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Review

Five failures and five challenges for prevention and early intervention for personality disorder

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Abstract

Despite global consensus regarding the early detection of personality disorder, current approaches to early intervention have failed to deliver for the majority of young people. This only serves to reinforce the enduring effects of personality disorder on functioning, mental and physical health, resulting in a reduction of quality of life and life expectancy. Here, we describe five significant challenges facing prevention and early intervention for personality disorder: identification, access to treatment, research translation, innovation and functional recovery. These challenges highlight the need for early intervention to shift from niche programmes in specialist services for a select few young people to become established in mainstream primary care and specialist youth mental health services.

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Introduction

There is now a broad evidence-based consensus that personality disorder is a reliable, valid, common and treatable mental disorder, with adverse and severe personal, social and economic consequences that include persistent functional disability, high family and carer burden, vocational disengagement and unemployment, physical ill-health, a greater burden of mental disorders and recurrent self-harm [1]. A personality disorder is associated with a nearly two-decade reduction in life expectancy [2,3], and young people with personality disorder have a ten-fold increased mortality rate compared with the general population [3]. Moreover, the associated poor short-term and long-term outcomes for young people are evident regardless of whether they meet the DSM-5 diagnostic threshold or have 'subthreshold' features of borderline personality disorder (BPD) [4,5].

Despite these damning statistics and many advances in understanding and treating personality disorder, early intervention for personality disorder has not delivered for the vast majority of young people. While many of these failures are shared in common with other mental disorders [6], personality disorder finds itself uniquely discriminated against [7] and excluded from major policy initiatives, such as the Global Burden of Disease [8] or efforts to reduce excess mortality in people with severe mental disorders [9]. In this paper, we outline five 'failures', which represent future challenges for prevention and early intervention for people with a personality disorder. For the purpose of this paper, we use the term borderline and severe personality disorder interchangeably [10].

1) Failure of identification

The clinical onset and peak prevalence of personality disorder both occur in adolescence and young adulthood [1]. The cumulative prevalence of any personality disorder from age 14–22 is 25.7% [11]. By age 24, almost one-fifth of young people with have a personality disorder, with one-fifth of these people having severe personality disorder [12]. Although people with personality disorder are high utilisers of health services, nondiagnosis or delay in diagnosis is the norm, especially in young people [1,13], where only 1% of young people attending a national primary care youth mental health service network had a primary diagnosis of BPD or 'borderline traits' recorded [13]. Evidence suggests that the true prevalence of BPD in primary care is likely to be 4 to 82 times higher than recorded [14,15].

Early intervention refers to the stage of the disorder, rather than the chronological or developmental age of the person with personality disorder [16]. Its success is

dependent upon a reliable and coherent method of early detection during this developmental period, across all healthcare settings. Such a detection system needs to recognise the continuity of personality disorder with other psychopathology and with normality [17]. Consistent with other international early intervention programmes in youth mental health, the epidemiology of the onset of the major mental disorders, normative development [18] and contemporary developmental neuroscience [19], an age range of 12–25 years 'young people' has been proposed for early intervention services [20]. Hitherto, the focus for early intervention in personality disorder has been on 'adolescents', with 18–25 year-olds falling through the gaps in service systems because they have limited access to 'adult' mental health services.

2) Access failure

Even when identified, referrals to specialist personality disorder care are infrequent [21]. Although effective specialised psychosocial treatments exist for personality disorder [22], they are usually only offered in the wake of longstanding and severe problems 'late intervention', jeopardising their effectiveness and waiting lists are common [23]. Moreover, even under ideal clinical trial conditions, poor client engagement is common, with drop out rates usually ranging from a quarter to half of the participants [e.g., Ref. [24,25]].

In addition, the treatment offered must be appropriate to the stage of the disorder. Clinical staging models that include personality pathology [26,27] allow for transdiagnostic treatment regimens to be tailored to the needs of the individual and are consistent with trends in classification reflected in the ICD-11 and DSM-5 Alternative Model for Personality Disorder [28,29].

Primary care treatment for young people with a personality disorder is inconsistent and lacks an evidence base. Recently published Australian data demonstrate that the current offerings for young people with BPD in primary care are inadequate and frequently ineffective [13]. Less than 1% of young people had a primary diagnosis of BPD or borderline traits. The engagement was poor, with a mean of 3.44 (SD 2.64) sessions. Interventions ranged from supportive counselling to narrative therapy, with the most common being CBT, delivered to only 28% by session 3. Quality of life, distress and social and occupational functioning scores showed no improvement or deterioration in 69%, 60% and 45%, respectively, suggesting that usual practice is failing this patient group.

3) Research translation failure

The delay between treatment innovations and their implementation across mental health services is up to 17 years [30]. Evidence-based therapies for personality disorder have been difficult to implement within health services due to time commitment, staff and financial resource availability and lack of organisational support. Programmes commonly fail in the real world [31–35]. An implementation science approach can improve the chances of success, but these skills are lacking in mainstream practice.

4) Innovation failure

Psychosocial treatments for personality disorder have remained largely unchanged for the past four decades, being limited to office-based, individual or group psychotherapies that have rigid and/or restrictive entry criteria, are technically complex and require lengthy training. This leads to workforce capacity constraints and limited access to services because treatments are not 'scalable'. Crucially, such models of care are particularly unsuited to young people because of their inflexibility and also because of their limited ability to address co-occurring psychopathology and psychosocial problems, which are common among this age group.

Over a decade ago, we reported that structured Good Clinical Care (GCC), which included problem-solving and clinical case management, was effective in substantially improving psychopathology, self-harm and suicidal behaviour and social and occupational functioning in 15–18 year-olds with 2–9 DSM-IV BPD features [36]. Subsequently, other clinical trials have demonstrated the effectiveness of high-quality, structured care, leading the Cochrane and other systematic reviews to conclude that specialised therapies do not appear to be superior to other forms of structured clinical care among adult or adolescent populations, particularly in the longer term [22]. Such conclusions suggest room for innovation in the 'format' and 'target' of treatment [6].

Innovations might include digital and/or family interventions [e.g., Ref. [37]], along with using novel workforces for treatment, such as peer workers. The latter are people who have lived experience of mental illness and are trained to use that experience to function in various roles, such as providing case management, facilitating groups, or providing direct support to consumers. Peer involvement in delivering mental health care is a priority identified by consumers with person-

ality disorder, their family and friends 'carers' and treating clinicians [38,39]. Peer workers actively model recovery and provide hope for individuals in treatment while providing a validating voice and practical support. Peer work has the potential to provide a much-needed avenue for improved access to care, engagement and importantly, hope for a meaningful recovery. While some studies of formal peer support in mental health settings have shown promising outcomes, the lack of structured, measurable programmes makes these difficult to interpret and implement [40,41].

'Carers' (friends, family members, guardians) of adults with BPD report greater negative experiences of care and lower mental wellbeing than carers of those with other severe mental illness, including psychotic and mood disorders [42]. While studies involving carers of young people with BPD are scarce, they describe similar patterns of burden and psychological distress [43,44]. Carer interventions have proved effective in studies of young people with first-episode psychosis [45,46] and suicidal behaviour [47], and psychoeducation has proved effective in reducing subjective burden in carers of young people with BPD [43]. Despite this, carer interventions are not routinely offered alongside treatment for BPD, and the lack of research in this area leaves a question mark as to what may be effective.

5) Functional recovery failure

Existing interventions have limited impact on key domains of functional recovery such as social connectedness, employment or quality of life [48]. Not only are these deficits the most disabling and costly aspect of personality disorder, but also achieving functional recovery is the most valued goal for young people and their families.

Self-harm and suicide are common treatment targets and measured outcomes in BPD research. This suggests that, often, the bar for the effectiveness of treatment is only set at 'survival', and not necessarily meaningful survival, or quality of life. No study has shown that reducing self-harm protects individuals from suicide, and neither severity nor frequency of self-harm appears to be predictive of suicide attempt frequency in young people with BPD [49]. Longitudinal studies have shown that functional impairments in those with BPD persist, even when diagnostic 'remission' is achieved, whether through treatment or natural attenuation of diagnostic criteria [50,51]. To date, no treatment has proven effective at producing durable, functional improvements in BPD [52]. Yet, functional impairments, such as unemployment, in young people can have long term 'scarring' effects, with reduced labour market attachment and increased risk of future unemployment [53]. Danish national data show that, compared with all other psychiatric disorders, 'first-admission' patients with BPD have 32% lower odds of being in work or education after 9 years [54]. At the time of writing, the global COVID-19 pandemic is expected to have widespread detrimental effects upon mental health [55], and the negative effects of COVID-19 restrictions are expected to continue in young people, even when enforced isolation ends [56]. COVID-19 associated mental health risks are likely to have the greatest impact on people who are already disadvantaged or marginalised [57]. Massive job losses have already occurred, and it is expected that up to 25 million people globally could face unemployment in the resultant recession [58], with the majority of primary, secondary and tertiary education sectors facing significant challenges and downturns [59]. Young people are particularly vulnerable to the threat of unemployment and face prolonged detachment from the labour market [60]. Young people with existing mental health difficulties, such as personality disorder, are at great risk of economic exclusion and marginalisation, and protracted disengagement from employment further increases long-term mental health risks [61]. Early intervention strategies that include a targeted vocational response are needed to mitigate the potentially disastrous consequences of this economic crisis on the mental health of young people with personality disorders [48].

Conclusion

While early intervention for personality disorder has come of age, it needs to move beyond the ghetto of niche programmes in specialist services for a select few young people to become established in mainstream youth mental health services across primary care and specialist mental health settings. Five challenges that must be overcome in order to establish effective and scalable early intervention strategies for personality disorders are identification, access, translation/implementation, innovation and functional recovery. Researchers and service providers should work with young people, their families and friends to address these challenges in order to ensure effective innovation and implementation of early intervention for personality disorder at all levels of health systems. Improving the effectiveness of early intervention for a personality disorder is a matter of urgency, given the likely disproportionate adverse effects that the COVID-19 recession will have on young people with personality disorders.

Author contributions

Andrew Chanen: Conceptualization, Writing - original draft, Writing - review and editing; Katie Nicol: Writing - original draft, Writing - review and editing.

Conflict of interest statement

Nothing declared.

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