Evidence based Psychiatric Care
Journal of the Italian Society of Psychiatry

Società Italiana di Psichiatria

Review

The implementation of evidence-based therapies for borderline personality disorder in Mental Health Services

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Summary

Objectives. This work address the implementation of the effective therapies for borderline personality disorder, with particular regard to the settings of public Mental Health Services. The objective of this review is to illustrate how to date Evidence-Based (EB) and non-EB treatments have been implemented within the framework of the possibilities and resources available.

Methods. 85 published researches have been identified and then selected on the basis of criteria of relevance to the objectives of the review. In particular, meta-analyzes, systematic reviews and RCTs were privileged. Small sample studies were excluded or cited with specification of sample component number.

Results. The critical factors of the implementation of the EB treatments for BPD (DBT, MBT, ST and TFT) in European countries, are placed on three levels: (1) the professionals involved; (2) the methodology of the treatment and (3) the level of management and organization of services. On the level of the professionals characteristics, the primary positive factors are: the non-judgmental attitude, the positive approach towards BPD, the presence of a strong and supportive leadership, the possibility of accessing supervision. The commonly encountered obstacles in the application of manual treatments are: the duration and cost of training, the continuous updates of the manuals that require frequent re-adaptations; the difficulty of applying telephone coaching, the treatment time required for each individual patient on a weekly basis. To meet the needs of psychotherapy implementation of BPD in the public mental health settings, more flexible and pragmatic approaches, like Stepped Care or Good Psychiatric Management, must be developed.

Conclusions. The need to adopt effective intervention modalities for BPD in public Mental Health Services suggests the use of pragmatic approaches that focus on the common factors of EB therapies, the modular use of the parts that can be considered effective alone. Even in absence of the complete structure of the therapy, the stepped care approach, takes the least invasive intervention as the elective one at the different stages of severity of the disorder. Finally, the dissemination of reference values (non-judgmental services), should be the general framework of treatment of BPD.

Key words: borderline personality disorder, dialectical behavioral therapy, mentalization based therapy, transference focused therapy, schema therapy, general psychiatric management, stepped care, implementation

How to cite this article: Sanza M, Campa J, Menchetti M. The implementation of evidence-based therapies for borderline personality disorder in Mental Health Services. Evidence-based Psychiatric Care 2022;8:193-201; https://doi.org/10.36180/2421-4469-2022-17

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Conflict of interest
The authors declare that they have no conflict of interest nor that they have received compensation from third parties for the creation of this article.

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Introduction

Borderline Personality Disorder (BPD) is characterized by a pervasive pattern of instability in interpersonal relationships, affects, identity and marked impulsiveness that begins in early adulthood and is expressed in various contexts [1]. Surveys estimates hypothesize the prevalence of BPD around 1.6% of the general population and 20% in the clinical population [2]. BPD has long been considered resistant to any treatment, a bias that has contributed to widespread therapeutic pessimism. However, research in recent years has not only shown that BPD can be treated, but it has also provided several manualized and empirically validated psychotherapeutic treatments [3], while no psychopharmacological treatment has been shown to be more than moderately effective [4]. Moreover, longitudinal observational studies have made it clear that patients with BPD, even without intensive treatment, experience high rates of remission within ten years [5-8]. With the availability of validated and proven therapies, the question of treating BPD may seem to be resolved, but unfortunately, access to adequate care remains a problem as most Evidence Based (EB) therapies are highly specialized and require intensive training and many resources. If effectively implemented, EB treatments compared to generic psychiatric treatments currently provided, would reduce the direct and indirect health costs of BPD which is one of the psychiatric disorders that requires most economic resources [9]. Unfortunately, despite the range of existing treatment options, the demand for treatment far exceeds supply [10]. This work aims to address the issue of implementing effective therapies for borderline personality disorder, with particular regard to the operational settings of public Mental Health Services. The aim of this review is to illustrate how to date EB and non-EB treatments have been implemented within the framework of the possibilities and resources available to the services.

Methods

Using PubMed, we have identified studies carried out in Europe or in countries such as Australia and Canada, where specialist mental health care is mainly provided by public services. This criterion was adopted because the second objective of the research is the analysis of adaptations that favour a greater diffusion of EB therapies, through the definition of standards of care compatible: (1) with the resources of public services; and (2) with a stepped care principle whereby even patients who are not eligible for standardized therapies can receive quality interventions based on the principles of effective therapies. On the other hand, the studies carried out in the United States were not included in the review, because the access of mental health services are conditioned by the insurance systems and the public offer remains limited in the context of emergency urgency.

To extract the works, the following search strings were used to query the PubMed search engine:

- ((dialectical behavioral therapy) AND (borderline personality disorder)) AND (implementation))
- ((mentalization based therapy) AND (borderline personality disorder)) AND (implementation))
- ((transference focused therapy) AND (borderline personality disorder)) AND (implementation))
- ((schema therapy) AND (borderline personality disorder)) AND (implementation))
- ((general psychiatric management) AND (borderline personality disorder)) AND (implementation))
- ((stepped care) AND (borderline personality disorder)) AND (implementation)).

In this way, 85 papers published between ANNO 2005 and ANNO 2022 were identified and then selected on the basis of criteria of relevance to the objectives of the review. In particular, meta-analyzes, systematic reviews and RCTs were privileged. Small sample studies were excluded or cited with specification of sample component number.

The obstacles to the implementation of EB therapies for BPD

Dialectical Behavioral Therapy

The best known and most available EB therapy is Dialectical Behavioral Therapy (DBT), initially developed by Marsha Linehan [11] for highly suicidal patients who did not respond as expected to standard cognitive behavioral interventions. The DBT treatment includes individual psychotherapy, participation in the psychoeducational group of Skills Training and the possibility of using telephone coaching 24/24h. The success of DBT lies in the robust empirical support and the large amount of rigorous studies conducted on comparison with Treatment As Usual (TAU) [12-18].

DBT requires major organizational changes, such as weekly team meetings, skills training and a high level of team engagement; the coordination of these functions is crucial to ensure the success of its adoption. Despite the number of evidences supporting this therapy, there are many obstacles to the implementation of standard DBT in services. In fact, it requires many resources, especially in terms of both economic and therapy time and, even before, the training of therapists [10]: the 4 components of therapy (individual psychotherapy, Skills training group, telephone availability and regular therapist team sessions) require approximately 3-4 hours per week per patient. The training consists of two 5-day courses 12 months apart, separated by frequent team supervision with qualified teachers, and involves the study of manuals of over 1,000 pages in total. Considering the resources of the public health system, a model that foresees the generalization of the standard DBT with unlimited access possibilities is utopian, at least at present. In the last decade, numerous studies have been carried out on the development of DBT and both facilitating and hindering factors in the implementation process have

been identified. In particular, in the research by King et al. (2018) [19] and Swales et al. (2012) [20] on the survival of DBT programs in the UK, it was found that the factors that favoured implementation were individual characteristics of clinicians and organizational support, while the most cited obstacles were the high turnover rate and inadequate funding. Swales et al. (2010) [21] hypothesized that a *pre-treatment* at an organizational level is necessary, which includes the identification of objectives, the assessment of the organization's readiness to change and the achievement of a level of commitment by the organization. The study conducted in a community setting in Ireland by Flynn et al. (2020) [22], concludes that the clinicians participating in the study identified the lack of support from the telephone coaching system and the lack of time for the therapists dedicated to DBT as an obstacle. Toms et al. (2019) [23] categorize difficulties and facilitators and identify a *benign* approach to BPD and an optimal level of communication within the services as a precondition for the adoption of DBT. Furthermore, they emphasize the importance of the cognitive flexibility of the therapists who will make up the team and that their values are in line with those of the DBT, in particular that they share the non-judgmental point of view. Healthcare management, in the design phase of the DBT implementation, must provide for the possibility of supervision and, consider the time and personnel requirements required even before activating team training. The review by Flynn et al. (2021) [24] analyses the studies on the implementation of DBT in the public health system emphasizing the importance of financial support for team training, as well as the need for continuous supervision.

Recent studies [25,26] have highlighted the effectiveness of DBT interventions that offer only Skills Training, both as stepped care for less complex cases, and by applying the model in a prevention perspective [27]. The efficacy of the standard treatment components of DBT (standard DBT, DBT with Skills Training only, and DBT with Individual Therapy only) was investigated in a dismantling study [28] which concluded that standard DBT was not significantly more effective than the Skills Training associated with case management. The variants of the study that included skills training had significantly better results in terms of reducing self-injurious non-suicidal behaviors than the variant of DBT that did not include skills training. All three treatment variants showed comparable results regarding suicidal behavior in high-risk patients. A relevant aspect underlined by the study is that the variant of DBT which included only the Skills Training required an average time of 31.7 hours against 55.3 hours of the standard DBT.

The effectiveness of Skills Training alone was also confirmed by the Australian study by Heerebrand et al. (2021) [29] on adult patients with BPD who received Skills Training together with general psychiatric treatment. The conclusions highlighted the reduction in maladaptive behaviors, the decrease in psychological and depressive symptoms, as well as the decreased use of health services. Finally, recent research [30] has shown positive results of Skills Training also in the management of co-occurring symptoms of substance abuse in patients with BPD. The DBT, even in the modality of Skills Training alone, has a favorable cost/benefit ratio in the short term [31]. Further studies are used to investigate the result in the long term.

Mentalization Based Therapy

Mentalization-Based Therapy (MBT) is a dynamic approach treatment developed by Bateman and Fonagy and aims to stabilize a person's mentalization skills in stressful situations when the attachment system is activated [32]. MBT focuses on the development of mentalizing skills and does not involve homework. The basic training lasts three days and is reinforced by continuous supervision. A limitation of MBT is that few training centers exist. The fact that it is not intensely structured and does not consist of various parts such as the teaching of skills and phone coaching typical of DBT, has both disadvantages and advantages, since, although it does not require many resources to be learned, it could leave without reference points the less experienced therapists who need more guidance. The empirically tested version of MBT includes group therapy and a mentalizing team.

The factors responsible for the success or failure of the MBT implementation process in public mental health services were investigated in a study conducted in the Netherlands by Bales et al. (2017) [33]. Specifically, 6 mental health services and 7 MBT treatment programs were considered. It turned out that in two of seven programs the implementation could be considered successful, in two others the result was not entirely satisfactory and in three cases the implementation had failed. The difficulties were identified at the organizational, team and individual therapist level. Similarly, to what has already been observed for DBT, also in this case the facilitating factors were: organizational and economic support, strong leadership, the management of negative processes within the team, the selection of clinicians and the possibility of training. On the contrary, the lack, or the defect, of these factors was an impediment to implementation. It was observed, again by Bales et al. (2017) [34], that the success of MBT implementation, and its effectiveness, can be threatened by organizational changes: turnover, new inexperienced team members, renewed management, bad publicity, security risks. These are factors that impact adherence and the effectiveness of the treatment. In their study, the results of treatment before and after the aforementioned changes were compared, highlighting a worsening of the effectiveness of MBT.

Schema Therapy

Schema Therapy (ST) was developed on the basis of cognitive therapy and offers treatment for pervasive and lasting psychological disorders in which cognitive therapy has been less successful [35]. The ST format includes

cognitive therapy enriched with techniques from object relationship theories, attachment and Gestalt therapy. In the ST, attention is paid to the traumatic experiences of childhood and to an empathic and protective therapeutic relationship. Experiential techniques have been integrated into the model [36].
Some studies were considered that focused on the implementation of ST in public mental health service settings in Europe. In the Netherlands Nadort et al. (2009) [37] studied the factors promoting and hindering the implementation of ST for the treatment of BPD. In summary, the hindering factors were the length of the activation time, the high costs, the distance from the supervision site, and, finally, the need to offer telephone support to patients outside working hours. This particular aspect was studied by Nadort et al. (2009) [38] to facilitate the implementation of ST and there was no significant difference between the groups of patients who benefited from telephone coaching and those who did not, perhaps due to the particular organization of the Dutch health system that offers alternative options to telephone support as an intervention for crisis situations. As facilitating factors, the positive attention of the media towards ST and the evidence of effectiveness were identified. Another facilitating factor concerned the availability of audio-video materials for the training of clinicians. The result of this study suggests that ST can be successfully implemented in the Dutch public service and in countries with a comparable health system. The study found that ST is cost-effective and beneficial in the Netherlands and in countries with comparable health service organization [39].
Alternative models have also been proposed for ST, which reduce the costs of providing treatment. One of these is the Group Schema Therapy (GST) by Farrell and Shaw (2012) [40] authors of an 8-month RCT [41] study that showed efficacy in increasing the remission rate of BPD, reducing the severity of the disorder, improve psychosocial functioning, with a low dropout rate. Two German studies in small samples (n = 10, n = 9) [42,43] showed improvement in symptoms and general functioning in BPD patients with the same treatment modality.

Transference Focused Psychotherapy

Transference Focused Psychotherapy (TFP) is a psychoanalytically oriented treatment based on Kernberg's conception of the borderline personality organization he introduced in the 1960s. The characteristics, deriving from adverse temperamental and environmental factors, are: a widespread identity, confused internal operational models of relationships, unstable reality testing, variable empathy, hetero and self-directed aggression and the use of primitive defense mechanisms. The treatment consists of two sessions per week without group therapy and the patient's relational patterns are analyzed. TFP has proved useful in reducing aggression and improving mentalization [44,45]. As the work of Choi-Kain et al. (2016) suggests, TFP appears to be more suitable for clinicians experienced with psychodynamic training. Unfortunately, no studies on the implementation of TFP have been found.

Flexible intervention models for BPD

Stepped Care

Paris' (2013) [46] review which describes the use of Stepped Care as an alternative to the use of a routine extended treatment was considered. Paris starts from the observation that although BPD is a chronic disorder, there is no evidence that it benefits more from long-lasting interventions. Patients with BPD, in fact, show improvements even after short interventions within Stepped Care [47-50] models and closer to the resources actually available, also considering that duration is one of the obstacles to the availability of treatments. Stepped Care is a model for treating somatic and psychiatric disorders, which vary in intensity and prognosis, and consists of a spectrum of interventions ranging from minimal to very intense support, depending on the need and the level of severity. It does not aim at complete recovery, but recovery that allows the patient to self-manage and be monitored through, if necessary, follow-ups. This mode allows patients to contact services and obtain support tailored to the needs of the moment. An example of an algorithm [46,51] that depicts the possible steps proposed by Stepped Care, was drawn up in the article by Choi-Kain et al. (2016).

- In the "preclinical" stage, characterized by risk factors for BPD and some symptoms of the disorder that do not reach the threshold for diagnosis, the elective interventions, in a Stepped Care perspective, are psychoeducation (to the family and to the patient) psychological support and problem-solving interventions.
- In the early stage, with manifestations of the disorder reaching the threshold for diagnosis and self-harm, the suggested interventions are Case management, GPM and DBT ST.
- At a later stage, with self-harm and suicidality, GPM with medication management, DBT ST or EB treatment (MBT, DBT, TFP) is proposed.
- At the severe stage, characterized by potentially fatal suicide attempts, GPM medication management interventions, a higher level of care (residential treatment for example) or another EB therapy or an integration of EB therapies are proposed.
- In the case of a chronic and unresponsive level to previous treatments, GPM and supportive therapy is offered.

An example of an early intervention calibrated on the patient is the Helping Young People Early (HYPE) model studied in the RCT by Chanen et al. (2022) [52] which found good adhesion by users because it was tailored specifically on adolescents.

Any difficulties encountered in implementation, which are like those of other treatments, were also studied [53] for Stepped Care. Once again, they are divided into two levels: individual and organizational. In the first case, attitudes towards personality disorders and the opportunity to take part in training courses are crucial factors. While the organizational aspects particularly relevant to implementation were supportive leadership and organizational experience in managing change.

General Psychiatric Management

General Psychiatric Management [54] is a manualized treatment that Paul Link converted from John Gunderson's clinical guide for a treatment comparison study with DBT [12] which showed that GPM, a less intense and non-specialized intervention, had an outcome as much effective as the DBT also at one and two years of follow up [55] with a lower rate of drop out of patients who had a higher degree of comorbidity in Axis 1 [56]. This is not a model of psychotherapy in the strict sense, but a "good" psychiatric case management implemented by a doctor who has the basic knowledge of BPD and the vulnerabilities of patients with this diagnosis. Weekly psychotherapy is offered only to those who profit from it and those who show actual changes. Another important aspect of GPM is psychoeducation. The GPM focuses, in particular, on interpersonal sensitivity and aims to manage symptoms and comorbidities by optimizing the patient's functioning in relational dynamics. The central goal is to improve the quality of life. GPM training requires a one-day workshop and approximately 2.5 hours per week per patient [10]. With a Stepped Care perspective, the effectiveness of 10 sessions of GPM as a short intervention was studied [50]. Psychoeducation restores meaning to life events as a source of corrective experiences and growth rather than failure. At the beginning of the intervention, motivation and participation are promoted, and in subsequent sessions the criteria making up the diagnosis and any co-occurring disorders are evaluated. Throughout the entire treatment, the focus on the interpersonal hypersensitivity model is maintained, attributing meaning to the patient's life events and relationships. In the last sessions the clinical process and the understanding of the patient's difficulties are summarized, also involving other clinicians and family members. From here, short-term objectives can be formulated and possibly a "step up" or "step down" of the treatment in progress at that moment takes place. Generalist treatments such as GPM are not intended as an alternative to EB treatments, which remain the treatments of choice, but not in early stages of intervention.

Guideline Informed Treatment for Personality Disorders

Among the various approaches to the treatment of BPD, a particular reference should be made to the work of Hutsebaut et al. (2020) [57] presenting the Guideline Informed Treatment for Personality Disorders (GIT-PD). GIT-PD is an initiative of the Knowledge Center for Personality Disorders in the Netherlands and aims to develop high quality care for people with personality disorders as an alternative to regular and unstructured care. The background of this initiative is a twofold observation:

1. in the Netherlands only a minority of PD patients receive a treatment that follows multidisciplinary guidelines [58];
2. structuring the care according to an informed psychotherapeutic model leads to a significant improvement in quality (for example, Chanen et al. 2009). The principles of GIT-DP treatment derive from the common characteristics of EB treatments for BPD and the underlying idea is that the quality of care does not depend so much on the specific factors of the treatment program, but on generic ones, such as the attitude of basis of the therapists, the structure of the treatment program and the attention paid to the motivation and quality of the therapeutic relationship. The rationale for the development of GIT-PD is inherent in the contrast between the evidence supporting the centrality of psychotherapies for personality disorders and the low availability and accessibility of the same [58]. Valuing the experiences that show that non-evidence based structured psychotherapeutic interventions have similar results to those of EB specialized psychotherapy interventions, GIT-PD aims to provide treatment that is realistically applicable in public mental health services. It also provides a framework for clinician training and some evidence-based criteria for assessing the quality of care for people with PD.

Guidance of the Emilia-Romagna Region

The Guidelines of the Emilia-Romagna Region intend to promote the adaptation of the international guidelines of the BPD to the local context for the treatment of Serious Personality Disorders (SPD), since the BPD can be assimilated to the core symptoms of SPD. The LI investigate the configuration of the services, the functional integration with the Child-Adolescent Mental Health Services and the of the Mental Health Services for Adults, the characteristics of the therapeutic contract, the interventions on seizures, the diagnostic tools, the pharmacological therapies, the therapeutic interventions available in the services and those who can favour the therapeutic attitudes of the team towards the SPD.

The LI propose to foster the empowerment and autonomy of patients, as well as to establish a relationship based on trust and optimism regarding recovery. The LI are not anchored to a specific treatment, but establish the need to implement a step-by-step treatment, the stepped care.

Two levels of care intensity can be summarized as follows: There are two main programs: the simple and the complex treatment. The first consists in informed psychosocial intervention based on the principles of a non-judgmental attitude, patient empowerment and focuses on increasing personal resources in crisis management and emotional regulation; the second provides access to forms of spe-

cialized structured individual psychotherapy and/or the DBT Skills Training. The Guidelines of the Emilia Romagna Region envisaged the development of an expert function dedicated to SPD within the Mental Health Departments with the task of evaluating and treating people with SPD, training professionals, reducing stigma and implementing LI in the services of Mental Health Services, in the Addiction Units, and in the Child-Adolescents Mental Health Services, as well as to support them and develop a communication system between these services. It also has the task of involving patients and family members and informing them about the opportunities for support in services and in the sharing of information in the various Operating Units. In addition, promote social interventions and monitor the development of services for ethnic minorities.

Discussion

The analysis of the literature considered in this review leads to rather homogeneous conclusions. The critical factors of the implementation of EB treatments for BPD (DBT, MBT, ST and TFT) in European countries, are placed on three levels: 1) mental health professionals team; 2) methodology of the treatment; 3) management and organization of services. On the level of the characteristics of the professionals the necessary positive factors are: the non-judgmental attitude, the positive approach towards BPD, the presence of a strong and supportive leadership, the possibility of accessing supervision. The commonly encountered obstacles in the application of manual treatments are: the duration and cost of training, the continuous updates of the manuals that require frequent re-adaptations; the difficulty of applying telephone coaching, the treatment time required for each individual patient on a weekly basis. Finally, it must be considered that often, it is not necessary to offer extended EB treatment, but it is sufficient to offer some parts of it (e.g., psychoeducation or ST of DBT). The organizational obstacles that need to be addressed and possibly removed to facilitate the implementation of EB treatment for BPD are: scarcity of resources, staff turnover, clinician's resistance to change, weak involvement of health management on the Mental Health issues, a clinical governance lacking in flexibility, the difficulty in framing the necessary costs as investments in patient health and possible future savings. Furthermore, in the Guidelines, there is no indication for patients who are not motivated for treatment and, moreover, the Mental Health Services of European countries, which are generally public, must also give answers to patients who are not motivated or compliance with highly structured EB treatments. The GPM, the Stepped Care, the GIT-PD and the LI of the Emilia Romagna Region offer alternatives that overcome the limitations of the exclusive use of EB treatments and constitute the possibility of defining treatment standards for the totality of people with BPD who pertain to mental health services. Although very different between each other, these models have common characteristics in the reference values (non-judgmental attitude and patient empowerment), in the flexibility of formats, in the openness to EB therapies that patients could access after a phase of stabilization of symptoms or comorbidities (substance use disorders and mood disorders). Gunderson's GPM frames a phased treatment that uses psychoeducation and psychodynamic intervention to promote the search for the meaning of interpersonal experience in hypersensitive patients. It is arranged in phases of decreasing intensity and is open to the integration of modules of other therapies, such as the Skills Training of the DBT. It is a treatment that can also be carried out by educational staff, as well as by psychiatrists and psychologists, as long as they are properly trained. of Paris' Stepped Care is particularly interesting for the staging of 5 severity levels of BPD. Modular interventions of different and increasing intensity are identified, without neglecting the residual commitment to patients who are reluctant to treatments towards which to maintain an attitude of harm reduction. To avoid a worsening of patients' quality of life and for reasons of health economics, it is advantageous not to wait for the disease to require more intensive interventions, but act offering a lower level of care intensity when the disorder is adequately compensated or not serious. GIT-PD formulates a series of general treatment principles based on these common characteristics. The program is based on the characteristics of EB treatments, namely: a clear treatment framework, attention to the quality of the therapeutic relationship, active therapist, interventions aimed at improving self-reflection and interventions that increase motivation. Ensuring these commonalities may explain the most important effect in the treatment of PDs. The LI of the Emilia Romagna Region have in fact contextualized the international guidelines, proposing two levels of complexity and intensity of treatment that put the implementation of the Skills Training of the DBT at the centre of innovation in association with psychiatric treatment informed on the principles of EB treatments. These approaches, compared to EB treatments, are economical in terms of training, treatment time and human resources involved. They propose less intensive interventions for mild patients and do not require the adoption of a reference therapeutic paradigm. They consider the possibility of using "parts" of these EB treatments, proven in effectiveness, on their own but are not an alternative to therapies. The structure of these models, as verified in the Dutch experience and as suggested by unpublished data from the experience of Emilia Romagna, makes them an effective and reliable treatment for less experienced clinicians who have completed short training courses.

Conclusions

The need to adopt effective interventions for BPD in public Mental Health Services suggests the use of pragmatic approaches that focus on the common factors of EB therapies, the modular use of the parts that can be considered effective alone, even in the absence of the complete struc-

ture of the therapy, the stepped care approach which takes the least invasive intervention as the elective at the different stages of severity of the disorder; and finally the dissemination of reference values (non-judgmental services). This approach, certainly less expensive and more suited to the organizational logic of public services, still involves investments in planning, training and the use of time by clinicians. Current epidemiological trends see an increase in emotional regulation disorders in adolescents and young adults, often prodrome of BPD, which does not correspond to an equal increase in available resources. On the contrary, the resources allocated to Mental Health in Italy have decreased and in any case are concentrated more on the needs of residential care, a substitute for appropriate social and welfare interventions, on judicial processes, on urgent treatments. The implementation of treatments for personality disorders implies a paradigm shift that replaces the generalist psychiatric approach, centred on the pharmacotherapy of symptoms and the use of emergency services for crisis management. To do this it is necessary to overcome the doubts (OR worries?) of clinicians, remove organizational obstacles and ensure adequate resources for training and supervision. Research projects on the implementation of theoretical models and their adaptations in real-world clinical practice is needed to guide healthcare governance and clinicians with evidence of effectiveness.

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