers through the establishment of supportive and nurturing workplaces is a non-negotiable requirement if we are to have any chance of lasting success.

But it is not one-way traffic. Mutual obligation is fundamental. The mentally ill and the vulnerable must do their part.

Rehabilitation will only occur if a sufferer accepts their illness - and makes a genuine commitment to getting better.

While it is certainly the case that some people are just so badly damaged that the concept of mutual obligation is purely academic, I do not believe that this is the case for the overwhelming majority of sufferers.

In this submission, I have attempted to use the experiences I know best – my own – to demonstrate the tortured and often hidden path, causes and impacts of mental illness – as well as the importance of not making assumptions about the wellbeing and tolerances of someone without really knowing the facts.

I have also attempted to identify some of the deficiencies of our treatment approaches as well as a number of practical low cost options for alleviating the national mental health burden.

I can only hope that my willingness to share my experiences so openly and so candidly is not completely in vain.

Godwin Grech
2019