

Emergency Psychiatric Management of Borderline Personality Disorder: Towards an articulation of modalities for personalized integrative care

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Abstract:

Building on existing literature, the authors draw the landscape of psychiatric emergencies, and focus on Borderline Personality Disorder, frequently encountered, and strongly linked to death by suicide. A review of knowledge in terms of diagnosis, prognosis, etiology, and treatment, as well as their own experiences, lead them to propose areas of progress that would secure the patient's care pathway.

The evolution of society has led psychiatric emergency departments to play the role of a safety net and an entry point to the mental health system. Borderline personality disorder is one of the most common pathologies encountered in psychiatric emergencies. It represents a major concern, long

characterized by an often dramatic evolution, and by the human and economic stress it generates. However, since the 1990s, knowledge of this disorder has been refined, and today there are various means of evaluation, good clinical practices and psychotherapeutic treatments, thanks to which significant and lasting improvement is possible. Recent studies highlight the crucial role of hospital caregivers, and the benefit of consolidating their skills by providing them with the knowledge and tools specific to this disorder. They also converge on the interest of setting up specific emergency treatment modalities, particularly highly structured, safe and empowering for the patient, in order to improve their effectiveness. The authors suggest that a case formulation model for persons with borderline personality disorder in emergency would make it possible to activate these two levers of progress, while improving collaboration between hospital and outpatient care. This would also address their main concern of optimizing the patient's therapeutic pathway and reinforcing adherence to treatment that could bring remission, and should be supported by data from empirical research.

Introduction :

Psychiatric emergencies have become an essential point for the detection of psychic disorders. Borderline personality disorder is of particular concern because of its frequency and the all too often iatrogenic trajectories of the people who suffer from it, whereas psychotherapies that have empirically proven lasting benefits have existed for some twenty years.

1. Medical emergencies and psychiatry, facts and figures

Societal changes, technological advances, and economic pressures upon employee performance have contributed to increased demand for access to care and the need for increasingly rapid relief for both somatic and psychiatric conditions [1]. At the same time, the practice of psychiatry has been significantly disrupted by urbanization, the densification of housing and the breakdown of traditional social ties, leading to an increase in consultations [2]. Given the frequency of comorbidities and somato-psychiatric interactions encountered in emergency departments, collaboration between emergency medicine and psychiatry for a joint assessment is essential [1,3]. Also, health policies and regulations that define the missions and obligations of medical emergency services require the integration of psychiatric expertise [1,4,5]. Thus, psychiatric emergency services are called upon to play a role as a "safety net" for mental health: source of first aid and entry point to the psychiatric care system [6].

Over the last 40 years, the relationship between psychiatry and medical emergencies has evolved considerably: from a marked separation in the 1970s to an excessive alignment with the medical model aimed at the disappearance of symptoms in the 1980s, a more balanced rapprochement has developed since the 1990s [4]. This last evolution has been made possible, on the one hand, by

considering some key factors for effective management of mental disorders: the importance of the human encounter between patient and caregivers, the importance of the social as well as family context and personal history in the onset of disorders [1]. This has made it possible to better define and distinguish between psychiatry in emergency and crisis, and to adapt the admission system and practices accordingly [4]. On the other hand, since the end of the 1990s, the model of emergency care has evolved from a triage model to a treatment model that considers crisis intervention as a component of a longer-term therapeutic treatment [7].

Over the last two decades, the increasing number of people seen in general emergency departments is estimated at 4% per year [4,8], of which 4 to 6% have a psychiatric disorder [8,9,10]. Among these, it is relevant to distinguish between the needs of 'psychiatry in emergency' and 'psychiatric emergencies' [4]. Psychiatry in emergency corresponds to pathologies already identified and usually managed in hospital psychiatry (e.g. psychotic decompensation, bipolar disorder, substance abuse/dependence) and accounts for 30% of requests. The remaining 70% of the requests concern crisis i.e. distress situations related to disorders that have not yet been identified, and constitute 'psychiatric emergencies'.

The most frequent reasons for consulting a psychiatric emergency department are suicidal behaviour and self-injury (36%), followed by anxiety (19%), depression (11%), agitation (10%) and delusions (10%). The most common diagnostic categories are mood disorders (36%), substance abuse (9-18%), psychotic spectrum disorders (10-14%), and behavioural and personality disorders (8-13%) [4,6,8]. In terms of frequency of visits, there are significant disparities between categories: while mood disorders are responsible for the greatest number of visits, patients diagnosed with a personality disorder call upon emergency services up to 5 times more often than those with other diagnoses, especially individuals with borderline personality disorder for whom it is not uncommon to visit emergency services more than 12 times a year [6,11,12,13].

These figures highlight three important elements. Firstly, 70% of psychiatric emergency consultations constitute the first contact between a person with a mental illness and the health system, suggesting that psychiatric emergencies are a key access point for the mental health system. Secondly, suicidal and self-harming behaviour is the primary cause of consultation in psychiatric emergencies. Third, the relationships between reasons for consultation and diagnostic categories are not direct and unambiguous: for example, while suicidal behaviour may be found in different diagnostic categories, such as mood or personality disorders, not all individuals with these diagnoses necessarily present a high suicide risk. Thus, emergency departments, by their unique position in the medical system, play a crucial role in detecting people suffering from psychiatric pathologies and initiating the right care, particularly those at risk of suicide.

2. Suicidality and borderline personality disorder

One of the few psychological autopsy studies on suicide victims showed that 39% of them had been seen in the emergency service in the year preceding their death [14]. Although the risk of suicide is not specific to a diagnostic category, it is nevertheless established that 60 to 78% of people with borderline personality disorder have, or will attempt suicide during their illness [15]. Without appropriate treatment, it is the cause of death for 10% of them [16,17,18,19,20,21], and several studies have estimated that 55% of people who consult psychiatric emergencies following a suicide attempt also present with a borderline personality disorder [15], which in turn has been found in the psychological autopsies of more than a third of those who die by suicide [22,23,24]. More generally, a meta-analysis of North American and European studies has shown that suicide is the leading cause of death in people with borderline personality disorder [25]. Thus, suicidality and borderline personality disorder are strongly associated, and a large proportion of the people most frequently seen in emergency departments suffer from this disorder, including one in three with a high risk of death by suicide [6,13].

The term "borderline personality" is inherited from Anglo-Saxon psychoanalysis in the 1930s to describe patients who were considered "unanalysable" at the time [26] because they failed the classic cure, and could regress to the borderline of schizophrenia, without developing the chronic loss of contact with reality that characterizes psychoses [16,26,27]. These people were described as "self-centred, inconsistent, irresponsible, incurable, uncontrollable ... using the hospital to escape responsibility" (Klein and Houk, [27]). Since the 1980s, advances in psychiatry, the evolution of traditional analytical treatment towards a plurality of targeted psychotherapeutic treatments, and the establishment of measurable and valid diagnostic criteria, have made it possible to delimit borderline personality disorder as an independent, coherent, stable syndrome, and distinct from the pathologies to which it could have been assimilated, such as bipolar or depressive disorders [16]. Moreover, pharmacological studies have shown that effective treatments for confounding conditions have weak or contradictory effects on this disorder [26], which supports the idea of a specific diagnostic entity and the need for therapeutic means other than pharmacological ones.

Today, the 9 criteria for borderline personality disorder are established, and have not been modified between the last 2 versions of the DSM. They are: (1) chronic fear of abandonment; (2) intense and unstable interpersonal relationships; (3) identity disorder; (4) impulsivity (e.g., overspending, sex, substance use, eating); (5) suicidal or self-harming behaviour; (6) emotional instability; (7) chronic feelings of emptiness; (8) intense and uncontrollable anger; (9) paranoid ideation or transient dissociative symptoms under stress. As some of these criteria are common to other conditions, which must be differentiated to guide the appropriate treatment, the assessment of borderline personality disorder must include at least 5 of these 9 criteria, and may be based on anamnesis and

epidemiological evidence: onset of symptoms in adolescence or young adulthood [16,19], traumatic experiences in childhood [21,26,28], hereditary status, and female prevalence especially in the clinical population [21,29].

Clinically, borderline personality disorder is characterized by strong affective lability, with rapid mood swings, impulsive and self-destructive behaviours, in a picture underpinned by instability in interpersonal relationships, with hyper-sensitivity to social rejection, chronic fear of abandonment, and identity disorder manifested by sudden changes in beliefs, goals or aspirations, and a sense of inconsistency or emptiness. Cognitive symptoms of a dissociative or psychotic nature (paranoid ideation or auditory hallucinations) are reported in 40-50% of patients, but their rarity and brevity distinguish them from disorders on the psychotic spectrum [16].

Finally, borderline personality disorder is very frequently found in comorbidity with other pathologies, mainly anxiety and depression disorders (84%), other personality disorders (74%), substance use disorders, post-traumatic stress disorder, eating disorders [28,30,31,32].

3. Assessment and prognosis

The assessment of borderline personality disorder is complex because of the heterogeneity of symptoms, which may be common to other conditions, and the frequency of comorbidities. However, there are now various empirically validated questionnaires and interview guides that allow a reliable diagnosis to be established, and above all without fear that it is hopeless given the various effective treatments developed over the last 20 years [16,26,33,34].

Several prospective longitudinal studies (up to 27 years) have shown that 85% to 90% of people with a diagnosis of borderline personality disorder experience remission, i.e. a decrease in the number or intensity of their symptoms below diagnostic criteria. However, it typically takes several years or decades to achieve remission [19,20,29,35,36,37], especially in cases of misdirected therapy or iatrogenic intervention [19,35]. This period is critical: risk of relapse or loss of employment is directly related to the pathology and increased tenfold, significant deterioration of many health indicators often ensues (diabetes, hypertension, osteoarthritis, sleep disorders, substance use, risk behaviours), accompanied by 140% additional medical costs [32,38], a premature death rate of 14% [36] and a dramatic increase in the risk of death by suicide, which is 50 to 100 times higher than for the general population [19,20,21,25,28]. In addition, this remission is slower than for other personality disorders, and also more fragile [39]. In particular, overall functioning remains low, with a 10-year progression of the mean score on the Global Assessment of Functioning (GAF) scale from 53 to 57 out of 100, for thresholds of *correct* and *satisfactory* functioning positioned at 60 and 70 [29,32].

However, recent research shows that patients respond well to specialized contemporary psychotherapeutic treatments (Figures 1 and 2). Indeed, the nosologic concept of borderline

personality disorder is consistent, the knowledge acquired points both to a genetic vulnerability [26,28] and a multiple etiology [26,29] at the heart of which is a disorder of emotional regulation linked to an attachment disorder [18,29,40,41,42,43,44,45]. Also, the various clinically validated treatments essentially target the attachment disorder and the deficit of emotional regulation for beneficial repercussions in the affective, behavioural and functional domains [14,28,33,46]. In terms of results, they allow a significant reduction in the most risky behaviours (suicidal behaviour divided by 4 in 2 years), but also for more resistant temperamental symptoms (fear of abandonment divided by 3 at the same time), and we note significant improvements in all other symptoms, although less marked and rapid [47,48,49,50,51,52,53]. Eventually, remission does not equate to the disappearance of all symptoms, e.g., feelings of emptiness and identity disorders, although markedly improved, may persist at clinical levels impacting social functioning. Notwithstanding these caveats, these treatments have undeniable and long-lasting benefits, enabling people to overcome extreme affect and behaviour. They enable half of them to reach satisfactory levels of social, family and professional functioning. Above all, they reverse the curve of their clinical trajectory to divert it from too often tragic outcomes. In addition, the reduction in healthcare costs is substantial, estimated between 80 to 90% [33].

Regarding pharmacotherapies, these are recommended only to treat comorbidities or specifically target symptomatic dimensions (emotional instability, impulsivity, brief psychotic episodes, etc.). It is also recommended to limit poly medications in order to reduce adverse effects, and these therapies are insufficient to achieve remission of the disorder [54]. They are therefore only indicated in crisis situations, for example to manage severe anxiety or depressive states [12,26,28,55,56].

As for hospitalization, although it is sometimes necessary, particularly in suicidal emergencies, it is controversial and must be kept brief because of its negative consequences: behavioural regression, loss of responsibility, and breakdown of social ties [17,30,57]. Consequently, psychotherapy is the first treatment recommended by the American Psychiatric Association, the guidelines of the World Federation of Societies of Biological Psychiatry as well as those of the British NICE, and in the specialized literature [12,30,34,46].

Despite its adverse effects, borderline personality disorder is not an incurable pathology, and its outcome is very often favourable if it is detected and treated in an adapted manner [19,46,56]. It should nevertheless be noted that none of the contemporary psychotherapies provides a clearly formulated link between emergency care and outpatient psychotherapeutic treatment, which could be one of the reasons why the prevalence of hospitalisation remains high during treatment.

Figure 1: Dialectical Behavioral Therapy, randomized controlled trial of suicidal patients [49,50]

All patients are suicidal women (100% pre-study prevalence). For 1 year, they followed either a Dialectical Behavioral Therapy (DBT) or a standard treatment (control group). Various indicators were measured during the year of treatment, then 1 year after its completion, including: number of hospital admissions and length of stay, and number of suicidal acts and prevalence.

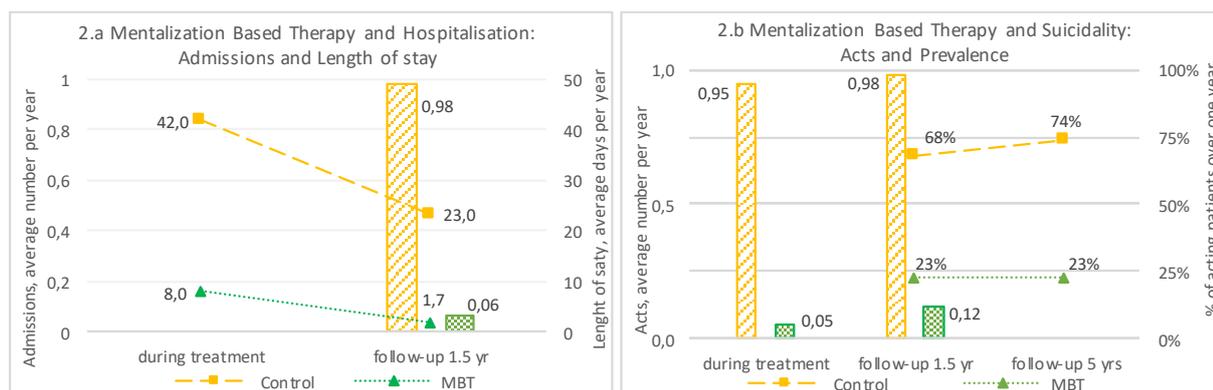


a) During the treatment, DBT patients made fewer hospital admissions: on average 0.36 and 8.4 days of stay per year compared to 0.55 and 38.8 days for the control group. These improvements continued after treatment.

b) During treatment, suicidal prevalence was reduced to 40% in the DBT group and 65% in the control group. At 1 year, it continued to decrease for the DBT group to 26%.

Figure 2: Mentalization Based Therapy, a double-blind randomized controlled trial [51,52,53]

For 18 months, the test group received Mentalization Based Therapy (MBT) while the control group received standard psychiatric treatment. Several indicators were measured during the treatment, then during the 18 months following its completion, and finally 5 years later, including: number of hospital admissions and length of stay, and number of suicidal acts and prevalence. It also should be noted that after 5 years, 87% of patients in the MBT group no longer met the diagnostic criteria for borderline personality disorder, compared to only 13% of the control group.



a) During treatment and 1.5 years after, patients on MBT had significantly less hospital use than those in the control group: 8 days per year compared to 42, then 1.7 days per year compared to 23, and an average of 0.06 admission per year compared to 0.98.

b) MBT had a very strong effect on the average number of suicidal act per year: from 0.95 to 0.05 during treatment, and 0.98 to 0.12 at 1.5 years. Then the suicidal prevalence was reduced to 23% and maintained at 5 years, compared to 68% and 74% for the control group.

4. Costs

The prevalence of borderline personality disorder is around 2% of the population and represents 10% of people receiving outpatient care and 20% of psychiatric inpatients [16,28]. Its burden on the health care system is considerable. On the one hand, in human terms, through the high frequency of recourse to emergency services and difficult symptomatic behaviour [34], and on the other hand, economically. Several studies indicate that the direct annual health costs per person with borderline personality disorder (emergencies, hospitalisations, treatments) vary greatly from one country to another: 3,921€ in Spain [58], 4,575€ in the Netherlands [59,60], 15,080€ in Germany [60], 16,780€ in Great Britain [61], 19,980€ in Australia [62], 38,770€ in the USA [63]. These differences should be considered in relation to the GDP per capita and the cost of the hospital day per country. Among these studies, some have also taken into account indirect costs (loss of productivity, job loss, suicide, etc.) to establish the total annual cost per person to society: €11,300 in Spain [58], €21,100 in the Netherlands [59], €28,000 in Germany [60]. These figures show that health costs account for 23% to 54% of the total cost to society. In Switzerland in 2011, a study has calculated an average annual hospitalisation cost of 32,600€ per person [64], an amount that should be multiplied by 1.8 to 4.3 according to the benchmarks in order to have a minimum estimate of the total annual cost per person of between 58,600 and 140,000€.

5. Factors common to clinically validated psychotherapies

The therapies indicated for the management of borderline personality disorder, whether they come from the cognitive-behavioral or the contemporary psychodynamic streams (respectively Dialectical Behavioral Therapy, or Transference Focused Psychotherapy and Mentalization Based Therapy), share different principles of intervention. First, the diagnosis, once established, is communicated and discussed directly with the patient [33]. This is the prerequisite for establishing the therapeutic aims, it also means affirming from the outset the confidence placed in the patient's ability to exercise agency in the treatment, and not encourage total dependency on the therapist [17,57,65]. This communication of the diagnosis is followed by the inclusion of a psychoeducation phase aimed at providing information about the disorder and its prognosis, which is usually favourable. Then, the aim of all therapies is to develop the patient's ability to regulate his emotions and behaviour, to "reinforce self-regulation through clinical practice" [44]. To do this, each one implements particular techniques, more or less direct and implicit, but for which the therapist must have been specifically trained. The practical modalities vary, but most provide for a few hours of intervention per week, individually and/or in groups, over a period of 1 to 3 years [19]. The therapist's posture varies according to the therapy: it can employ direct confrontation through the therapeutic relationship (Transference Focused Psychotherapy) or psychological techniques to improve specific skills (Dialectical

Behavioral Therapy). In all cases, the therapist adopts an active posture, in order to preserve the patient's agency and actively continue therapy during the crises, as well as a so-called "not knowing" posture, marked by humility and curiosity, avoiding knowing in the patient's place [33]. Indeed, because of the relational etiology of this disorder, a key lever of therapeutic effect lies in the relationship and trust established between the patient and the therapist [66].

6. Emergency care

As described above, people with borderline personality disorder are the most frequent users of psychiatric emergency services [13]. These visits are often triggered by interpersonal conflict that has provoked acute anxiety beyond the capacity for emotional regulation, which results in a state of crisis and intolerable distress [65,67]. The failure to cope with the perceived upset and the loss of control over thinking are manifested by acts that are harmful to the person: substance abuse, self-inflicted injuries, suicide attempts [56]. These behaviours, symptomatic of borderline personality disorder, are then expressed in an exacerbated manner that is quite distressing for those who approach the person: agitation, rapid fluctuation of intense emotions, outbursts of anger, aggressiveness. In the context of an emergency department, characterized by tension related to the unexpected, risks, and resource constraints, the attitude of these patients may be received with reluctance, even scepticism, by caregivers whose tolerance capacities may be exceeded. As a result, they are often perceived negatively, judged as manipulative and attention-seeking, because their symptomatology, unrecognised, stigmatised or considered incurable, is frustrating and repulsive [12,30]. Thus, the health care system may miss certain essential points that are key to the twofold challenge they present: making the person secure and bringing him or her back to a regulated state, making the right diagnosis and initiating the appropriate treatment for a real and lasting improvement. Therefore, many expert practitioners recommend disseminating the recently acquired knowledge specific to this disorder to somatic and psychiatric carers [56]. This can help them to be better prepared to deal with the high emotional intensity of their relationships with these patients, by limiting too personal an involvement in these stressful interactions, in order to maintain therapeutic optimism and to be able to provide the necessary non-judgemental, comprehensive and validating attention [13,30].

Difficulties in emergency assessment and management may arise from several factors: the numerous comorbidities possibly masking the clinical picture by acute symptoms (depression, agitation, anxiety, hallucinations, etc.); priority risk management by pharmacological treatments modifying affect, cognition and behaviour; the difficulty of establishing genuine contact with a person whose pathology is characterised by interpersonal and identity disorders; the aversion of health care staff to unpredictable, excessive and aggressive behaviour, which calls into question its legitimacy [30]. To address these difficulties, which are real barriers to treatment [13,30], a set of practical

recommendations has emerged. The first, through staff training, address the stigma of borderline personality disorder and the lack of knowledge that this disorder is amenable to treatment. As it is often difficult for mental health professionals to establish and announce this diagnosis, it is essential to consolidate their skills by providing them with specific knowledge and tools, and by informing them, or even training them, in the various effective psychotherapeutic treatments. In the clinical setting, transparency, authenticity, and direct communication with the patient are agreed upon [12]. This posture is essential because it is the basis for establishing a trusting interpersonal relationship, which makes it possible to go beyond the punctual treatment of symptoms and to initiate the process of post-crisis psychotherapeutic care. Once these elements are in place, it is possible to communicate the diagnosis to the patient and his or her family, and to inform them about the disorder and its prognosis, which will help to form or strengthen a network of supportive social interactions [13,19]. The clinician can then accompany the patient in exploring recent interpersonal events to identify the factors that triggered the crisis [12], while stimulating the patient's responsibility and reflexivity [67], which may be the beginning of the psychotherapeutic process.

7. For a model of case formulation and integrative care linking urgency to treatment

Psychiatric emergency and crisis intervention units are the best places to detect persons with borderline personality disorder and, after a reliable diagnosis, to engage them in appropriate outpatient psychotherapeutic treatment [68,69]. However, there is a wide gap between this possibility and reality, and the trajectories of these people remain largely chaotic and iatrogenic, with significant negative consequences in terms of health, social functioning [35,38,68], and a high lethal risk [15,16,17,18,22,23,25,28].

Why is this the case when effective diagnostic tools and treatments exist?

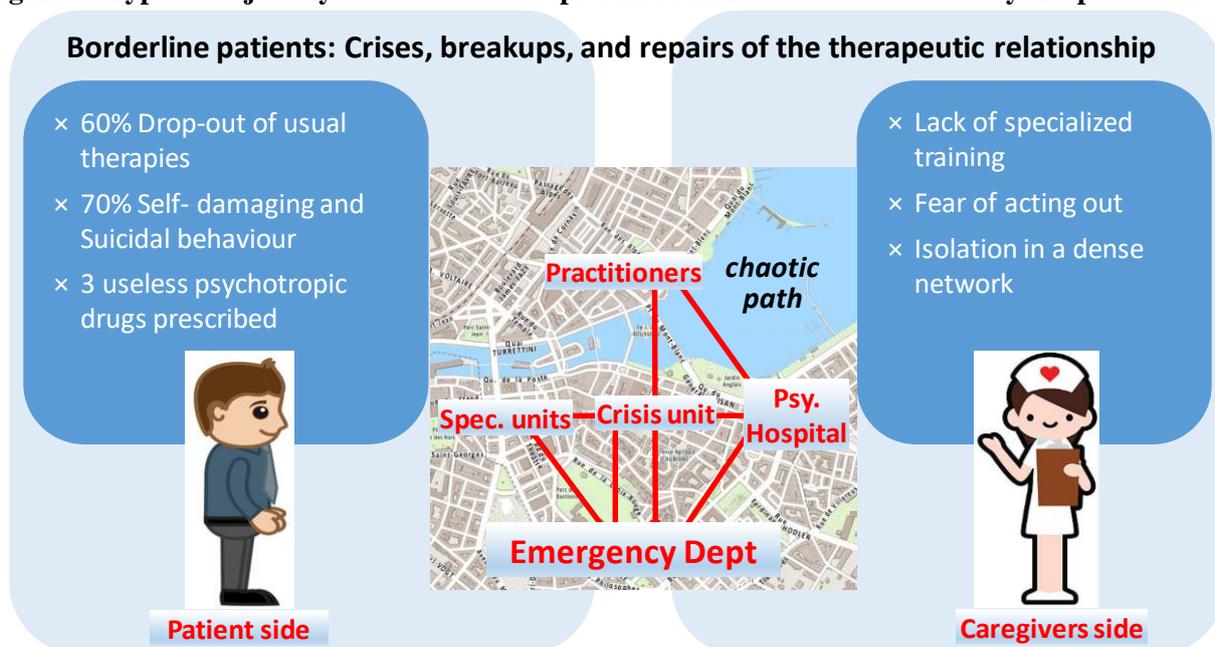
A first reason lies in their recent development, and their implementation is still insufficient. Indeed, the diagnosis established at the first contact between a person with borderline personality disorder and a psychiatric specialist is wrong in almost 70% of cases, and it takes on average 3 to 4 years for a reliable diagnosis to be made and for the appropriate treatment to be initiated [35].

A second reason is inherent to the mission and the unpredictable and potentially high-risk nature of emergency department activity. In a potentially tense context, emotional lability, impulsive or destructive behaviours, and symptom heterogeneity make borderline personality disorder difficult to apprehend, and the focus on short-term security may overshadow the need for longer-term management.

A third reason comes from the discontinuities between the hospital system, town medicine and outpatient psychotherapeutic care, which make it very difficult to plan and carry out a smooth and continuous course of care after hospitalisation (Figure 3). For people with borderline personality

disorder, who are particularly sensitive to interpersonal relationships and exposed to fear of abandonment, and whose psychological security requires continuity, predictability and regularity, this discontinuity introduces rupture, uncertainty and frustration, the effects of which are aggravating. For example, among people leaving psychiatric emergency departments and requiring external treatment, half of them do not continue their care, even when continuity has been organized by hospital services [68,69]. In particular, only 25% of people with personality disorders actually attend their first outpatient appointment [71]. Drop out has many unfavourable consequences. It doubles the risk of re-hospitalization within a year [71], whereas following treatment is a protective factor since it divides the risk of relapse by 2.5 within 6 months [21]. When care is again initiated by going through the "emergency" box, the worsening of the situation often weakens its effectiveness, which contributes to a deterioration in the morale of patients and caregivers, and an increase in health care effort, costs and risks [21,70,71,72]. With regard to suicidality, the absence of treatment within 6 months of hospital discharge increases the risk of suicide by a factor of 3 for people with borderline personality disorder, and by a factor of 6 for those who were previously suicidal [21]. Thus, the first lifespan risk factor for death by suicide is the existence of previous attempts, which multiplies its probability by 10 and dramatically reduces life expectancy to around 42 years [36,72]. Ensuring continuity of treatment between hospital and outpatient care is therefore a fundamental issue in modifying the prognosis of people with borderline personality disorder received in psychiatric emergency departments.

Figure 3: Typical trajectory of the borderline patient seen from Geneva University Hospitals in 2019.



The pathway leads between different hospital departments and outpatient care, in a chaotic and iatrogenic trajectory. The daily experience of carers argues in favour of a model that repairs the link between patient and carers throughout the whole health system.

There already exist initiatives aimed at improving the management of people with borderline disorders who are hospitalized in emergency departments [34,73]. They confirm some key factors of effectiveness, such as the recognition and the affirmation of the crucial role of caregivers and the importance of supporting them with additional specialist training to strengthen their ability to overcome the anxiety, or even aversion, that they may feel towards some symptomatic patient behaviours [73], and go beyond short-term risk management to open up the prospect of outpatient psychotherapeutic care. They also confirm the value of implementing a specific approach to borderline personality disorder, following predetermined routines that structure time and provide security, aiming at progressive objectives, anticipating with the patient his or her discharge date, and providing for the outpatient care plan up to the point of considering the possibility and criteria for re-hospitalisation [34]. Recent studies have also shown that the continuity of care for people with borderline personality disorder is significantly improved by the implementation of a stepped care model [74, 75]. In this model, an intermediate stage articulates the link between crisis hospitalisation and outpatient psychotherapeutic treatment. This stage consists of a brief intervention of 4 structured clinical interviews, one of which is with the patient's relatives. This model clarifies the purpose of each stage: securing and symptomatic de-escalation for hospitalisation, involvement in psychotherapy for the brief intervention, symptom remission and psychological recovery for psychotherapy. At no additional cost compared to usual post-crisis treatment [74], this model radically changes the trajectory of care since 84% of patients go to their first outpatient appointment, and 45% engage in psychotherapeutic treatment [75]. Moreover, this brief intervention by itself brings significant short-term benefits, with a decrease in the severity of symptoms, especially distress and suicidal ideations and behaviour, and an improvement in the perceived quality of life [75]. In the longer term, one study shows that it would allow a 68% reduction in hospitalisation compared to only 35% in the usual treatment condition (from 13 days per year to 4 days per year compared to 8 days per year), which represents, in this study, an annual saving of €2400 per patient in hospital costs alone, not counting other gains in health and indirect costs [74].

To follow up on these studies, we may build on the different modalities they tested, and integrate the theoretical and clinical contributions of specialized therapies for borderline personality disorder. This leads to constructing a model of case formulation and care intake that addresses discontinuity in order to create, for each patient, a secure, flexible and personalised network linking hospital and outpatient care providers. This model would make it possible to bring the knowledge and skills of field staff together with assessment tools and therapeutic methods validated by research, in a coherent whole which articulates the interventions of hospital and outpatient players to address the diversity of this

issue: from additional specialist training to the initialization of psychotherapeutic treatment, including crisis management, diagnosis, referral to the therapy best suited to each patient, inclusion of relatives, etc. In addition to improving the quality of emergency care for the benefit of patients and carers, it would aim to strengthen adherence to treatment which, in the perspective of the treatment model, should be initiated as soon as the crisis intervention begins [7]. This model could be evaluated through clinical studies, focusing on individuals and the improvement of their health, and providing data to quantify its benefits in human and economic terms and to investigate statistical modelling that could help predict individual prognoses. The whole of this approach would contribute to the development and deployment of new methods and cross-cutting clinical practices to improve patient health, improve the job satisfaction of carers, and reduce the burden on the healthcare system.

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