Australian BPD Foundation Limited

Advocacy & Support for Borderline Personality Disorder & Complex Trauma

Submission to the Productivity Commission
Mental Health and Suicide Prevention Agreement Review

BPD and Complex Trauma:
a Human Rights, Mental Health and Suicide Prevention Priority

1 in 10

"ONE in TEN af all suicides
is related to a diagnosis of borderline personality disorder

Treatment saves lives

With access to appropriate treatment and support services we can make significant progress towards zero suicides and enable people living with BPD to lead a full and productive life"

Rita Brown

Rita Brown - Lived experience (carer);
President Australian BPD Foundation;
Associate Director Lived Experience Workforce and Advocacy, Spectrum: specialising in Personality Disorder and Complex Trauma (Vic);
Adjunct Lecturer Monash University

For further information on this submission
contact: Rita Brown (President):

Contents

Acknowledgments

We acknowledge the diverse lands on our board and members live, work and play and pay our respects to the Traditional Custodians of those lands, recognising their ongoing connection to Country, and the impact of history on their communities.

We recognise the intergenerational impact of the history of invasion, disposition and colonisation and are committed to the recognition, respect, inclusion and wellbeing of Australia's first peoples.

We deeply value and honour the lived and living experience of everyone who have helped inform this submission in some way. I wish to especially acknowledge the people who live with suicidal distress. You have taught me more than I could ever express – about resilience, strength, the immense challenges you face daily, and the courage it takes to keep going against seemingly impossible odds. Your expertise, insights, and shared experiences are vital in shaping services that are not only safe and inclusive but also truly responsive to the needs of the community.

We recognise that the mental health system has not always provided the support that individuals deserve, and at times, it may have contributed to further trauma. In recognition of this, we are committed to fostering an environment where your voices are heard, respected, and central to the development of services that prioritise healing, understanding, and empowerment.

Australian BPD Foundation Ltd

The Australian BPD Foundation is volunteer-led and run national charity which advocates for systemic change and a positive culture that supports the recovery and wellbeing of people living with borderline personality disorder (BPD), with or without complex trauma, and their family, friends, kin (carers).

Our board members represent major stakeholders in the sector including individuals with lived experience of BPD and of people supporting someone with the condition. We aim to bring together the voices and expertise to create an open dialogue where consumer, carers and clinicians can listen to and learn from one another to create better outcomes for everyone.

The Foundation advocates that with early diagnosis, appropriate treatment and support, the prognosis for people with BPD is positive and recovery is a reality. However, without proper treatment, many experience a lifetime of stigma and discrimination, often being denied care, shunned by services or offered inadequate treatments. This results in prolonged reliance upon welfare and health systems, an outcome which could be avoided with the right support.

Terminology & Background

'**BPD**' is used to represent *borderline personality disorder* and complex trauma throughout this submission.

Clinical Guidelines - Since the NHMRC Australian *Clinical Practice Guidelines for the Management of BPD* were rescinded in 2018 we have been advised by the Minister for Health, the Hon Mark Butler MP that Australia currently operates under the UK National Institute for Health and Care Excellence (NICE) clinical guidance despite the 2011 Expert reference Group for BPD deeming Australian specific guidelines were warranted. https://www.nhmrc.gov.au/about-us/publications/clinical-practice-guideline-borderline-personality-disorder

Classification - The Foundation further recognises the UK NICE website summarises the situation as: '*the latest revision of the International Classification of Diseases (ICD-11) no longer distinguishes the previous separate types of personality disorder, but defines it as a single condition, classified by severity. The new classification does not include borderline personality disorder as a separate condition. We are currently exploring whether the existing recommendations can be amended in line with ICD-11 or whether we need to withdraw this guideline'*. [1] https://www.nice.org.uk/guidance/CG78

It is the Foundation's strong view that shifts in classification do not further neglect this group of vulnerable people who would benefit from evidence-based treatment and support associated with what we have known till now as borderline personality disorder (with or without complex PTSD).

Comorbidity There is significant comorbidity of BPD, PTSD and CPTSD i.e. 66% of people with BPD have coexisting PTSD; 50% of people with BPD will also have CPTSD and 8% with people with CPTSD will have coexisting BPD.

Suicidality - Research[2] shows that 10% of all suicides in Victoria over a five year period had a diagnosis of BPD or symptoms consistent with a diagnosis. Further research shows that this cohort of people is reaching out for help yet are unable to have their needs met. In a retrospective study of Ambulance attendances in Victoria over a seven year period between January 2012 and May 2019 found, in comparison to attendances for 'other mental health conditions that 56.2% of attendances involved suicide attempts, suicidal ideation, or non-suicidal self-injury (NSSI) related to borderline and other personality disorder. Of these 20.9% were for a suicide attempt. [3]

Executive Summary

"We deserve hope and evidence-based practice
just like every other person with a mental or health diagnosis."
Person with lived experience of BPD

We know that Treatment works[4]

Yet it is widely known that many Australians living with BPD (with or without complex trauma) experience significant suicidal distress, violation of their human rights and discrimination when reaching out for support. They are often denied or unable to access evidence-based mental health treatment and adequate psychosocial support. See examples of the experiences of accessing care that people living with BPD, the support community and clinicians have shared with us in Appendix 1. Research shows that with treatment '*most people recover, stop wanting to die, find meaning and their place in the world.*[5]

[1] https://www.nhmrc.gov.au/about-us/publications/clinical-practice-guideline-borderline-personality-disorder {accessed 09/03/2025

[2] Jillian H. Broadbear, Jeremy Dwyer, Lyndal Bugeja, Sathya Rao, Coroners' investigations of suicide in Australia: The hidden toll of borderline personality disorder, Journal of Psychiatric Research, Volume 129, 2020, Pages 241-249, https://doi.org/10.1016/j.jpsychires.2020.07.007

[3] JH Broadbear, RP Ogeil, M McGrath, DS Scott, Z Nehme, F Moayeri, D Lubman, S Rao, Ambulance attendances involving personality disorder – investigation of crisis-driven re-attendances for mental health, alcohol and other drug, and suicide-related events, Journal of Affective Disorders Reports, Volume 20, 2025, https://doi.org/10.1016/j.jadr.2025.100882 .

[4] Zanarini, M. C., Frankenburg, F. R., Reich, D. B., & Fitzmaurice, G. (2012). Attainment and stability of sustained symptomatic remission and recovery among patients with borderline personality disorder and axis II comparison subjects: a 16-year prospective follow-up study. The American journal of psychiatry, 169(5), 476–483.

[5] Gunderson JG, Stout RL, McGlashan TH, Shea MT, Morey LC, Grilo CM, Zanarini MC, Yen S, Markowitz JC, Sanislow C, Ansell E, Pinto A, Skodol AE. Ten-year course of borderline personality disorder: psychopathology and function from the Collaborative Longitudinal Personality Disorders study. Arch Gen Psychiatry. 2011 Aug;68(8):827-37. doi: 10.1001/archgenpsychiatry.2011.37 .

In 2018 a report commissioned by the National Mental Health Commission concluded *'The current Australian mental health system is not designed to best meet the needs of people living with BPD which remains highly stigmatised and misunderstood.'*[6]

In 2020 the Mental Health Productivity Commission Inquiry Report: Actions and Findings No. 95 (Action 8.1) identified that a National Stigma Reduction Strategy should *'…focus on the experiences of people with mental illness that are poorly understood by the community, including those with schizophrenia and borderline personality disorder"*[7]

The Australian BPD Foundation is extremely concerned that despite numerous reviews, agreements and the expenditure of millions of dollars, little progress has been made improving access to evidence-based treatment and psychosocial support for people living with BPD.

Traditional mental health services provide essential care, yet there is increasing recognition of the unique and vital role that peer support plays in suicide prevention. Peer support—delivered by individuals with lived experience of suicide or mental health challenges—has been shown to enhance engagement, improve recovery outcomes, and reduce stigma. We advocate that any National Suicide Prevention Strategy is informed from the outset by lived experience expertise and that peer support is a core component of any government-funded suicide prevention programs. Embedding lived experience expertise into traditional mental health services also has a considerable impact upon service accessibility, engagement, and outcomes by fostering trust, reducing stigma, and ensuring more person-centred, compassionate care.

BPD – A Human Rights, Mental Health and Suicide Prevention Priority

In 2016 the Australian BPD Foundation launched a discussion paper to trigger debate o developing a national strategy for the management and treatment of BPD: *Towards developing a National Strategy for BPD – a dollar a citizen per year will get us started in the right direction.*

In 2021 we developed a *National Consensus Statement: By, With and For People Impacted by BPD* in collaboration with and endorsed by key stakeholders in the mental health sector. It calls for a:

1. National model of care for people living with BPD

- Improve mental health outcomes for both individuals living with BPD, their carers.
- Reduce emergency service dependency through better family support and education about supportive strategies of responding to crisis. [8]
- Ensure consistent and equal access to education, support, and resources across Australia.
- Promote a collaborative, discrimination-free approach between families, mental health services, and the wider community.
- Improve early intervention, so people receive treatment before reaching crisis point.

2. Accompanying national framework for family/carers

- Provide structured psychoeducation and training on BPD, crisis response, and effective communication and coping strategies.
- Ensure access to carer support groups and mental health services to prevent carer burnout and development of their own serious mental health issues.
- Standardise the involvement of carers in treatment planning and mental health service coordination.

[6] Carrotte E, Hartup M, Blanchard M. "It's very hard for me to say anything positive": A qualitative investigation into borderline personality disorder treatment experiences in the Australian context. Aust Psychol. 2019;1–10. https://doi.org/10.1111/ap.1240010

[7] p16 Mental Health Productivity Commission Inquiry Report: Actions and Findings No. 95, 30 June 2020 {Accessed 09/03/2025] https://www.pc.gov.au/inquiries/completed/mental-health/report/mental-health-actions-findings.pdf

[8] Wheeler, J., Mildred, H., Broadbear, J., Mellor, D., & Rao, S. (2024). Assessment of suicide risk in people with borderline personality disorder: a qualitative analysis of risk protocols. Australian Psychologist, 1-6.

3. National training framework for health professionals

- All health professionals are adequately prepared to manage this population at high risk of suicidal distress, Non Suicidal Self Injury (NSSI), significant life-time disadvantage, reduced lifespan and high level of social welfare and health service involvement.
- Improve understanding, reduce human rights violations, and equip clinicians with evidence-based skills to provide compassionate care:
- Expand the capacity and capability of the workforce with the willingness and skillsets capable of delivering effective, treatment support and care across the lifespan.
- Training health professionals in evidence-based care would reduce unnecessary emergency presentations and long-term healthcare costs.
- Improve workforce wellbeing and satisfaction.
- Provide training across all sectors to create a more unified and effective healthcare response for BPD.
- Align with national health reform goals and improves service capacity.

4. Establishment of specialist centres in each state and territory of Australia

- Not discussed in this submission

5. Additional recommendation: 24/7 Teleweb Service

- Provide the person experiencing or supporting a person living with chronic risk commonly associated with BPD. Access to trained peer support to be available during business hours.
- Provide an ongoing referral point for current crisis services to use when they feel they have no alternative except to ring the police and/or ambulance.
- Provide 24/7 specialised secondary consultation and support to clinicians e.g. GPs supporting someone in their practice that they feel is at risk of suicide,
- Provide ongoing referrals to other services and supports.
- Upskill existing crisis/helpline staff.

What is borderline personality disorder (BPD)?

BPD is a common mental illness impacting at least 2-5% of the adult population with symptoms usually first appearing in mid to late teens. It is a condition of the brain and mind. If someone has BPD, it is not their fault, and they did not cause it. Many people living with BPD experience self-harm and significant suicidal ideation and may also have a history of childhood trauma. [9] [10]

Living with BPD impacts every aspect of a person's wellbeing especially the way they think and respond to emotional distress. It often results in much personal suffering, in addition to distress for their family, friends and colleagues and comes with substantial medical and welfare costs.

[9] Aikaterini Malafanti, Vasiliki Yotsidi, Georgios Sideridis, Eleni Giannouli, Evangelia P. Galanaki, Ioannis Malogiannis, The impact of childhood trauma on borderline personality organization in a community sample of Greek emerging adults, Acta Psychologica, Volume 244, 2024, https://doi.org/10.1016/j.actpsy.2024.104181

[10] Perry, C., Lee, R. (2020). Childhood Trauma and Personality Disorder. In: Spalletta, G., Janiri, D., Piras, F., Sani, G. (eds) Childhood Trauma in Mental Disorders. Springer, Cham. https://doi.org/10.1007/978-3-030-49414-8_12

BPD is characterised by a pattern of behaviours and symptoms that can be recognised by trained, experienced health professionals.

BPD is a mental illness where a person:

- *struggles with a sense of self. It is hard for a person to feel comfortable in themselves and they often live with high levels of self-hatred, worthlessness, and hopelessness,*
- *experiences challenges in relationships,*
- *frequently experiences high levels of distress and anger (may be internalised or externalised),*
- *experiences challenges in regulating their intense emotions and impulses,*
- *will often engage in self-harm behaviours and have frequent/consistent thoughts of suicide.*

To read more about the signs and symptoms of BPD, please refer to the *RANZCP Fact Sheet on Borderline Personality Disorder*.[11]

Recommendations

Implementation of the National Consensus Statement: By, With and For People Impacted by BPD [12]

In November 2019 the Australian BPD Foundation invited stakeholders and people with lived experience (consumers and carers) to a forum to participate in the development of a National BPD Consensus Statement. The day was chaired by our Patron Dr. Peggy Brown AO.

Launched in August 2021 after an iterative development process, the statement has been endorsed by numerous organisations in the Australian mental health sector, with over 500 individuals showing their support online.

1. A 'no wrong door' approach to services for people with borderline personality disorder (BPD) that enables them to access compassionate, appropriate, and strengths-based supports, regardless of complexity and their personal background.
2. People living with BPD:
    - have their need for care, treatment and support recognised early, with timely referrals in line with their wishes
    - are recognised as the experts of their life and supported to lead the planning for their own care and goals
    - receive appropriate, best-practice evidence-based psychotherapies and psychosocial supports (informed by lived experience) as needed, throughout their life
    - have access to support by trained (and supervised) peer workers
    - receive a holistic, integrative, whole-of-service approach individualised to their experiences and preferences, not a one-size-fits-all approach
    - are free from stigma and discrimination
    - are supported to live a meaningful life
    - reside within a network of family, friends, supporters, kin who are provided with the education and support they require to enable them to appropriately support the person experiencing BPD.

[11] https://www.yourhealthinmind.org/mental-illnesses-disorders/bpd {accessed 09/03/2025]
[12] https://bpdfoundation.org.au/national-consensus-statement.php {accessed 09/03/2025]

3. All mental health professionals in Australia are educated and equipped to proactively facilitate access to evidence-based pathways to recovery for people living with BPD.
    - Health professionals (including general practitioners and other primary care practitioners) have the knowledge, attitude and skills to provide compassionate triage and referral for people living with BPD to appropriate and available mental health services within a stepped model of care that is free from stigma and discrimination.
    - Clinical practice in mental health services incorporates the common factors approach for effective treatment of BPD, including being respectful, trauma-informed, strengths-based, recovery oriented and peer-informed.
4. Children at risk of psycho-social stressors are identified and issues of concern are addressed early, with appropriate supports provided for the child and their family.
5. The essential role of family, friends, supporters, kin as a part of the person's support network is acknowledged, and they are included in plans and treatment options (unless it is inappropriate to do so). Family, friends, supporters, kin are offered and able to access evidence-based, peer-informed psychoeducation and support.
6. The health system and community managed organisations that support people living with BPD are a showcase for mental health services in Australia and globally.

The statement calls on all governments and elements of the service system to work together to make our vision a reality through:

1. **Endorsement of a national model of care for people with BPD;**
2. **Accompanying national framework for the family and carers of people with BPD;**
3. **National training framework for health professionals;**
4. **Establishment of a BPD Centre of Excellence in each state and territory of Australia.**

Establishment of a 24/7 specialised Teleweb service

The establishment of a 24/7 specialised Teleweb service would:

- Support to individuals living with chronic risk associated with BPD and their supporters. Provide access to trained peer support during business hours.
- Ongoing referral point for current crisis services to use when they feel they have no alternative except police and/or ambulance
- 24/7 specialised secondary consultation and support to clinicians (e.g. GP's supporting someone in their practice they feel is at risk of suicide, and after-hours services
- Ongoing referrals to other services and supports
- Upskill existing crisis/helpline staff.

Rationale for Recommendations

1. National Model of Care for People Living with BPD

A National Model of Care for people Living with BPD is essential to address the current widespread gaps in treatment, crisis response, and long-term management. It will:

- **Improve mental health outcomes** for both individuals living with BPD and their carers.
- **Reduce emergency service dependency** through better family support and education about supportive strategies of responding to crisis.
- **Ensure consistent and equal access** to education, support, treatment and resources across Australia.
- **Promote a collaborative, discrimination-free approach** between families, mental health services, and the wider community.
- **Improve service options** to provide early intervention eg Safe Havens, peer-lead programs eg Alternatives to Suicide (Alt2Su) so people receive support and/or treatment before reaching crisis

The Australian BPD Foundation believes a national model of care is an investment that will save lives and significant savings to health budgets. It would provide consistent, evidence-based, and compassionate treatment and care for people with living with BPD, reducing suicide rates, easing pressure on emergency services, and improving long-term outcomes. Without it, people with BPD will continue to fall through the cracks of an underprepared system.

1. High Rates Suicide and Self-Harm [13] [14]

- Up to 10% of people with BPD die by suicide, with 60-90% having a history of self-injury or suicidal ideation.
- BPD accounts for 95% of personality disorder-related suicides.
- Most people with BPD experience chronic suicidality, making standard acute suicide prevention models ineffective.
- Overdose on prescribed medications is a leading cause of suicide attempts and deaths, highlighting the need for safer prescribing practices.

2. Over-Reliance on Emergency Services [15] [16]

- Ambulance and emergency departments (EDs) are often the default response to BPD crises, Unfortunately, they often cause unintended further harm and distress.
- 8.3% of BPD patients account for nearly 50% of all personality disorder-related ambulance attendances.
- 99% of people with BPD who die by suicide had prior mental health contact, but current systems fail to intervene effectively.

[13] Broadbear, J. H., Dwyer, J., Bugeja, L., & Rao, S. (2020). Coroners' investigations of suicide in Australia: The hidden toll of borderline personality disorder. Journal of Psychiatric Research, 129, 241–249. https://doi.org/10.1016/j.jpsychires.2020.07.007

[14] Ludäscher, P., Greffrath, W., Schmahl, C., Kleindienst, N., Kraus, A., Baumgärtner, U., ... & Bohus, M. (2009). Pain perception in borderline personality disorder and self-injury. Biological Psychiatry, 65(5), 432-438. https://doi.org/10.1016/j.biopsych.2008.10.023

[15] Broadbear, J. H., Rotella, J. A., Lorenze, D., & Rao, S. (2022). Emergency department utilisation by patients with a diagnosis of borderline personality disorder: An acute response to a chronic disorder. Emergency Medicine Australasia, 34(4), 731–737. https://doi.org/10.1111/1742-6723.13970

[16] Duncan, E. A., Best, C., Dougall, N., Skar, S., Evans, J., Corfield, A. R., ... & Stark, C. (2019). Epidemiology of emergency ambulance service calls related to mental health problems and self-harm: A national record linkage study. Scandinavian Journal of Trauma, Resuscitation and Emergency Medicine, 27(1), 1-8. https://doi.org/10.1186/s13049-019-0611-9

3. Lack of Access to Evidence-Based Treatment [17] [18]

- No pharmacological treatment exists for BPD, yet polypharmacy is common, leading to medication-related harm.
- Current best practice shows that reducing suicide and self-harm in people with BPD requires appropriate support and psychotherapy However, access remains limited due to appropriate skilled workforce shortages and cost barriers.
- Despite misconceptions that still exist amongst mental health practitioners BPD is treatable and for most individuals a structured generalist psychotherapy is appropriate. This is currently poorly taught in clinical curriculums. The 2013 NHMRC Clinical Guideline for the Management of BPD 19 examined the evidence-based psychotherapies available at the time and developed an overview of the 'core principles' required to offer effective treatment and support to people living with BPD. Over the intervening decade these have been further refined. Very few individuals require long-term specialist therapies such as Dialectical Behavioral Therapy, Mentalization Based Therapy or Schema Focussed Therapy.
- Only a small percentage of people with BPD receive timely, specialised care, leading to unnecessary suffering and worsening symptoms.

4. Inconsistent and Stigmatised Care across Services [20]

- Many mental health professionals feel unequipped to manage BPD especially if the person also has other co-existing condition eg AOD, leading to inconsistent care.
- Stigma within healthcare settings results in people with BPD being dismissed or undertreated, despite their high risk of suicide.
- BPD is as lethal as schizophrenia and bipolar disorder yet is often seen as "too difficult" to treat, causing fragmented or inadequate care and a potential breach of the person's human rights.

5. Cost to the Healthcare System [21] [22]

- Frequent hospital and emergency service use by BPD patients creates a financial burden on the healthcare system.
- Investing in early intervention, community-based treatment, and crisis alternatives would reduce reliance on high-cost emergency services.
- Studies show that effective BPD treatment significantly lowers healthcare costs by at least $4,000 per patient per year. [23]

[17] Meuldijk, D., McCarthy, A., Bourke, M. E., & Grenyer, B. F. (2017). The value of psychological treatment for borderline personality disorder: Systematic review and cost offset analysis of economic evaluations. PLOS ONE, 12(3), e0171592. https://doi.org/10.1371/journal.pone.0171592

[18] Zanarini, M. C., Frankenburg, F. R., Reich, D. B., & Fitzmaurice, G. (2012). Attainment and stability of sustained symptomatic remission and recovery among patients with borderline personality disorder: A 16-year prospective follow-up study. The American Journal of Psychiatry, 169(5), 476–483. https://doi.org/10.1176/appi.ajp.2011.11091407

[19] https://www.nhmrc.gov.au/about-us/publications/clinical-practice-guideline-borderline-personality-disorder {accessed 09/03/2025]

[20] McCann TV, Savic M, Ferguson N*, et al* Recognition of, and attitudes towards, people with depression and psychosis with/without alcohol and other drug problems: results from a national survey of Australian paramedics. *BMJ Open* 2018;**8:**e023860. doi: 10.1136/bmjopen-2018-023860

[21] Paris, J. (2017). Half in Love with Death: Managing the Chronically Suicidal Patient. Routledge.

[22] McCann, T. V., Savic, M., Ferguson, N., Bosley, E., Smith, K., Roberts, L., ... & Lubman, D. I. (2018). Paramedics' perceptions of their scope of practice in caring for patients with non-medical emergency-related mental health and/or alcohol and other drug problems: A qualitative study. PLOS ONE, 13(12), e0208391. https://doi.org/10.1371/journal.pone.0208391

[23] Meuldijk D, McCarthy A, Bourke ME, Grenyer BF. The value of psychological treatment for borderline personality disorder: Systematic review and cost offset analysis of economic evaluations. PloS One. 2017;12:e0171592.

2. Accompanying National Framework for Family, Friends, Supporters and Kin Supporting a Person Living with BPD

A **National Framework for the Families and Carers of People with BPD** is essential to:

- **Improve mental health outcomes** for both individuals living with BPD and their carers.
- **Reduce emergency service dependency** through better family support and crisis management strategies.
- **Ensure consistent and equal access** to education, support, and resources across Australia.
- **Promote a collaborative, discrimination-free approach** between families, mental health services, and the wider community.

A National Framework for Family and Carers of people with borderline personality disorder is essential to provide guidance, education, and support to those who play a critical role in supporting a person living with BPD. Families and carers experience significant emotional, financial, and psychological distress, yet they often receive little/no formal support. An accompanying national framework would address these issues and ensure a consistent, evidence-based approach to supporting carers across Australia. It's important to note that whilst there are some similarities in the challenges of supporting people living with other mental health conditions the experiences of a carer supporting someone with BPD/chronic suicidality is unique and highly nuanced.

1. Carers Experience High Levels of Psychological Distress [24] [25] [26]

- Families and carers of people with BPD report high levels of stress, anxiety, depression, and burnout
- Many carers experience vicarious trauma from witnessing their loved one's self-harm, suicidal behaviours, and emotional distress (NHMRC, 2012).
- carers supporting someone with BPD have a higher incidence of mental health issues of their own than carers supporting people with other mental disorders, yet few receive targeted support

2. Carers Are Critical to Reducing Crises and Emergency Service Use

- Supported and educated family involvement reduces the need for emergency services and improves long-term outcomes for people with BPD
- Many carers are the primary crisis managers, but they often lack education and support, leading to burnout and ineffective crisis responses
- A national framework would help standardise training, education, and crisis intervention strategies for carers to ensure better support.

3. Lack of Accessible and Coordinated Carer Support

- Carers often feel isolated, unsupported, and overwhelmed, yet there are limited formal support services available.
- A national framework would ensure that families have access to structured education, peer support, and professional guidance.
- Currently, support services vary across states and territories, leading to inconsistent and unequal access to essential.

[24] Bailey RC, Grenyer BF. Burden and support needs of carers of persons with borderline personality disorder: a systematic review. Harvard Review of Psychiatry. 2013;21:248-58

[25] Bailey RC, Grenyer BF. Supporting a person with personality disorder: a study of carer burden and well-being. Journal of Personality Disorders. 2014;28:796-809.

[26] Jillian H. Broadbear, Jeremy Dwyer, Lyndal Bugeja, Sathya Rao,Coroners' investigations of suicide in Australia: The hidden toll of borderline personality disorder,Journal of Psychiatric Research, Volume 129, 2020, Pages 241-249, https://doi.org/10.1016/j.jpsychires.2020.07.007. [accessed 9/03/2025]

4. Carers Play a Vital Role in Recovery, yet Are Often Excluded

- 88% of people with BPD who die by suicide had contact with mental health services within six weeks of their death.
- Carers often feel excluded from treatment decisions, despite being key figures in ongoing support.
- A national framework would promote collaboration between mental health professionals, families, and people with BPD, ensuring better communication, care coordination, and outcomes.

5. Addressing Human Rights Violation, Discrimination and Misunderstanding of BPD

- Families often face stigma from healthcare professionals and society, leading to isolation and reluctance to seek help
- Public misconceptions about BPD contribute to negative attitudes, making it harder for carers to access support and services (NHMRC, 2012).

3. A National Training Framework for Health Professionals

A National BPD Training Framework for health professionals is urgently needed in Australia to:

- Reduce human rights violations, discrimination and negative attitudes towards people with BPD.
- Ensure consistent, evidence-based care across all healthcare settings and across the lifespan.
- Substantially reduce suicide rates and improve patient outcomes.
- Reduce reliance on emergency services and lower healthcare costs.
- Expand the trained mental health workforce and improve access to psychotherapy.
- Promote integrated, coordinated care between hospitals, GPs, and mental health services.

BPD is a highly prevalent, complex, and misunderstood mental health condition that places significant demand on Australia's healthcare system. Despite the high rates of emergency presentations, suicide risk, and service engagement, many health professionals lack adequate training in diagnosing and managing BPD. A National BPD Training Framework is essential to standardise care, reduce stigma, improve patient outcomes, and enhance healthcare efficiency.

Without a nationally coordinated approach, people with BPD will continue to receive inconsistent, ineffective, and sometimes harmful care, placing both patients and the healthcare system at risk.

1. High Prevalence and Impact of BPD in Australia

- BPD affects approximately 2-5% of Australians, yet frontline health professionals frequently lack training in its best-practice support and treatment.
- Up to 23% of mental health outpatients and 43% of inpatients are estimated to have BPD (NHMRC, 2012).
- Suicide risk is extremely high—up to 10% of people with BPD die by suicide, and 60-90% engage in self-harm or suicide attempts.

2. Stigma and Negative Attitudes among Health Professionals [27]

- People with BPD experience discrimination and violation of their human rights in Australian healthcare settings, which can lead to inappropriate or dismissive treatment leading to further trauma.
- Studies show many Australian health professionals feel ill-equipped or reluctant to treat people with BPD, perceiving them as "difficult"
- Stigma directly impacts patient outcomes, discouraging individuals from seeking help and increasing the risk of suicide and self-harm.

[27] Daniel Ring & Sharon Lawn (2019): Stigma perpetuation at the interface of mental health care: a review to compare patient and clinician perspectives of stigma and borderline personality disorder, Journal of Mental Health, DOI: 10.1080/09638237.2019.1581337

3. Inconsistent and Inadequate Training across Australia[28] [29]

- No mandatory, standardised training exists for Australian health professionals on BPD, leading to high variability in diagnosis, treatment, and attitudes (Productivity Commission, 2020).
- Many clinicians rely on outdated or incorrect models, contributing to ineffective treatment and over-reliance on medication, hospitalisation, and crisis services (NHMRC, 2012).
- Some emergency, general practitioners and psychiatrists receive little to no formal training on BPD, despite being key first points of contact.

4. Reducing Emergency Presentations and Healthcare Costs

- People with BPD frequently rely on emergency services due to lack of access to specialised care, with up to 50% of personality disorder-related ambulance attendances coming from just 8.3% of patients.
- Many individuals cycle through emergency departments without receiving appropriate long-term care, contributing to avoidable hospital admissions and high healthcare costs (Productivity Commission, 2020).
- Evidence-based treatments significantly reduce self-harm, crisis presentations, and long-term healthcare costs, yet access remains limited due to a lack of trained providers.
- Increase health professionals understanding on how to support people experiencing chronic suicidal ideation (a core feature of BPD)

5. Addressing the Shortage of Specialised BPD Treatment Services

- Despite BPD being a leading cause of mental health-related emergency visits, Australia lacks specialised BPD services and trained clinicians.
- Only a small percentage of people with BPD receive appropriate psychotherapy, largely due to workforce shortages and poor distribution of trained clinicians.
- Many general mental health professionals feel unequipped to provide treatment, leading to over-reliance on crisis care instead of prevention.

6. Improving Collaboration between Healthcare Sectors

- Many BPD patients are repeatedly passed between primary care, emergency services, and psychiatric hospitals without coordinated care (Productivity Commission, 2020).
- General practitioners, emergency staff, psychiatrists, and community mental health teams need unified training to ensure a consistent, coordinated response.
- Integrated care models, supported by national training, would improve continuity of care and reduce fragmentation of services (NHMRC, 2012).

7. Aligning with Australia's Mental Health Reform Priorities

- The National Mental Health Strategy and Productivity Commission reports highlight the need for better-trained mental health professionals to improve care outcomes (Productivity Commission, 2020).
- Current reforms aim to strengthen workforce training in evidence-based mental health care, making BPD an urgent priority

[28] Lindell-Innes, Rhea; Phillips-Hughes, Alexander L.; Bartsch, Dianna; Galletly, Cherrie; Ludbrook, Cathy. Attitudes of psychiatry trainees towards patients with borderline personality disorder: Does the stigma begin during training? Personality and Mental Health Vol:17 Issue 4 https://doi.org/10.1002/pmh.1587

[29] Sharon Lawn and Janne McMahon (2015) Experiences of care by Australians with a diagnosis of borderline personality disorder. Journal of Psychiatric and Mental Health Nursing, 2015, volume 22, pp 510 - 521, https://api.semanticscholar.org/CorpusID:13491138

National BPD Training Strategy

In 2017 the National Mental Health Commission granted funding to the Australian BPD Foundation to build a National BPD Training and Professional Development Strategy: "Upskilling and Engaging Clinicians Working with People with Borderline Personality Disorder and their Families". This project was delivered in collaboration with Project Air Strategy (NSW), the Mental Health Professionals Network (MHPN) and Spectrum: specialising in Personality Disorder and Complex Trauma.

We commend this National Training Strategy to you as a proven way to provide a National Training Framework for Health Professionals at nominal cost

Stage	Component	Year
Stage 1	Webinars x 6	2018
Stage 2	e-learning modules x 5	2019
Stage 3	Core Competency and Train the Trainer Workshops • in all states and territories • regional and metropolitan	2021
Stage 4	Post Training Support	2022

There are several evidence-based specialist treatments for BPD, such as Dialectical behaviour Therapy (DBT), Mentalization-Based Treatment (MBT), Schema-Focused Therapy (SFT) and Transference-Focused Psychotherapy (TFP). However, these require many years of mastery and often have limited availability. Recently, structured generalist approaches ('common factors' have been developed drawn from the core principles of 'what works' from these specialist therapies. They have been proven to work for people experiencing BPD.

The common factor principles of care can be easily incorporated into regular clinical practice and other situations when engaging with a person with BPD. This expands the capacity of the mental health sector to provide treatment and support that works and helps to ensure that every interaction (whether therapy or not) can make a therapeutic. difference.

The training provided under our National Training Strategy focussed on the 'common factors' of effective treatment and support for people with BPD that are shared by both specialist and generalist treatments[30] [31] [32] [33] [34] The aim was to upskill and engage clinicians working alongside people living with BPD and their families to improve mental health practitioners' and service providers' capacity to recognise, respond to and treat people with BPD, and provide better support to their families and carers using a 'common factors' approach.

[30] Weinberg I, Ronningstam E, Goldblatt MJ, Schechter M, Maltsberger JT. Common factors in empirically supported treatments of borderline personality disorder. Curr Psychiatry Rep. 2011 Feb;13(1):60-8. doi: 10.1007/s11920-010-0167-x. PMID: 21057901.

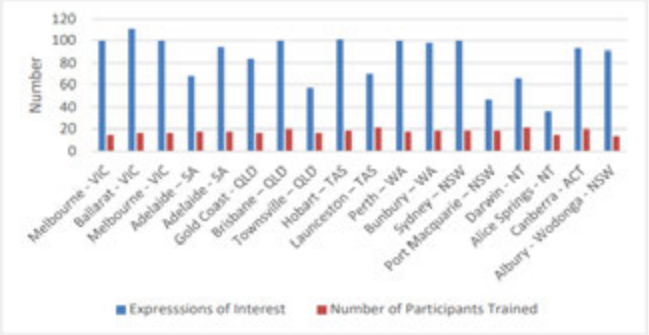
[31] Bateman, A. W., & Krawitz, R. (2013). Borderline personality disorder: An evidence-based guide for generalist mental health professionals. Oxford University Press.

[32] Beatson, J., & Rao, S. (2014). Psychotherapy for borderline personality disorder. *Australasian Psychiatry, 22*(6), 529–532. https://doi.org/10.1177/1039856214555531

[33] Choi-Kain LW, Albert EB, Gunderson JG. Evidence-Based Treatments for Borderline Personality Disorder: Implementation, Integration, and Stepped Care. Harv Rev Psychiatry. 2016 Sep-Oct;24(5):342-56. doi: 10.1097/HRP.0000000000000113. PMID: 27603742.

[34] Bateman A, Campbell C, Luyten P, Fonagy P. A mentalization-based approach to common factors in the treatment of borderline personality disorder. Curr Opin Psychol. 2018 Jun;21:44-49. doi: 10.1016/j.copsyc.2017.09.005. Epub 2017 Sep 14. PMID: 28985628.

With training, our evaluation data shows they feel empowered and motivated to work with people with BPD, thereby reducing stigma and enabling better access to care.



Expressions of interest in the training vs training provided.

Over 324 clinicians (52% metropolitan and 48% regional) participated in the Core Competency Workshops which exceeded the minimum contractual requirement of training 216 clinicians.

Click here to view the evaluation reports for this project.

4. Establishment of a BPD Centre of Excellence in each state and territory of Australia

As we do not consider this relevant to the current enquiry, we will not discuss this further.

5. Establishment of a 24/7 Teleweb (Digital service)

The establishment of a 24/7 specialised teleweb service would:

- Support to individuals living with chronic risk associated with BPD and their supporters. Provide access to trained peer support during business hours.
- Ongoing referral point for current crisis services to use when they feel they have no alternative except police and/or ambulance
- 24/7 specialised secondary consultation and support to clinicians (e.g. GP's supporting someone in their practice they feel is at risk of suicide, and after-hours services
- Ongoing referrals to other services and supports
- Upskill existing crisis/helpline staff.

Rationale

As outlined earlier BPD is often associated with self-harming behaviours, thoughts of suicide and deaths by suicide.

Many describe feeling suicidal MOST if not all the time. They have frequently lived with suicidal thoughts, behaviours and urges for years. 10% will die by suicide and many more as the result of accidental death following actions involving self-harm. Current mental health/crisis helpline workers tend to work from a perspective of acute risk and frequently do not have the skill set to support a person at chronic risk of suicide. This means that the crisis services that many people experiencing suicidal distress related to BPD are usually referred to do not have the capacity to meet their needs and inadvertently exacerbate harm.

It is essential that clinicians supporting people living with BPD have the capacity and understanding to support people living with chronic suicidal behaviour. It is vital that a helpline service dedicated to people living with BPD is developed to help move the system response away from being driven by an acute crisis response to one sensitive to their needs and minimise the iatrogenic harm currently being experienced.

There are few readily accessible service options available to people with BPD, their carers and clinicians out of hours. This is despite evenings and weekends being a time of vulnerability.

- **Hospital Emergency Departments: frequently the only option to access crisis support for** people living with BPD and their carers out of hours. It is well known that the hectic environment of emergency departments is inappropriate for people experiencing mental distress where staff focus predominantly on physical health issues. This creates iatrogenic harm and often the person is at greater risk.

  "*What do I need to do for someone take my distress seriously*"
  Person with lived experience.

- **Mainstream mental health crisis/support lines:** Mainstream crisis support telephone lines do not feel trained to provide the level of support people with severe BPD require generally. Unfortunately, we frequently hear that the currently available crisis lines, which are marketed as the 'gold standard' for people to access crisis support, do not meet the needs of people living with BPD. The reality we hear is that their responses frequently exacerbate a person's distress.
- **Peer Support Services:** [35] Peer support is a powerful and evidence-based approach to suicide prevention, offering relational, practical, and emotional benefits that traditional mental health services may not fully provide. Investing in peer support initiatives will enhance suicide prevention efforts, improve engagement with mental health services, and ultimately save lives.

  However, there are also some challenges for the services and often for the peer workers themselves[36]. Eg:

  - **Sane** staff often describe to me the challenges they and the peer workers experience in supporting callers/participants living with BPD.
  - **Roses in the Ocean Peer Warm line** – This is a call-back service. It does not offer 'real-time' support. From conversations will others it appears not to be meeting their needs and as a result they are not contacting them. Personally, as a carer I feel the service would be of little assistance to me when my family member has just stormed out of the house in intense distress and making statements of an intent to die. Similarly, it does not offer people experiencing suicidal distress or the clinicians support in 'real time'.
  - **Alt2Su** – Alternatives to Suicide is a peer-based response to supporting people who have made suicidal attempts or who have experienced suicidal thoughts. Support is offered via in person or online groups by trained peers. Anecdotally, I have heard that people have experienced the support offered through these groups as 'life-saving'.[37] [38] This service does not offer people experiencing suicidal distress, carers or the clinicians supporting them real time support.
  - **Wellbeing** of the lived experience workforce paramount and many gaps currently exist in this space eg professionalism of the workforce, services failing to make allowances for the additional stressor and experiences of vulnerability when working from the perspective of your own lived experience.

[35] Barr et al. Borderline Personality Disorder and Emotion Dysregulation (2020) 7:20 https://doi.org/10.1186/s40479-020-00135-5
[36] https://mhlepq.org.au/wp-content/uploads/2024/03/Psychosocial-Hazards-Project-Report-Final.pdf [accessed 12/03/25]
[37] https://alt2su-nsw.net/wp-content/uploads/2023/10/Alt2Su-Research-Report-August-2022-Released-Sept-2023.pdf [accessed 12/03/25]
[38] https://www.lelan.org.au/wp-content/uploads/2024/05/Alt2Su-Evaluation-Quick-read.pdf [accessed 12/03/25]

Proposal

This service would offer 24/7 Teleweb (telephone and online based) support service for people with BPD and their family/friends/carers in addition to mental health staff through the provision of primary and secondary consultation.

The service would be staffed by clinicians with expertise in BPD 24/7 and with peer workers (consumer and carer) available to offer peer support during business hours. The ability to access trained peers during business hours would assist in the development of a connection and a feeling of being listened to and 'not alone'. The line would also have the capacity to provide tailored consumer and carer-led referrals to other services and supports.

Consumers and carers would access the Teleweb service via referral from:

- Another 'crisis' line in situations where the line feels unable to support the person without calling an ambulance (considering level of risk),
- A State Crisis Assessment team,
- A General Practitioner,
- A mental health professional.

Once referred the person would be able to access support by contacting the service directly.

Clinicians working in the public, private and NGO sector would be able to access the service to support a client where required.

An ongoing role of the service would be to upskill current helpline staff and volunteers to embed appropriate responses for people living with BPD across the sector.

Evaluation

A French study [39] published in January 2024 which researched a service comparable to our proposal found the mean number of suicide attempts was 3 times lower in the hotline group and the mean number of self-injurious behaviours was 9 times lower and concludes 'Such support is easy to use, cheap and flexible, and therefore easy to implement on a large scale.'

As part of our pilot, we propose embedding an outcome monitoring framework into the initial set-up to ensure that the support service is delivering outcomes for the community and return on investment using, e.g., globally endorsed ICHOM measures[40]. Personality Disorders – ICHOM Connect

[39] Buronfosse A, Robin M, Speranza M, Duriez P, Silva J, Corcos M, Perdereau F, Younes N, Cailhol L, Gorwood P, Pham-Scottez A. The impact of a telephone hotline on suicide attempts and self-injurious behaviors in patients with borderline personality disorder. Front Psychiatry. 2024 Jan 4;14:1288195. doi: 10.3389/fpsyt.2023.1288195. PMID: 38239907; PMCID: PMC10794764.

[40] Prevolnik Rupel V, Jagger B, Fialho LS, Chadderton LM, Gintner T, Arntz A, Baltzersen ÅL, Blazdell J, van Busschbach J, Cencelli M, Chanen A, Delvaux C, van Gorp F, Langford L, McKenna B, Moran P, Pacheco K, Sharp C, Wang W, Wright K, Crawford MJ. Standard set of patient-reported outcomes for personality disorder. Qual Life Res. 2021 Dec;30(12):3485-3500. doi: 10.1007/s11136-021-02870-w. Epub 2021 Jun 2. PMID: 34075531; PMCID: PMC8602216.

Conclusion

The Australian BPD Foundation asserts that these initiatives are not just necessary but an urgent, life-saving investment in both human lives and the healthcare system.

Without immediate action, countless individuals will continue to suffer unnecessarily, and the strain on emergency, healthcare services and the community will only escalate. By implementing a National Model of Care, an accompanying Carer Framework, a Training Framework for Health Professionals, and a dedicated Teleweb Service, Australia can shift from a failing, reactive crisis model to a proactive, recovery-driven approach that prioritises prevention, support, and long-term stability.

Now is the time to act. Delay is not an option. A comprehensive, compassionate, and evidence-based response to BPD will save lives, ease the burden on families and carers, and strengthen the entire mental health system. Every Australian deserves access to quality, informed, and effective care—anything less is unacceptable.

Appendix 1 - Qualitative Data from the National Consensus Statement By, With and For People Impacted by BPD

Here we present a selection of quotes for which consent has been given to use when people recorded their support for the National Consensus Statement Campaign.

Indicative quotes:

Sharon Lawn, Chair, Lived Experience Australia says:

- *People with BPD experience significant stigma and discrimination in their attempts to access support for their mental and physical health needs. Much more needs to be done to educate the health and mental health workforce to reduce this situation. There also needs to be greater investment in ensuring evidence-based therapies that help people with this diagnosis are more widely available and accessible, earlier and more consistently regardless of where people live.*

People living with the mental distress currently diagnosed as BPD say:

- *We need to start normalising conversations about BPD in the same way we are with anxiety and depression.*
- *I have experienced the traumatising mistreatment of health care professionals & stigma in the community that comes with having a BPD diagnosis. I have also witnessed the benefits of working with properly educated health care professionals & having expert, evidence-based practice available. I know that extending this throughout the country will improve thousands upon thousands of lives, allowing people with BPD to live happy, full & productive lives, contributing to society.*
- *There is no immediate, long-term, and affordable support for people living with BPD. I am unable to access local or national support peer networks. Evidence suggests BPD requires DBT, with a minimum of 1 year treatment. Rehabilitation centres in Australia start at $40,000 to more than $100,000 for a short stay. I am now considering offshore options but this should not be the case … Early and specialised treatment should have been available and well-known when I was a child. Change needs to happen now.*
- *BPD is seriously misunderstood … and it is difficult to receive the correct treatment and support. It has dominated my life and prevented me from achieving. If earlier interventions, and stigma reduced to enable more understanding, especially from frontline workers, then lives and money could be saved.*
- *It is in everyone's best interests that people with BPD are provided with compassionate, accessible, evidence-based health care. Those affected with this condition can recover; I am proof that recovery is possible. BPD sufferers need the support, care, understanding, and awareness necessary to become the best versions of themselves. … My plea is a heartfelt, empathetic one for those, like myself who have had to suffer incredibly due to this condition.*

Family members or friends supporting someone with the mental distress currently diagnosed as BPD say:

- *This is one of the most chaotic and cruel of the mental illnesses that needs attention drawn to it. Many of the people affected are highly intelligent and creative. We need to support them and their families who are often intrinsically involved in their mental health journey. It is a loss of sense of self, a loneliness that is achingly unbearable, a dysregulated response in triggering situations and a desire to be normal but not knowing how. Skills need to be taught to both clients and carers. Health professionals must learn not to fear this group of clients.*
- *My son suffers from acute BPD but has been trying unsuccessfully to access mental health care for the last year. Because he couldn't he ended up in jail and on his release he still cannot access care.*
- *My 20yo daughter has BPD. She is unemployed, unsatisfied in life & let down by the health system (eg. has had 2 traumatic experiences with violent police intervention just to get her to the ED, which have made her worse). Our work life is now part time as we dedicate our time and finances to her. We are all slowly collapsing :(*

- *My family is being torn apart due to my daughter suffering this terrible condition. We are seeking recommended support, but it is slow, difficult to access and expensive. This does not just affect an individual it has caused emotional and physical effects in every member of our immediate family who are having to seek help. The cost in general is huge not just to us as individuals but to society in general in loss of productivity, visits to ER, the list go on. All this for the one psychological condition that can be cured with the right help.*
- *My sister was diagnosed with BPD in her early 20s and was not able to find the right type of support for her. She was able to try a couple of interventions but she still really struggled to cope, feel heard and to be understood. Unfortunately, she died by suicide at 26. I want to support any cause which ensures that appropriate and effective support is available and accessible for people with BPD so they don't have the experience that my sister did.*
- *BPD is still not well understood in the broad community and stigma is still rife. People do not choose to have BPD; and more often than not, they and their families struggle to get the help they need. Hospitals are generally an inappropriate environment for people struggling to regulate their emotions. We need more trained workers and more services geared to supporting people with BPD, including short and long stay accommodation services with the right supports in situ. Supporting people with BPD appropriately has been shown to be cost effective. It is time for a significant increase in investment into services which support people with BPD and their families.*

Worker at a youth justice centre says:

- *Working in a youth justice centre with young people (aged between 10 - 21yrs), they don't have enough services to help them with their mental health.*

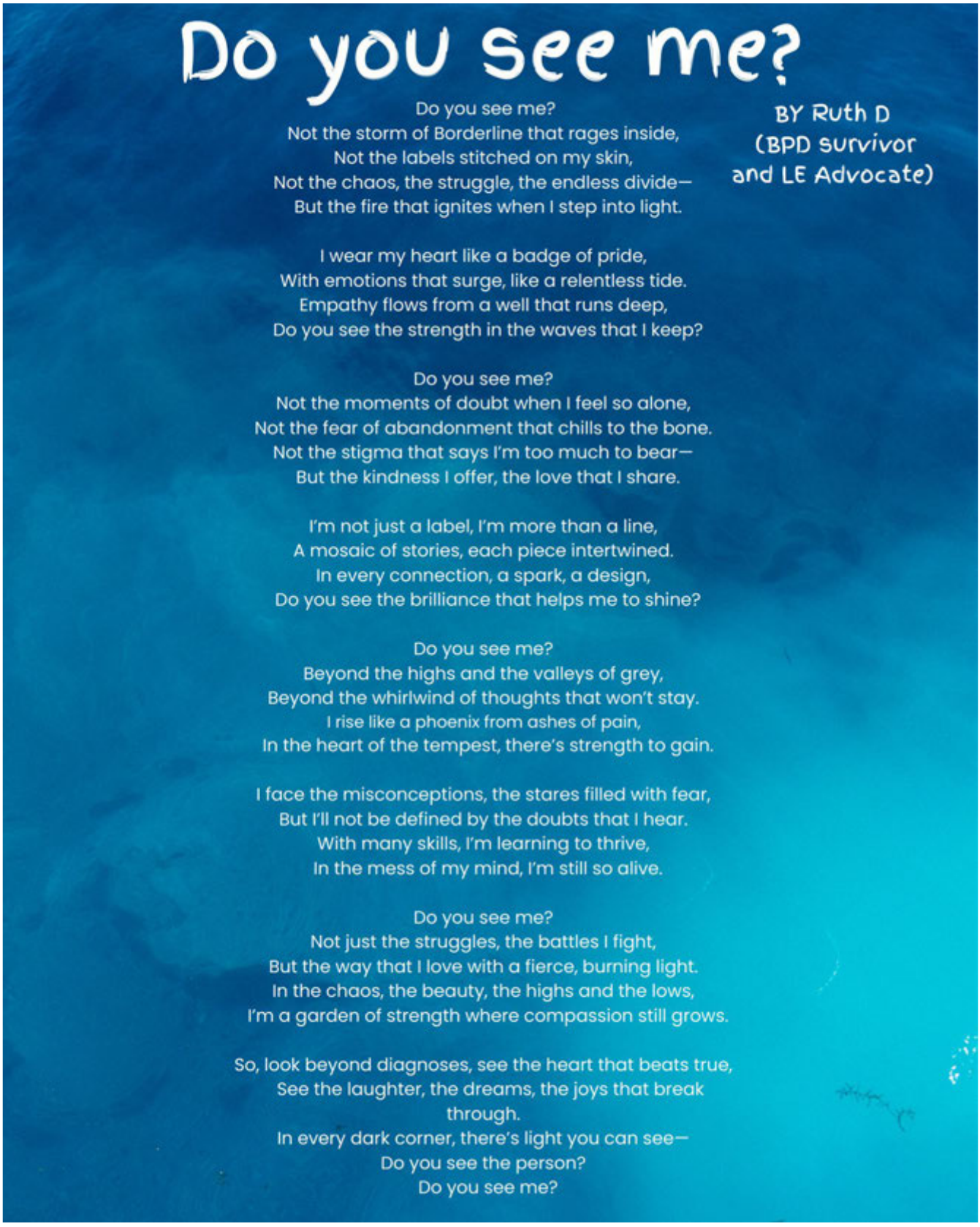
Mental Health Workers say:

- *People with Borderline Personality Disorder require specialised care and are in the top 4 diagnostic groups within my health service however have not traditionally received appropriate care.*
- *I have seen the struggle and pain caused by stigma, misdiagnosis, and waiting to see a psychologist. I have witnessed mistreatment of people diagnosed with BPD in the public mental health care system, especially inpatient units.*
- *As a coal-face MH clinician, I believe what is being asked for is 100% required.*
- *I work with vulnerable clients who suffer significant adverse effects to their physical, social and mental health due to the lack of support, awareness and evidence-based interventions not made available from an early age, I am passionate about this and frustrated at the lack of affordable and accessible treatment pathways.*
- *As soon as a diagnosis of BPD is seen, the individual is treated differently, and that needs to change.*
- *All health practitioners need to improve their capacity to work effectively with this cohort of patients.*
- *I have spent seven years in the community service sector supporting with a variety of mental health diagnoses, including BPD. The lack of compassion and understanding of people with BPD and the lack of availability best practice support indicates that things need to change.*
- *It's time to call out that people living with BPD can connect, can cope, can contribute. A diagnosis of BPD should bring a spark of hope about what's possible, and I want to be part of that change.*

Assoc. Prof Josephine Beatson, Patron of the Australian BPD Foundation says:

I have worked with people with borderline personality disorder (BPD) for 39 years. There is still a lack of adequate and appropriate assessment and treatment services for them. The problems are vividly described in Sarah Krasnostein's Quarterly Essay, now in all major newsagents. Please read it. It demonstrates the need for a statewide (ideally nationwide) approach to care for people with BPD. People with BPD have higher levels of suicide than other mental illnesses and suffer profound emotional pain. They respond well to effective treatment, but that treatment (psychotherapy) is often unavailable

Appendix 2 – ‘Do you see me’



Do you see me?

BY Ruth D
(BPD survivor
and LE Advocate)

Do you see me?
Not the storm of Borderline that rages inside,
Not the labels stitched on my skin,
Not the chaos, the struggle, the endless divide—
But the fire that ignites when I step into light.

I wear my heart like a badge of pride,
With emotions that surge, like a relentless tide.
Empathy flows from a well that runs deep,
Do you see the strength in the waves that I keep?

Do you see me?
Not the moments of doubt when I feel so alone,
Not the fear of abandonment that chills to the bone.
Not the stigma that says I'm too much to bear—
But the kindness I offer, the love that I share.

I'm not just a label, I'm more than a line,
A mosaic of stories, each piece intertwined.
In every connection, a spark, a design,
Do you see the brilliance that helps me to shine?

Do you see me?
Beyond the highs and the valleys of grey,
Beyond the whirlwind of thoughts that won't stay.
I rise like a phoenix from ashes of pain,
In the heart of the tempest, there's strength to gain.

I face the misconceptions, the stares filled with fear,
But I'll not be defined by the doubts that I hear.
With many skills, I'm learning to thrive,
In the mess of my mind, I'm still so alive.

Do you see me?
Not just the struggles, the battles I fight,
But the way that I love with a fierce, burning light.
In the chaos, the beauty, the highs and the lows,
I'm a garden of strength where compassion still grows.

So, look beyond diagnoses, see the heart that beats true,
See the laughter, the dreams, the joys that break through.
In every dark corner, there's light you can see—
Do you see the person?
Do you see me?