LETTERS

Letters to the Editor

Prescribing and borderline personality disorder

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In a challenging therapeutic area, where evidence to guide practice is scarce, Andrew Chanen and Katherine Thompson provide an insightful, pragmatic review on prescribing for patients with borderline personality disorder.[1]

The authors' reference to the high rate of comorbid conditions complicating accurate diagnosis and potentially overwhelming the clinical picture was of particular interest to us. Our interdisciplinary team of care coordinators assists complex patients to navigate the healthcare system, promoting self-management and facilitating communication between healthcare providers. These patients are typically high users of hospital or emergency services and at the higher end of functional decline with multiple comorbidities. Patients with borderline personality disorder – both diagnosed and undiagnosed – are highly represented in our patient cohort.

Comorbid mood disorders, chronic pain, anxiety or substance use disorders present significant challenges for treating clinicians. Fragmented care and delayed communication regarding medication management from hospital admissions or specialist outpatient clinics only serve to magnify problems. Embedding a clinical pharmacist within our care coordination team has enhanced timely, collaborative medication management across the care continuum particularly for this patient group. Having an agreed prescribing framework between specialists (knowing who is responsible for prescribing certain drugs), a dedicated GP and dispensing community pharmacist provides reassurance and role certainty among all members of the team. The combination of care coordination with medication management is a useful adjunct in caring for patients with borderline personality disorder.

Deirdre Criddle
Complex care coordinator pharmacist

Carolyne Wood
Team leader North Metropolitan Health Service

Complex Needs Coordination Team
Sir Charles Gairdner Hospital
Nedlands
Western Australia

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Andrew Chanen and Katherine Thompson, the authors of the article, comment:

We thank Deirdre Criddle and Carolyne Wood for their comments. People with borderline personality disorder are highly represented among those with severe mental illness, and miscommunication and polarised opinions about management are especially common in relation to this patient group.

Comorbidity can be a misleading term in this context. Many patients report co-occurring symptoms or syndromes (such as mood or anxiety disorders) that are not truly separate diseases (that is, not true comorbidities) and which require care to be integrated with the treatment of borderline personality disorder. However, truly comorbid conditions (such as cardiovascular disease) are also more common among this patient group[1] and the interaction of borderline personality disorder with the management of these conditions often leads to poor outcomes, including premature mortality.[2]

Of the possible mechanisms that might underlie these poor outcomes, the relational difficulties that lie at the heart of borderline personality disorder are commonly enacted with health professionals. This often leads to suboptimal clinical decision making by the health professionals or poor self-care by the patients.

Interdisciplinary care coordination is a promising innovation in the care of these patients and warrants support to develop an evidence base in borderline personality disorder.

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