Early Intervention for Adolescents with Borderline Personality Disorder: Comparison with a New Service Delivery.

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Borderline personality disorder (BPD) affects approximately 1 - 6% of the general population1,2. Symptoms usually start before adulthood, and in the general population of adolescents, the prevalence is approximately 3%3. These figures are likely to be higher, but numbers might be limited by delayed diagnosis or use of substitute terminology when sub-threshold symptoms are present such as "BPD traits", "features", or "borderline pathology". Previous research has shown that 22% of young people in outpatient clinics present BPD features4, and this prevalence is as high as 49% in inpatient adolescents5. Adolescence is a delicate period during which borderline personality traits emerge within an often complex clinical picture6. In clinical practice, the diagnosis and treatment often get delayed until adulthood. The Global Alliance for Prevention and Early Intervention for BPD asserts that early intervention, i.e. diagnosis and treatment of BPD when an individual first meets the DSM-5 criteria for the disorder, regardless of their age, should be a routine part of child and youth mental health practice7. The Alliance also asserts that very early intervention, 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.

People with a diagnosis of BPD continue to face significant challenges in seeking help, receiving effective and consistent care, and being understood8. A review of the literature reveals several Australian studies examining the application and outcomes of early intervention services for adolescents with BPD. Australia's largest youth-focused mental health organisation (Orygen) in Melbourne recently completed a large randomised control trial9. This study demonstrated marked and sustained improvement in the psychosocial functioning of adolescents with BPD across three treatment types; the Helping Young People Early (HYPE) dedicated BPD service model for young people, combing with weekly cognitive analytic therapy (CAT), HYPE combined with weekly befriending psychotherapy control condition, and a general youth mental health service (YMHS) model combined with befriending. The study concluded that early intervention is likely to be effective if it includes a service culture that is non-stigmatising towards BPD, youth-friendly and orientated to early detection and treatment for BPD.

Mentalisation Based Therapy (MBT) and Dialectical Behavioural Therapy (DBT) are recommended by the Australian Psychological Society and have been shown to have the greatest impact on suicidality and self-harm in adolescent clients seeking early intervention10. One study11 considered Headspace (a national youth-focused mental health organisation) and found that young people with diagnosed BPD or BPD traits would most commonly receive Cognitive Based Therapy (CBT), supportive counselling and Interpersonal Therapy (IPT). Although traditional CBT does not treat the core challenges of BPD, in adults, it has been found to map well onto the pathology of personality disorders. For example, CBT emphasises the connection between thought, behaviours and emotions and provides practical goals12. This study proposed that early intervention modalities should target key symptoms such as poor emotion regulation, identity, interpersonal effectiveness and self-injurious behaviour. DBT directly addresses these areas of dysfunction.

One study proposed a staging model for BPD and related potential interventions. Ranging from mild/subthreshold to 'severe', each stage of BPD requires foundational psychosocial interventions such as mental health literacy, family and individual psychoeducation, parenting skills and family interventions, substance use reduction, supportive counselling, and problem-solving13. Medications, too, may play a role when patients reach the threshold of the disorder.

A large Cochrane systematic review14 investigating the psychological therapies for people of all ages with borderline personality disorder concluded that there are indications of beneficial effects for both comprehensive psychotherapies as well as non-comprehensive psychotherapeutic interventions, for BPD core pathology and associated general psychopathology. However, there is insufficient evidence to say which therapies work best for whom. Overall, our understanding of the treatment of BPD in adolescents is limited by the low-quality evidence available at present and further research is required.

The Belmont Young Adult Unit

The Young Adult Unit (YAU) at Belmont Private Hospital is a new 10 bed in-patient unit which caters for young people age 16 to 21. While service is not specifically directed at BPD and we admit young people with a range of mental health problems, patients often present with undiagnosed co-morbid BPD. The program caters to all stages of BPD, from mild/sub-threshold to severe. The YAU offers planned three week admissions and a group therapy program which includes elements of Dialectical Behaviour Therapy (DBT), Acceptance and Commitment Therapy (ACT), Cognitive Behaviour Therapy (CBT), psychoeducation, creative therapies, life skills education, and physical activity sessions. This introduces structured psychotherapy that patients can later build on with Belmont Private Hospital's Day Therapy Program. The YAU provides in-depth diagnostic assessment, family and carer support sessions, and individual sessions with the psychiatrist, psychiatry registrar or psychologist, which can take the form of brief psychotherapy, psychoeducation or supported problem-solving. The unit also provides supported withdrawal from co-morbid cannabis and alcohol dependence.

Following discharge, patients can attend the day therapy programs which include 'DBT for Young Adults' (12 week and 6 month programs), 'ACT for Young Adults', and 'Managing ADHD', and 'Creative Therapies for Young Adults'. In parallel to this, they can receive psychiatric follow up and are encouraged to engage in ongoing individual psychological treatment.

While we have not carried out formal evaluation of outcomes, we believe that our service is in keeping with evidence based early intervention for BPD as described above. Our initial impression is that young people engage very well in the program, and show a substantial improvement inn mood and functioning, and a reduction in BPD behaviours such as self harm, suicide attempts and substance use.

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