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To the Mental Health Productivity Commission

My name is Aaron Fornarino. I currently work full-time for the South Australian Government as a public servant and study a Bachelor of Laws and Legal Practice at Flinders University in South Australia part-time. I also undertake advocacy work in mental health-related fields where possible and am a Sane Australia Peer Ambassador.

I was diagnosed with Borderline Personality Disorder (BPD) at the age of 14 however was formally diagnosed at 18. I wish to make clear, I do not believe in anonymity because I wish to be recognised in assisting others with similar-type mental health conditions and consider myself a personal example of how to obtain employment even with an at times debilitating disorder and several life challenges. A person with such a condition may successfully seek employment with the right stability, supports and people in their lives.

I wish to discuss prevention and early intervention, seeking, gaining and maintaining employment in addition to mental health issues in the justice system. As a third-year law student, I am particularly interested in the challenges faced with acknowledging mental health in the justice system and what more can be done to assist those struggling with mental health issues.

I would like to thank the Mental Health Productivity Commission for the initiative and opportunity to present a submission. I hope you find the contents within useful, informative and consider the topics from a lived experience perspective. I do have references available, although I have not disclosed these within the document. If the Commission wishes to view these, I can make these available.

Yours faithfully

Aaron Fornarino

## PREVENTION AND EARLY INTERVENTION

As aforementioned, I was diagnosed with BPD at the age of 14 by a psychiatrist after presenting to hospital with self-harm related injuries. To assist the Commission, I will set out the diagnostic criteria for BPD as described in the Diagnostic and Statistical Manual of Mental Disorders version 5 (DSM 5).

1. Frantic efforts to avoid real or imagined abandonment (Note: Do not include suicidal or self-mutilating behaviour covered in Criterion 5)
2. A pattern of unstable and intense interpersonal relationships characterised by alternating between extremes of idealisation and devaluation
3. Identity disturbance: markedly and persistently unstable self-image or sense of self
4. Impulsivity in at least two areas that are potentially self-damaging (e.g. spending, sex, substance abuse, reckless driving, binge eating) (Note: Do not include suicidal or self-mutilating behaviour covered in Criterion 5)
5. Recurrent suicidal behaviour, gestures, or threats, or self-mutilating behaviour
6. Affective instability due to a marked reactivity of mood (e.g. intense episodic dysphoria, irritability or anxiety usually lasting a few hours and only rarely more than a few days)
7. Chronic feelings of emptiness
8. Inappropriate, intense anger or difficulty controlling anger (e.g. frequent displays of temper, constant anger, recurrent physical fights)
9. Transient, stress-related paranoid ideation or severe dissociative symptoms

Much of BPD involves severe issues with interpersonal relationships, emotional dysregulation, mood swings and impulsivity. A common misconception by some in the public and some mental health professionals are that if someone diagnosed with BPD can identify and acknowledge their symptoms, then they must know the behaviours affecting those around them. This is not entirely true.

BPD has the highest mortality rate out of any mental illness. Approximately the risk of suicide with BPD persons is 45% higher than the general population. The average life span of a person with BPD is cut by 27.5 years from that of the general population.

From personal experience, I did not have appropriate skill sets many are taught at an early age to cope with stress-related events. In turn, I would get angry, lash out, self-harm when I had no idea on how to identify an issue, figure out a solution and resolve a problem. What appeared to me and from those I have spoken to with BPD is a common theme; some mental health professionals do not have the time, tolerance, resilience and ability to listen to those experiencing the abovementioned symptoms. Some continue to deny the disorder is a mental illness and label the disorder as purely ‘behavioural’. BPD may be described by some professionals as a nuisance in the mental health care system, for example terminology used by professionals like ‘frequent flyer’ a way to describe someone with BPD who repeatedly presents to hospital seeking treatment.

The merry-go-round of hospital admissions I am all too familiar with and have borne the brunt of much questionable commentary, attitudes and treatment. I will not set these out here.

So how do governments across Australia, both Federal and State work together to combat this issue? How can the mental health care system prevent not only BPD-related admissions to emergency departments but also assist a person at an early stage with BPD to avoid some of the most destructive behaviours like self-harm and suicide attempts? There are treatments that can make a marked improvement with overall BPD symptoms and functioning. Psychiatric medication only treats certain symptoms and there is no on-going form of medication unless a comorbid condition (e.g. depression) is present.

## Investment and ATAPS

A general lack of mental health investment is one large issue. For example, in 2011, the Gillard Government stripped the ATAPS scheme from 18 sessions to just 12. I personally requested a meeting with former Attorney-General Nicola Roxon and former Federal Mental Health Minister Mark Butler over this issue. I was told the decision was a temporary 'setback'. We are now in 2019. This scheme has not changed since.

Respectfully, the Minister for Health, Greg Hunt must have known through petition mechanisms the current scheme is inadequate for people with BPD. 12 sessions are inadequate to a person with BPD when presentations to hospital and requests for help may be required on a weekly basis in various stages. I was dismayed when the Minister announced those with eating disorders would receive 40 sessions under the scheme with no mention of BPD. This is not said in anger or jealousy towards those with eating disorders, I just found this initiative a big slap in the face for many who have been campaigning for an increase in available sessions with a psychologist.

I hope the Health Minister revisits a decision at some stage to increase the amount of ATAPS for those with BPD, as it is an essential preventative measure to full-blown crises admissions to hospitals.

## Prevention is Limited

There appears to be a recommendation in the DSM 5 and previous versions adolescents cannot be diagnosed with BPD because they are not 18. Some of the reluctance stems from on-going personality development and the effects of stigma in receiving a diagnosis of BPD. Many within the mental health system who receive a diagnosis of BPD are heavily stigmatised as they draw strong reactions from health professionals. For whatever reason, the psychiatrist who diagnosed me with BPD at an early age must of seen something in myself to make the diagnosis with certainty.

I was one of the worst financially draining patients with BPD the hospital system had more than likely seen in South Australia from 1994-2000. From the ages of 14-17, I was informed by a health professional I had been admitted to hospital more than 40 times as an adolescent. Admissions personally would fluctuate from child-related wards to adult wards in adult facilities. I do not say this as a badge of honour, it is somewhat humiliating but when you quantify the amount it would have cost, it was exorbitant to keep me alive.

I was a Ward of the State at the age of 15 with transient accommodation in government units with other adolescents who were at times, violent and aggressive. I hardly went to school. When I did, it was for never long. Drug use was common place, whether it was alcohol or illicit substances. Was this an appropriate scenario or setting for an adolescent with mental health issues? Did this exacerbate my mental health problems? I believe it did.

BPD was never taken seriously or acknowledged properly by some mental health professionals in 1995 onwards. I have seen some promising signs in the last few years, particularly from the South Australian government is promising in acknowledging at least, BPD is a serious issue. Continual ignorance has been a costly exercise.

There are treatments for adolescents available. The USA appears to be leading in this area. Many of the ideas relating to prevention include capturing adolescents before things like self-harm become prominent. There are many BPD-related treatments, the most common is Dialectical Behavioural

Therapy (DBT). These treatments need more investment, more interest from professionals and a change in thinking from an older workforce mentality of BPD as an ‘untreatable disorder’.

The Commonwealth should invest more into BPD-related treatments in partnership with states and territories because the economic benefits of treating BPD at an early stage would save the apparently ever-increasing costs of health-related care.

I am an example of someone who came out of a very dark place, has gained successful employment, have a happy and healthy daughter and an ability to persevere and move forward. Sometimes I wonder what life would have been like if I had been captured earlier, if my mental health issues had been taken more seriously and if I was treated as a human being instead of a nuisance or a pest.

## SEEKING, GAINING OR MAINTAINING EMPLOYMENT

Private mental health services may be considered by the very few who have the privilege of being able to afford such a service, the reality is many with BPD end up isolated, unemployed, also possess a lack of social support and struggle financially. Someone with BPD finds it incredibly hard to meet the criteria for a Disability Support Pension and are expected to participate and work on the level as a normal unemployed adult. That is wrong in my opinion. With respect to the private health sector, the symptoms mentioned above should not be considered as a gateway for private insurers to cash out on the vulnerability of sufferers.

I first gained employment in the retail sector at the age of 27. I cannot clearly state to the Commission why I decided one day to seek employment but much of it stemmed from social isolation and boredom. The biggest preclusion to employment was my lack of schooling but also on many employment forms, a job seeker will often see the following query in both public and private sectors,

“Do you currently have any disability (including learning disability) or medical condition which might prevent or impede you from being able to satisfactorily perform any duties or functions that might be reasonably required of you in the role for which you have applied?”

From my personal experience and discussions with several other persons with BPD, this question can be the end of an application. Many of those with BPD may feel they are lying to a potential employer if they answer in the negative.

The following should not be considered as legal advice and merely an example to assist the Commission. I came across a legal case during some research and it bothered me because of a discussion regarding advising an employer about BPD. The following scenario may apply to all mental health diagnoses. This case is important in the private sector because it demonstrates an employer must not discriminate against a person with a mental illness and also, a person not ticking a health enquiry on an application form is not considered 'dishonest' in some circumstances.

A person applied for a job with a bus company and the application form asked the following question,

"Do you suffer from any medical condition, disability or injury that may have an effect on your performance of the duties in the job for which you have applied?"

He ticked no. The employer alleged this act was 'dishonest' as he had not disclosed BPD on the application form. On face value, ticking 'no' may appear dishonest but does not necessarily conclude an act of dishonesty,

> "The question on the form is confined to medical conditions, disabilities or injuries that "may have an effect on (the person's) performance of the duties" of a bus driver. Having driven a bus without incident since being diagnosed with borderline personality disorder in 2014, we find that * answered the question honestly."[1]

This person proved their case of discrimination and was awarded $10,000.

This case demonstrates an employer cannot use mental illness to discriminate against a person and doing so may backfire, if a person can prove a disadvantage. More importantly, those with a mental illness should be made aware of this fact to encourage employable opportunities. Of course, if a person does feel their illness would impede their performance in a job, a person should disclose their illness.

I consider myself fortunate to have received support from the South Australian Government in maintaining employment despite several difficulties over the years. I have received on-going support from managerial staff. I have been working full-time for nearly 7 years at the time of submission.

I hope federal and state governments will consider more initiatives for employers to recruit those who identify as having a mental illness because a cycle of low self-esteem coupled with a mental illness is an awful exclusionary situation. I hope that employers in particular are more willing to accept a person on the basis of their capability and not their illness.

## MENTAL HEALTH ISSUES IN THE JUSTICE SYSTEM

Previous figures relating to BPD were heavily gender biased towards women with a figure of 75:25 ratio often quoted by health professionals. The correct ratio is closer to 50:50. It is thought men may indulge in drug and alcohol related issues more heavily than women who may in turn be considered to seek psychiatric support and help. In short, women are extroverted with emotions whereas men have a tendency to be more introverted. Men too suffer from co-morbid drug and alcohol issues which many may end up in the criminal justice system at some point in their lives. This is not to say women do not come into contact with the criminal justice system and there have been several examples in South Australia of on-going 'ping pong' matches of responsibility towards care and treatment of individuals with BPD.

There is no data on the presence of BPD in prison populations. It should be noted BPD can co-exist with other personality disorders such as Anti-Social Personality Disorder (ASPD). Persons with mixed co-morbid personality disorders may have a poor chance of rehabilitation.

The judiciary appear to take a dim view as to BPD when used in mitigation and for the purposes of criminal sentencing. Many in the public, government and judicial arenas have a poor understanding of BPD, the mechanisms and features and see the disorder as an 'excuse' for criminal wrongdoing. Mental health professionals also differ in opinion as to whether BPD is even a mental illness. Many with BPD face on-going discrimination, stigma and unfounded criticisms. Courts have a tendency to rely on psychiatric reports for sentencing purposes.

I find the offence of disorderly behaviour interesting when a person with BPD is claimed to have a behavioural disorder. A criminal offence of this nature directed at someone with BPD is quite ironic. I personally support for all states and territories to uniform a fine mechanism for unruly behaviours instead of clogging court systems. Disorderly behaviour is also subjective, in the sense that was offensive to one person may not be offensive to another.

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[1] *Chalker v Murrays Australia Pty Ltd* [2017] NSWCATAD 112.

The law categorises mental health incompetence defences as a line between knowing whether a person has the fortitude to know what is right or wrong. I would propose because of issues that are now recognised with BPD and problems with the amygdala and pre-frontal cortex is it fair to suggest that people with BPD have a choice with brain chemistry? What difference does this make to more inherently accepted psychotic disorders such as schizophrenia and bipolar? This is not suggesting that people with BPD should not be held accountable for their actions. For example, if you were to withhold pain medication from a burn victim would you be surprised at the agitation, distress and potential abuse to follow? Of course not. That is cruel and inhumane to subject a burns victim to that sort of treatment. Why then are people with BPD treated with such disdain, contempt and apprehension? Why are governments reluctant to provide treatment when cost analysis demonstrates that with the right treatment many with a diagnosis of BPD can lead fulfilling and productive lives?

Prison environments most often exacerbate BPD-related symptoms. Issues with other inmates, staff may be a trigger for assaults which can increase a sentence. Because of poor impulse control issues, BPD can cause on-going issues for rehabilitative purposes.

BPD should be recognised by courts as a legitimate mental illness rather than an ‘excuse’ and appropriate treatment should be offered. Treatments should be accessible not only to those before sentencing but also those who are incarcerated. This may be done in the form of treatment intervention programs such as here in South Australia. It is quite rare for a person with BPD to commit an offence warranting an immediate jail term, although this does happen. Prison should be used as a last resort and I hope the judiciary are careful when considering the issue of general deterrence; people with BPD are not appropriate vehicles for general deterrence due to on-going issues with impulsivity. As a metaphor, that’s like asking a driver to prevent a crash in a shoddy car. These issues are further compounded by a lack of appropriate treatment avenues, confusing literature, sensationalist media reports and a lack of public education.

I am pleased to see South Australia is in the final stages of facilitating a new BPD Centre of Excellence based on the New South Wales, Project Air and the Victorian Spectrum model and would hope the Commonwealth assist state and territory services with long term funding. The treatments offered by professionals should be accessible, evidence-based and not just viewed as a cost benefit for governments but recognised that treatments improve lives and the mental health of the population, therefore leading to a more beneficial, equitable and strong workforce.