

Prevention and early intervention for borderline personality disorder: a novel public health priority

There is now a broad evidence-based consensus that borderline personality disorder (BPD) is a reliable, valid, common and treatable mental disorder¹. The adverse personal, social and economic consequences of BPD are severe. They include persistent functional disability², high family and carer burden³, incomplete education with fewer qualifications and disproportionately high unemployment⁴, physical ill health⁵, greater burden of mental disorders, recurrent self-harm, and a suicide rate of around 8%¹. The high economic costs of BPD (estimated to be €16,852 per patient per annum in the Netherlands) are attributable to high direct treatment costs and high indirect costs, chiefly work-related disability¹. BPD is a stronger predictor of being on disability support than either depressive or anxiety disorders⁶.

Although BPD usually has its onset in the period between puberty and emerging adulthood (young people)⁷, delay in the diagnosis and treatment is the norm, and discrimination against people with BPD is widespread. Specific treatment is usually only offered late in the course of the disorder, to relatively few individuals, and often in the form of inaccessible, highly specialized and expensive services⁴. Accumulating evidence indicates that such “late intervention” often reinforces functional impairment, disability and therapeutic nihilism.

The proliferation of knowledge about BPD in adolescents and emerging adults (“youth”) over the past two decades^{8,9} has provided a firm basis for establishing early diagnosis and treatment (“early intervention”) for BPD and for subthreshold borderline personality pathology⁷. Several salient issues arise from this literature. First, personality disorder begins in childhood and adolescence, and can be diagnosed in young people. Second, DSM-5 BPD is as valid and reliable a diagnosis in adolescence as it is in adulthood, based on similarity in prevalence, phenomenology, stability and risk factors, marked separation of course and outcome from other disorders, and efficacy of disorder-specific treatment. Third, BPD is common among young people: the estimated prevalence is 1-3% in the community, rising to 11-22% in outpatients, and 33-49% in inpatients^{7,8}. Fourth, when BPD is compared with other mental disorders, it is among the leading causes of disability-adjusted life years (DALYs) in young people⁹. BPD is also a substantial financial burden for the families of young people, with estimated average costs per annum in the US of \$14,606 out-of-pocket, plus \$45,573 billed to insurance¹⁰. Fifth, the “first wave” of evidence-based treatments has demonstrated that structured treatments for BPD in young people are effective⁴. Finally, the weight of empirical evidence has led the DSM-5 and the UK and Australian national treatment guidelines to “legitimize” the diagnosis of BPD prior to age 18.

The Global Alliance for Prevention and Early Intervention for BPD had its origins at a meeting convened under the auspices of the National Education Alliance for BPD in New York

in May 2014. The Alliance calls for action through a set of scientifically based clinical, research and social policy strategies and recommendations.

Clinical priorities include: a) early intervention (i.e., diagnosis and treatment of BPD when an individual first meets DSM-5 criteria for the disorder, regardless of his/her age) should be a routine part of child and youth mental health practice; b) training of mental health professionals in evidence-based early interventions should be prioritized; c) indicated prevention (preventing the onset of new “cases” by targeting individuals showing sub-threshold features of BPD) currently represents the best starting point toward developing a comprehensive prevention strategy for BPD; d) early identification should be encouraged through workforce development strategies (knowledge about BPD as a severe mental disorder affecting young people should be disseminated among trainees and clinicians in the child and youth mental health professions; programs should address clinician-centred discomfort with the label, mistaken beliefs, and prejudicial and discriminatory attitudes and behaviour); e) the diagnosis of BPD should not be delayed (non-diagnosis of BPD is discriminatory because it denies individuals the opportunity to make informed and evidence-based treatment decisions, and excludes BPD from health care planning, policy and service implementation, ultimately harming the young people’s prospects); f) misleading terms, or the intentional use of substitute diagnoses, should be discouraged (when sub-threshold BPD is present, terms such as “BPD features” or “borderline pathology” are preferred); g) family and friends should be actively involved as collaborators in prevention and early intervention (typically, family and friends are the “front line” for young people with BPD, and their central role should be recognized and supported).

Research priorities are as follows: a) prevention and early intervention for BPD must be integrated with similar efforts for other severe mental disorders, such as mood and psychotic disorders, acknowledging the “equifinal” and “multifinal” pathways for the development of psychopathology; b) building a knowledge base for a health care system response to prevention and early intervention for BPD can take two approaches (for indicated prevention and early intervention, a critical task is to identify risk factors for the persistence or worsening of problems, rather than the “onset” or incidence of disorder *per se*; or treatment development can be based upon causal mechanisms that underlie risk, such as environmental adversities); c) novel, low-cost preventive interventions that can be widely disseminated should be developed and evaluated (such interventions will need to be developmentally appropriate, and stage/phase specific, incorporating stepped care service models); d) education and skill development programs for families with a young person with BPD are a key priority for treatment research; e) research needs to fully quantify the educational, vocational and social

outcomes for young people with BPD; f) further development and validation of brief and “user-friendly” assessment tools is needed to promote the systematic use of standardized evaluation in research and clinical settings; g) detailed health economic data are needed to support prevention and early intervention programs for BPD and should be included in all clinical trials; h) research identifying methods to improve access to evidence-based treatments and reduce treatment dropout is a priority (this should include novel locations and formats for delivery of treatments, such as in schools, out-of-home care, or youth forensic settings).

Social and policy priorities include the following: a) BPD needs to be recognized as a severe mental disorder at all levels of the health system; b) evidence-based policy is needed to address BPD from primary through to specialist care, with the aim of building a health care system response to prevention and early intervention with young people and those who care for them as its focus, and including young people and families as partners in the design of such systems; c) discriminatory practices in health care systems must be eliminated, especially regarding BPD as a “diagnosis of exclusion” from services and refusing health insurance coverage for people with BPD.

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DOI:10.1002/wps.20429

Integrated care for mental, neurological and substance use disorders in non-specialized health settings: rising to the challenge

Worldwide, mental, neurological and substance use (MNS) disorders are major contributors to the global burden of disease as estimated by disability adjusted life years, and this is rising especially in low- and middle-income countries (LMIC)¹. MNS disorders commonly co-occur with other chronic health conditions, both communicable (e.g., HIV/AIDS) as well as non-communicable (e.g., diabetes, cardiovascular disease) and, if untreated, worsen the outcome of these conditions. People with MNS disorders and their families are doubly challenged by stigma that further worsens their quality of life, affects social acceptability, employability and interferes with help seeking.

Financial resources for developing and maintaining mental health services in LMIC are very low. The level of public expenditure on mental health is less than US\$2 per capita. Furthermore, the number of mental health workers is below 1 per 100,000 in LMIC compared to over 50 in high-income countries². The scarcity and unequal distribution of services means that 76-85% of people with MNS disorders in LMIC do not receive the care they need.

Recognizing the urgent priority to scale up services for MNS disorders, global initiatives have pressed for reforms to ensure

that people with these disorders receive care that is effective and affordable, and respects their rights and dignity^{3,4}. In line with the World Health Organization (WHO)'s leadership in the field of global public health, the Mental Health Gap Action Programme (mhGAP)⁵ was initiated, with the objectives to scale up services and enhance coverage. Through its objectives, the mhGAP is contributing towards achieving the targets of the Comprehensive Mental Health Action Plan 2013-2020, particularly in providing comprehensive, integrated and responsive mental health and social care services in community-based settings. The underlying principle of mhGAP is to strengthen non-specialist primary health care systems and providers to deliver MNS services, thus facilitating the vital link to integrate mental and physical health⁶.

To support countries to strengthen MNS care by non-specialist health care providers, the mhGAP Intervention Guide (mhGAP-IG) was developed in 2010 using evidence-based guidance and extensive stakeholder consultation. The mhGAP-IG was translated in over 20 languages and has had widespread application by a range of stakeholders in over 90 countries for integrated management of priority MNS disorders. It has been