



The National Centre of Excellence
in Youth Mental Health

Early intervention for BPD: an overdue reform

Andrew Chanen MBBS, PhD, FRANZCP

*Orygen, The National Centre of Excellence in Youth Mental Health
Centre for Youth Mental Health, The University of Melbourne
Orygen Youth Health, Northwestern Mental Health*

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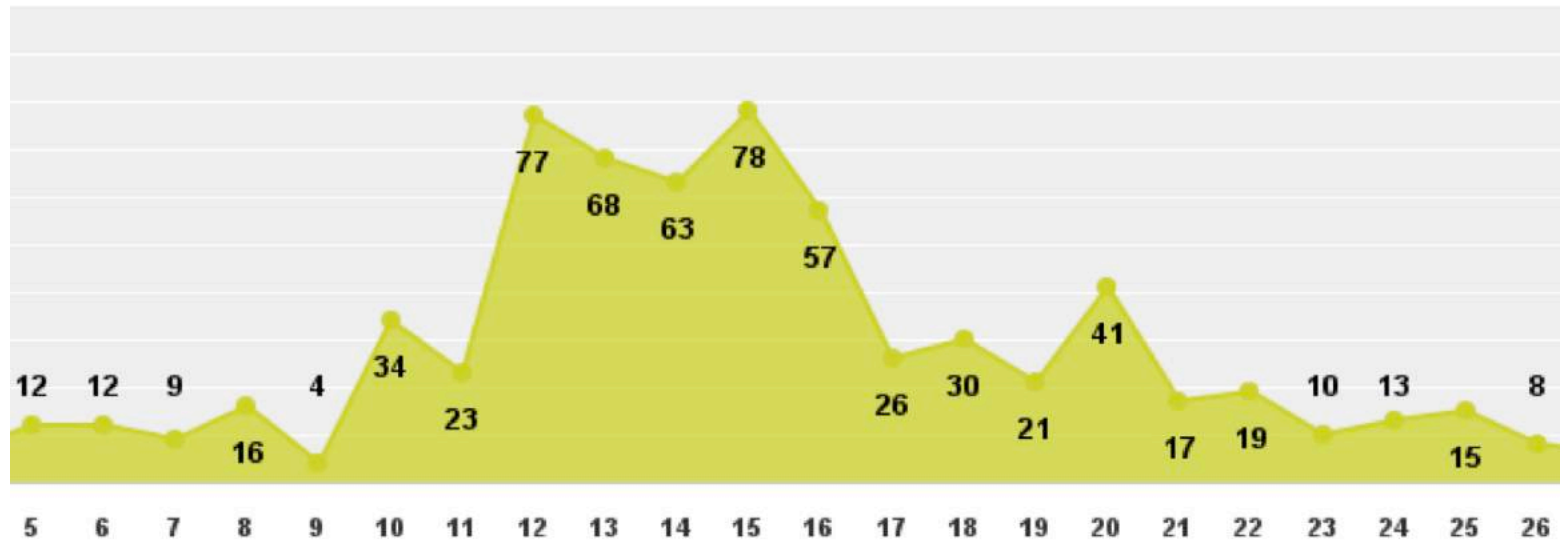
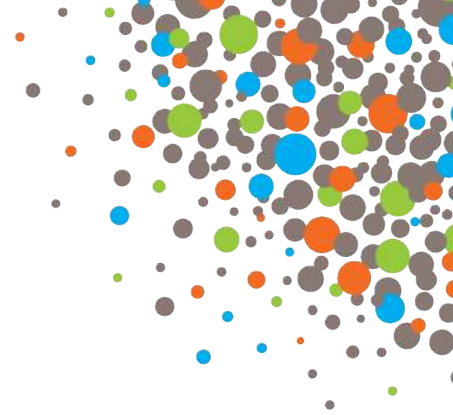
Personality disorder begins in childhood and adolescence

But DSM-5 & ICD-10 do not mention it in disorders of childhood and adolescence



Age of onset of BPD

(Hoffman, personal communication)



BPD is among the most common problems seen in psychiatric practice

Up to 1/5 psychiatric outpatients

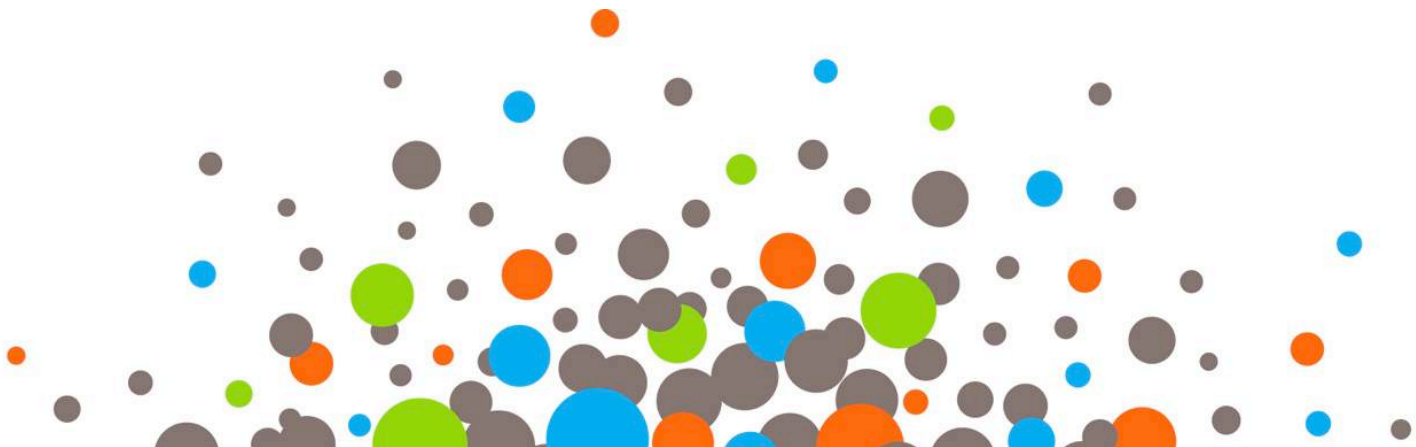
(Chanen et al. 2008, Korzekwa et al. 2008)



BPD = severe PD (Sharp 2015)

Demarcates a group with:

- high morbidity and mortality
- risk of particularly poor outcome.



The seeds of harm are sown early in the course of personality disorder (Chanen 2015)





Severe and persistent functional disability is an under-recognized and devastating hallmark of BPD

(Gunderson, Stout et al. 2011)

- Among 15- to 34-year-olds, BPD is the
 - 4th leading cause of disability-adjusted life years (DALYs) in females
 - 6th leading cause in males
- (The Public Health Group 2005)
- 15-25 year-old Australians with BPD: annual cost of reduced employment participation approx. \$475 million (Thompson, in preparation).

Vocational impairment is present early in the course of BPD

- BPD age 14 predicts poor academic and occupational attainment and greater welfare reliance 20 years later (Winograd, Cohen et al. 2008)
- 57% of 15-24 year-old BPD patients are ‘NEET’ (Chanen, in preparation)
 - first-episode psychosis 47% NEET (Caruana et al., in press).
- 40% of 20-24 year-old BPD have completed high school or equivalent (Chanen, in preparation)
 - cf 87% of community 20-24 year-olds (State Government Victoria, 2014)

Disability benefits

- PD more strongly associated with receiving disability benefits than anxiety or depression
- BPD traits have the strongest positive association with receiving disability benefits
- BPD 8 times more likely to be receiving disability benefits than those with no PD
- 40-50% BPD in receipt of the disability benefits at any point over 10-year follow-up

Unemployment is high among those with BPD (Sansone et al. 2012)

- 45% unemployed in the long term
- 20 to 45% on disability benefits



The majority of the high costs attributable to BPD are due to indirect costs

- Chiefly work-related disability (van Asselt et al. 2007, Salvador-Carulla et al. 2014)

BPD is associated with poor physical, sexual and reproductive health

- Cardiovascular disease among younger adults
- Arthritis and gastrointestinal conditions among all ages
- Youth with BPD have significantly greater substance use than their healthy peers
 - predictors of mortality
- Sexual relationships at a younger age, unsafe sex, sexual violence

8% suicide

- usually early in the course of the disorder

(Pompili, Girardi et al. 2005)



Patients with severe personality disorder have a two decade reduction in life expectancy (Fok, Hayes et al. 2012)





'Late intervention' is the norm

- Diagnosis delayed
- Treatment typically late in the course of the disorder
 - Functional impairment entrenched
 - Harms perpetrated by the health system
 - Modest effectiveness of treatment
 - Especially upon functioning

(Bateman, Gunderson, & Mulder, 2015; Gunderson et al., 2011).

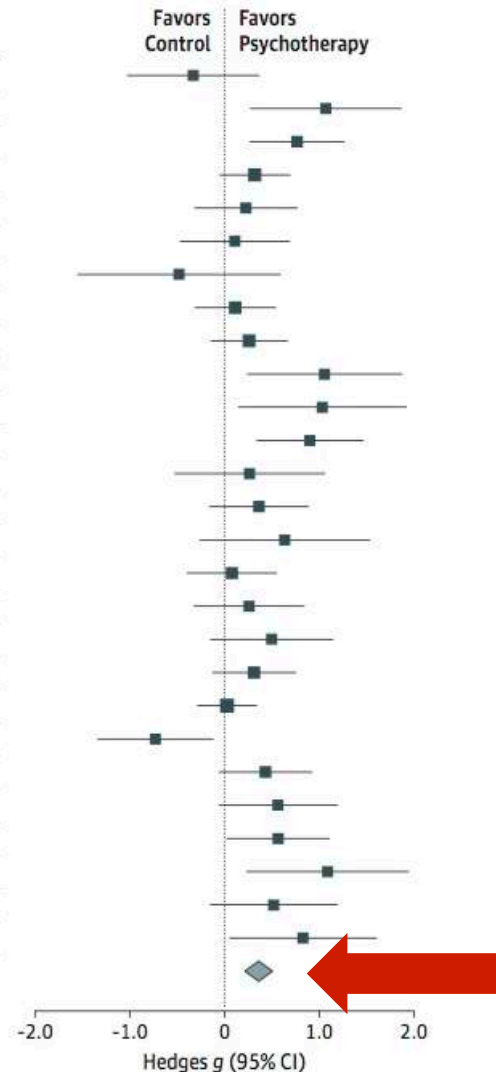


Psychotherapies are only modestly effective

Cristea et al. *JAMA Psychiatry*. 2017;74(4):319–328

Figure. Borderline-Relevant Outcomes

Source	Hedges g (95% CI)
Amianto et al, ⁴³ 2011	-0.34 (-1.01 to 0.34)
Bateman and Fonagy, ³⁷ 1999	1.06 (0.28 to 1.83)
Bateman and Fonagy, ¹⁶ 2009	0.75 (0.28 to 1.23)
Blum et al, ⁴⁴ 2008	0.31 (-0.04 to 0.66)
Bos et al, ⁴¹ 2010	0.22 (-0.30 to 0.74)
Carter et al, ⁴⁵ 2010	0.10 (-0.45 to 0.66)
Cottraux et al, ⁴⁶ 2009	-0.48 (-1.53 to 0.56)
Davidson et al, ¹⁷ 2006	0.10 (-0.30 to 0.51)
Doering et al, ¹⁸ 2010	0.25 (-0.13 to 0.64)
Farrell et al, ⁴⁷ 2009	1.04 (0.25 to 1.84)
Gratz and Gunderson, ⁴⁸ 2006	1.02 (0.16 to 1.88)
Gratz et al, ⁴⁹ 2014	0.89 (0.35 to 1.43)
Gregory et al, ⁵⁰ 2008	0.26 (-0.51 to 1.03)
Jørgensen et al, ⁵¹ 2013	0.35 (-0.15 to 0.85)
Koons et al, ⁴² 2001	0.62 (-0.25 to 1.50)
Kramer et al, ⁵² 2014	0.07 (-0.38 to 0.52)
Leppänen et al, ⁵³ 2016	0.25 (-0.31 to 0.81)
Linehan et al, ³⁸ 1991	0.49 (-0.14 to 1.11)
Linehan et al, ¹⁹ 2006	0.30 (-0.12 to 0.72)
McMain et al, ⁴⁰ 2009	0.02 (-0.27 to 0.31)
Pascual et al, ⁵⁴ 2015	-0.73 (-1.32 to -0.14)
Priebe et al, ⁵⁵ 2012	0.42 (-0.05 to 0.89)
Reneses et al, ⁵⁶ 2013	0.55 (-0.05 to 1.16)
Soler et al, ⁵⁷ 2009	0.56 (0.04 to 1.08)
Turner, ⁵⁸ 2000	1.07 (0.24 to 1.91)
Verheul et al, ³⁹ 2003	0.51 (-0.14 to 1.16)
Weinberg et al, ⁵⁹ 2006	0.82 (0.06 to 1.57)
Overall	0.35 (0.20 to 0.50)





Delay in diagnosis is potentially harmful

- Decrease likelihood of appropriate intervention
- Increased likelihood of inappropriate or harmful intervention
 - Inappropriate prescribing
 - Polypharmacy (multiple medications)



Early diagnosis and treatment leads to clinically meaningful improvements

Evidence-based treatments are more effective than 'treatment as usual'

(Chanen 2015 & 2014, Sharp & Fonagy 2015)



A health system response to BPD



Health service systems are not fit for purpose for BPD

- No coordination
- Excessive focus upon self-harm and hospitalisation
- Excessive focus on individual psychotherapy
- Marginalisation of families
- Fee for service environment unsuited to many (most?) people with BPD

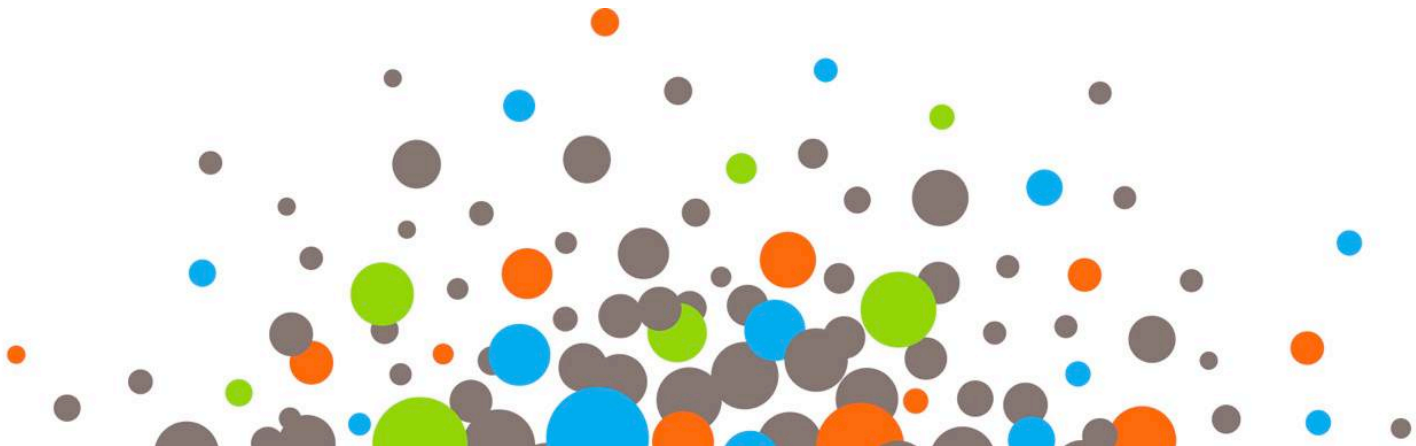




Access to evidence-based treatment poor

Dropout is unacceptably high

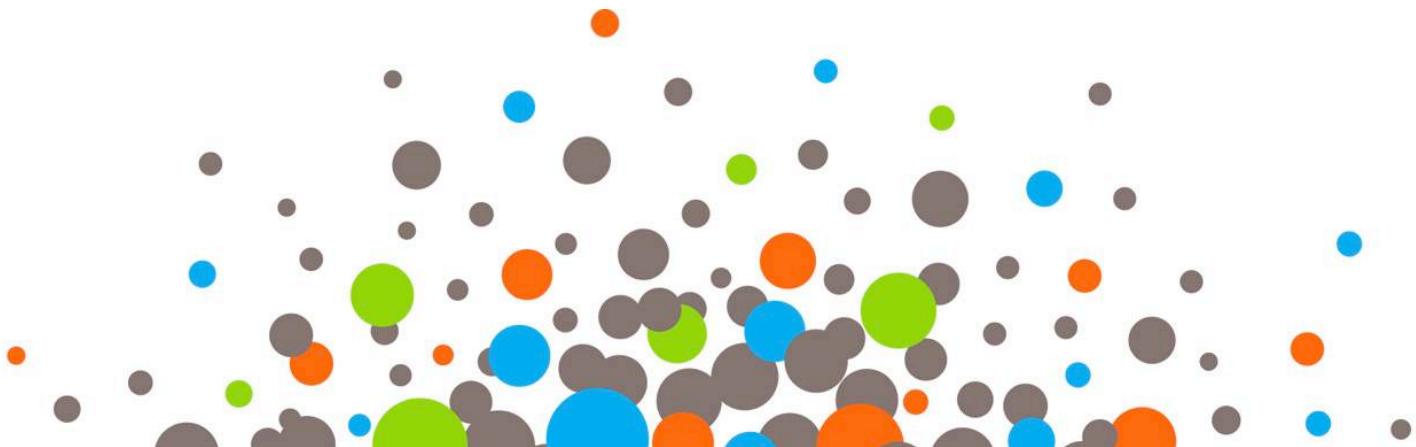
Most of the harms associated with personality disorder emerge early, so we need to intervene early



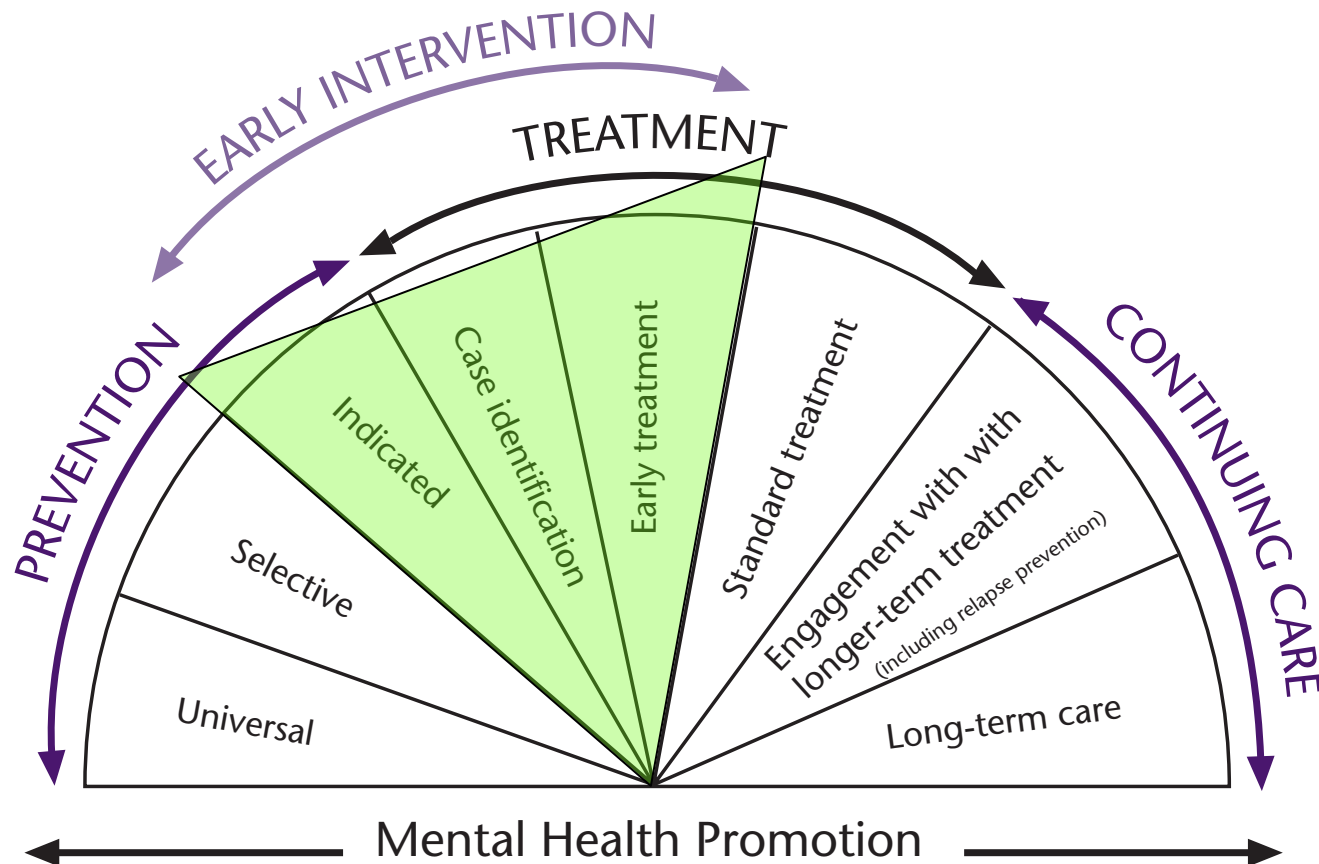


Not all treatment that occurs among young people is 'early intervention'

Many young people already have enduring problems by age 18.



What do we mean by prevention & early intervention



(adapted from Mrazek & Haggerty, 1994)

Prevention and early intervention

- Not specifically concerned with the aetiology of disorders
- Complete account of causal mechanisms unnecessary for prevention
- Identify ‘risk factors’ for persistence or deterioration of problems
 - rather than the ‘onset’ or incidence of disorder *per se*



Clinical staging

(McGorry et al 2006, 2010; McGorry 2007)

- Staging is a useful subtyping strategy to help select safe and effective treatments and predict outcome
- A more refined method of diagnosis
- Staging benefits
 - restore the utility of diagnosis
 - promote early intervention



Key principles of clinical staging



- Treatment needs differ by stage
- Treatment more benign and effective in earlier stages

(McGorry et al 2006, 2010; McGorry 2007)



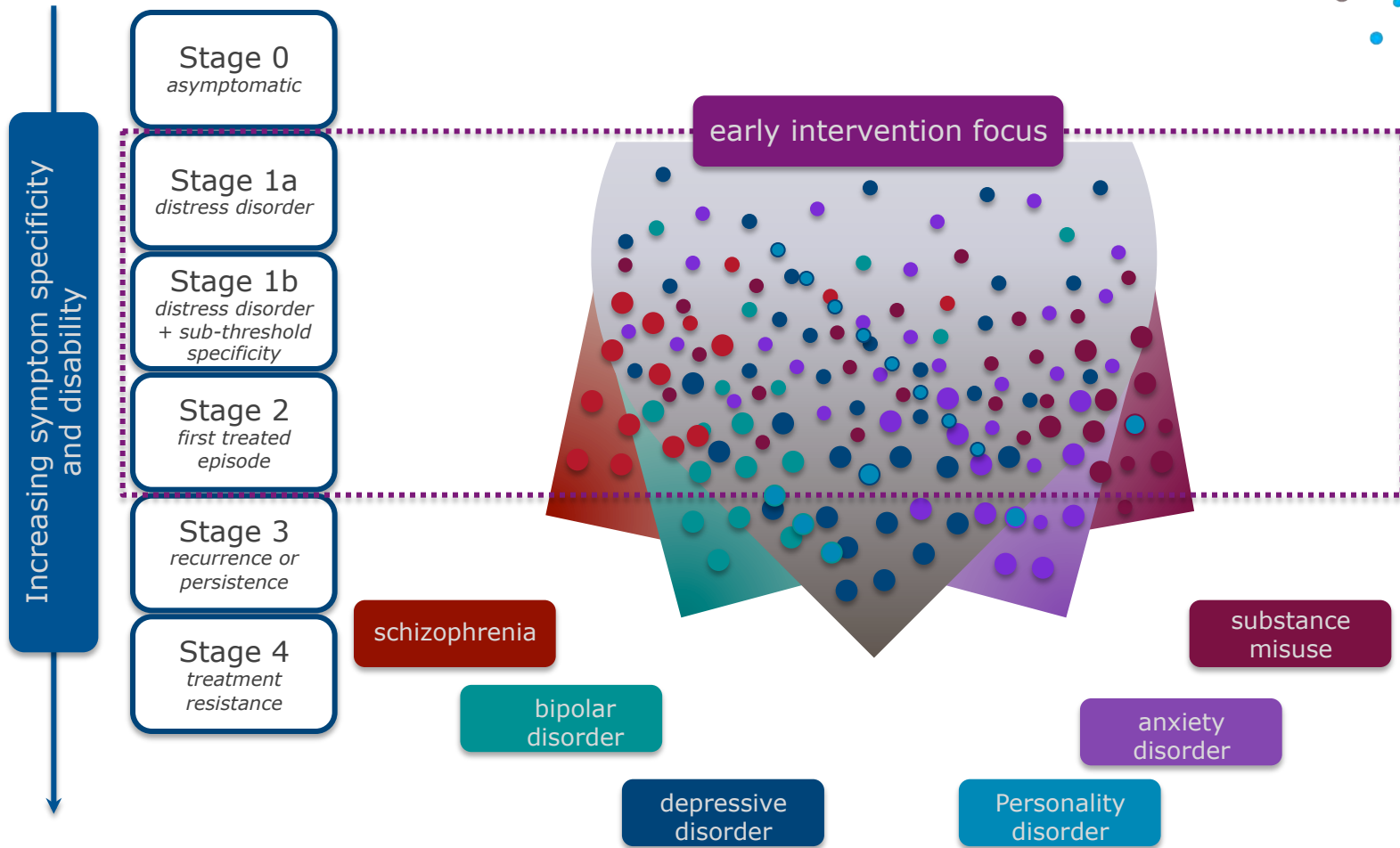




Prevention cannot happen in silos



Clinical Staging: Diagnostic utility and stepwise care



**What is the best psychotherapy
for borderline personality
disorder?**



How can we intervene early at the scale required by the prevalence of the disorder?

How can we fit the health system to the needs of young people with BPD?



What do we need to know?

- Clarify comparative effectiveness of specialised services over and above high quality mental health care
- Contribution of individual therapy over and above specialised general clinical care
- The level of training and competency required for effective delivery of services.

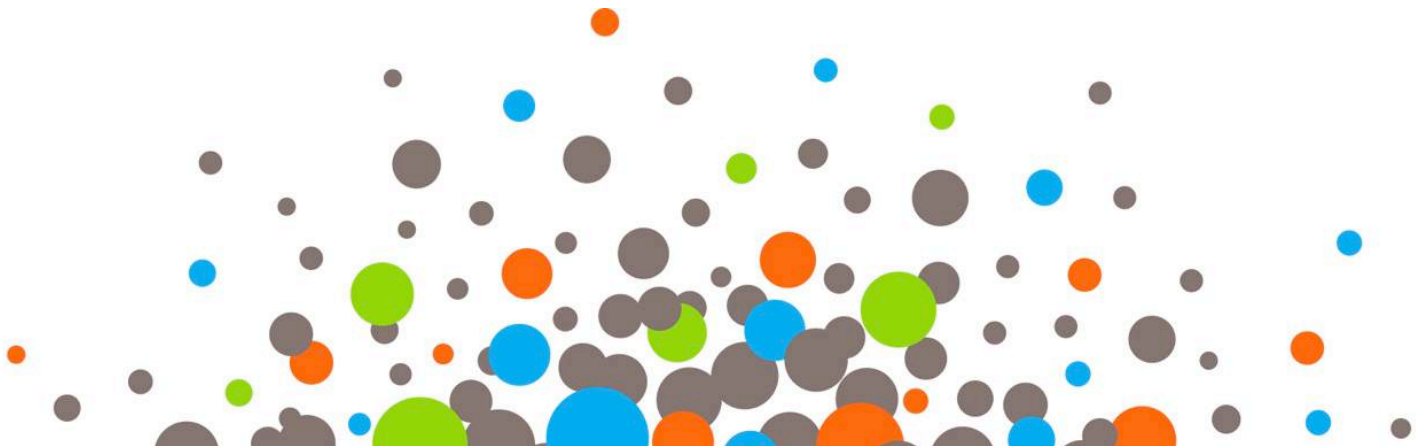


Changing the culture of mental health services



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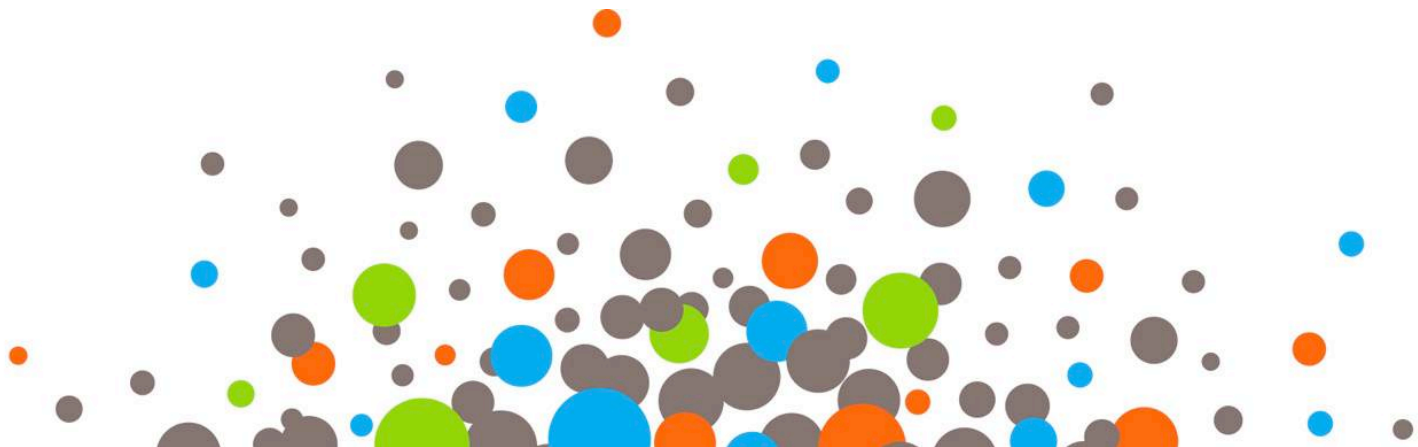
**Who would argue for late
intervention?**





**Stop delaying the diagnosis of
BPD because of fear of stigma.**

Challenge ignorance, prejudice and
discrimination among the health workforce



Address mistaken beliefs

- That personality pathology is transient or normative among young people
- That the diagnosis is not allowed in adolescence
- Nothing ‘developmentally special’ about age 18
- Abandon misleading terms such as “adolescent PD” or “emerging PD”.



It's not rocket science...



- Culture change in mental health services is necessary but not sufficient
- BPD needs a seat at the policy and planning table
- Early diagnosis and treatment a priority
- Treatment must fit needs of patients and families, not vice versa