

Borderline personality disorder

## **Costing report**

Implementing NICE guidance

January 2009

NICE clinical guideline 78



This costing report accompanies the clinical guideline: 'Borderline personality disorder: treatment and management' (available online at [www.nice.org.uk/CG78](http://www.nice.org.uk/CG78)).

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#### **This guidance is written in the following context**

This report represents the view of NICE, which was arrived at after careful consideration of the available data and through consulting healthcare professionals. It should be read in conjunction with the NICE guideline. The report and templates are implementation tools and focus on those areas that were considered to have significant impact on resource utilisation.

The cost and activity assessments in the reports are estimates based on a number of assumptions. They provide an indication of the likely impact of the principal recommendations and are not absolute figures. Assumptions used in the report are based on assessment of the national average. Local practice may be different from this, and the template can be amended to reflect local practice to estimate local impact.

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## **Executive summary**

This costing report looks at the resource impact of implementing the NICE guideline 'Borderline personality disorder: treatment and management' in England.

### ***Supporting implementation***

The NICE clinical guideline on borderline personality disorder is supported by a range of implementation tools available on our website [www.nice.org.uk/CG78](http://www.nice.org.uk/CG78) and detailed in the main body of this report.

### ***Significant resource-impact recommendations***

Because of the breadth and complexity of the guideline, this report focuses on recommendations that are considered to have the greatest resource impact and therefore require the most additional resources to implement or can potentially generate savings. They are:

- Training professionals to recognise, diagnose and treat people with borderline personality disorder.
- Establishing multidisciplinary teams.
- Communicating across organisations, for example, between primary care trusts and mental health trusts.
- An increase in the use of services due to greater awareness and better diagnosis.
- Providing literature and video materials to patients about their treatment options.

### ***Total cost impact***

Because of the range of services covered in the guideline and the lack of detailed information about the prevalence of borderline personality disorder, it has not been possible to establish a baseline measure of existing service provision and the likely change in resources following implementation.

The resources required will need to be established locally as they will depend largely on existing service provision for this condition, care pathways for patients with comorbid conditions and the level of skills and awareness of professionals working in the services covered by the guidance.

It is expected that expenditure on the recommendations in this guidance will fall into programme budgeting category 205X 'other mental health disorders'. Currently, mental health services are excluded from 'Payment by results'.

### ***Benefits and savings***

Implementing the clinical guideline may bring the following benefits:

- A reduction in the use of A&E services.
- Fewer admissions as a result of self-harm episodes. Self-harm is the subject of NICE clinical guidance CG16 (available from [www.nice.org.uk/CG16](http://www.nice.org.uk/CG16)).
- A small reduction in number of drugs prescribed to patients with borderline personality disorder.

### ***Local costing template***

No costing template accompanies this report because the baseline provision of compliant services varies greatly, and so the potential impact of activities resulting from implementation of this guidance will need to be assessed locally. This cannot be captured and quantified in a costing template.

# 1 Introduction

## 1.1 *Supporting implementation*

1.1.1 The NICE clinical guideline on borderline personality disorder is supported by the following implementation tools available on our website [www.nice.org.uk/CG78](http://www.nice.org.uk/CG78):

- a national costing report; this document
- a slide set; key messages for local discussion
- audit support.

1.1.2 A practical guide to implementation, 'How to put NICE guidance into practice: a guide to implementation for organisations', is also available to download from the NICE website. It includes advice on establishing organisational level implementation processes as well as detailed steps for people working to implement different types of guidance on the ground.

## 1.2 *What is the aim of this report?*

1.2.1 This report discusses the potential costs arising from implementation of guidance on borderline personality disorder in England.

1.2.2 This report aims to help organisations plan for the financial implications of implementing NICE guidance. NICE clinical guidelines are developmental standards in the Department of Health's document '[Standards for better health](#)'. This costing report may help inform local action plans demonstrating how implementation of the guideline will be achieved.

1.2.3 This report does not reproduce the NICE guideline on borderline personality disorder and should be read in conjunction with it (see [www.nice.org.uk/CG78](http://www.nice.org.uk/CG78)).

1.2.4 No costing template accompanies this report because the baseline provision of compliant services varies greatly, and so the potential impact of activities resulting from implementation of this guidance will vary from area to area. This cannot be captured and quantified in a costing template.

### **1.3 *Epidemiology of borderline personality disorder***

1.3.1 Coid and colleagues (2006) reported that the weighted prevalence of borderline personality disorder in a random sample of 626 British householders was 0.7%. Based on a population of England that are 17 years old and over, 39,888,500 and assuming a weighted prevalence of 0.7%, we estimate that around 279,200 people aged 17 or older have borderline personality disorder in England.

1.3.2 In primary care, the prevalence of borderline personality disorder ranges from 4–6% of people who attend (Moran et al. 2000; Gross et al. 2002).

1.3.3 People with borderline personality disorder are more likely to visit their GP frequently and to report psychosocial impairment than people with no personality disorder. In spite of this, borderline personality disorder is under recognised by GPs (Moran et al., 2001).

1.3.4 In mental healthcare settings, the prevalence of all personality disorder subtypes is high. Several studies report a prevalence of more than 50% in the sampled population; see for example Singleton and colleagues (1998). Borderline personality disorder is generally the most prevalent category of personality disorder in non-forensic mental healthcare settings. It is particularly common in people who are drug and/or alcohol dependent, people with an eating disorder (Zanarini et al. 1998), and people presenting with chronic self-harming behaviour (Linehan et al. 1991).

- 1.3.5 Borderline personality disorder is often comorbid with depression, anxiety, eating disorders, post-traumatic stress disorder, alcohol and drug misuse, and bipolar disorder (the symptoms of which are often confused with borderline personality disorder). Cases of borderline personality disorder where there is no comorbid condition are thought to account for only 3–10% of all cases (Pfohl et al. 1986). Clinical opinion suggests that treatment of borderline personality disorder can also be beneficial to the patient by alleviating comorbid conditions.
- 1.3.6 Estimating the prevalence of borderline personality disorder as a method of establishing service need and expected levels of patients presenting or referrals is challenging. It would seem reasonable to assume that not all cases are diagnosed and not everyone known to have the condition will seek treatment; in some cases, people with borderline personality disorder may fear treatment or diagnosis. It is also unknown how many people with borderline personality disorder are being treated for comorbid conditions such as anxiety and/or depression.

## **1.4 *Models of care***

- 1.4.1 The guideline covers care provided within primary, community, secondary and specialist health care services within the NHS, including:
- care in general practice and NHS community care
  - hospital outpatient, day and inpatient care, including secure hospitals
  - primary/secondary interface of care
  - the transition from child and adolescent services to adult services
  - care in prisons and the transition from prison health services to NHS health services.

## Current provision of services

1.4.2 Limited up-to-date data are available on the current service provision for people with borderline personality disorder. In 2003 it was reported that many general health services struggle to provide an adequate service for people with personality disorder (National Institute for Mental Health in England [NIMHE] 2003).

1.4.3 A questionnaire issued to all trusts in England providing general adult mental health services in 2002 found that:

- 17% of trusts provide a dedicated personality disorder service
- 40% provide some level of service
- 28% provide no service at all (NIMHE 2003).

No response was received from the remainder of trusts. The NIMHE clarify these findings, suggesting that 'clinicians and practitioners in every trust will assess and provide some kind of intervention for people with personality disorder, if only to exclude them from active treatment' (NIMHE 2003). This supports our own findings in discussion with practitioners (see section 3.3.3).

1.4.4 Estimating current service provision is further complicated by the significant level of comorbidity in this group of people. An axis I diagnosis of a mental disorder is more likely to be reported than an axis II diagnosis of a personality disorder<sup>1</sup>. Almost one third of trusts provide no service, although it would be reasonable to assume that a proportion of people with borderline personality

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<sup>1</sup> The Diagnostic and Statistical Manual of Mental Disorders (American Psychiatric Association, 2000) categorises each psychiatric diagnosis into a different domain that may help clinicians plan treatment:

axis I: clinical disorders, other disorders that may be the focus of clinical attention (includes major mental disorders, such as depression and anxiety, as well as developmental and learning disorders)

axis II: personality disorders, mental retardation

axis III: general medical conditions

axis IV: psychosocial and environmental problems

axis V: global assessment of functioning.

Where a patient has both axis I and axis II disorders, the principal diagnosis is normally assumed to be axis I unless otherwise specified.

disorder are engaged with services for treatment of comorbid conditions.

### **Future service provision**

- 1.4.5 Anecdotal evidence based on discussions with clinicians and other mental health experts supports the view that a diagnosis of borderline personality disorder remains one of exclusion. Effective implementation of the guidance may result in more people engaging with services; clearly, this may have resource implications.
- 1.4.6 Expert opinion was also that many trusts do not have specialist teams dealing with borderline personality disorder and that trusts with specialist teams have insufficient resources. This guidance recommends care pathways in primary and secondary settings for diagnosis and treatment of those with borderline personality disorder so that services might become more inclusive.

## **2 Costing methodology**

### **2.1 *Process***

- 2.1.1 Little information about borderline personality disorder has been systematically collected that would enable the building of a comprehensive bottom-up model for costing (a costing methodology where the unit cost of individual elements and number of units are estimated and added together to provide a total cost). In addition, the current provision of compliant services and care pathways cannot be established as they are so varied.

### **2.2 *Scope of the cost-impact analysis***

- 2.2.1 The guideline offers best practice advice on the care of adults who are suspected of having, or are diagnosed with, borderline personality disorder. The guideline covers the following groups:

- adults (aged 18 and older) with a diagnosis of borderline personality disorder
- people younger than 18 with borderline symptoms, or putative borderline personality disorder
- people with borderline personality disorder and a learning disability.

2.2.2 The guidance does not cover treatments not normally available on the NHS or the separate management of comorbid conditions and other personality disorders – for example, antisocial personality disorder. Therefore, these issues are outside the scope of the costing work. A separate guideline concerning antisocial personality disorder has been published in parallel with this one.

2.2.3 A significant number of people with borderline personality disorder are likely to be receiving treatment for their comorbid conditions covered by existing NICE guidance (see appendix B).

2.2.4 We worked with the GDG and other professionals to identify the recommendations that would have the most significant resource impact (see table 1). Costing work has focused on these recommendations.

**Table 1 Recommendations with a significant resource impact**

High-cost recommendations	Recommendation number	Key priority?
People with borderline personality disorder should not be excluded from any health or social care services because of their diagnosis or because they have self-harmed.	1.1.1.1	✓
Mental health professionals working in secondary care services, including community based services and teams, child and adolescent mental health services (CAMHS), and inpatient services, should be trained to diagnose borderline personality disorder, assess risk and need, and provide treatment and management in accordance with this guideline. Training should also be provided for primary care healthcare professionals who have significant involvement in the assessment and early treatment of people with borderline personality disorder. Training should be provided by specialist personality disorder teams based in mental health trusts.	1.1.9.1	
Community mental health services (community mental health teams, related community-based services, and tier 2/3 services in CAMHS) should be responsible for the routine assessment, treatment and management of people with borderline personality disorder.	1.3.1.1	✓
Before offering a psychological treatment for a person with borderline personality disorder or for a comorbid condition, provide the person with written material about the psychological treatment being considered. For people who have reading difficulties, alternative means of presenting the information should be considered, such as video or DVD. So that the person can make an informed choice, there should be an opportunity for them to discuss not only this information but also the evidence for the effectiveness of different types of psychological treatment for borderline personality disorder and any comorbid conditions.	1.3.4.2	
When considering drug treatment for any reason for a person with borderline personality disorder, provide the person with written material about the drug being considered. This should include evidence for the drug's effectiveness in the treatment of borderline personality disorder and for any comorbid condition, and potential harm. For people who have reading difficulties, alternative means of	1.3.5.5	

<p>presenting the information should be considered, such as video or DVD. So that the person can make an informed choice, there should be an opportunity for the person to discuss the material</p>		
<p>Mental health trusts should develop multidisciplinary specialist teams and/or services for people with personality disorders. These teams should have specific expertise in the diagnosis and management of borderline personality disorder and should:</p> <ul style="list-style-type: none"> <li>• provide assessment and treatment services for people with borderline personality disorder who have particularly complex needs and/or high levels of risk</li> <li>• provide consultation and advice to primary and secondary care services</li> <li>• offer a diagnostic service when general psychiatric services are in doubt about the diagnosis and/or management of borderline personality disorder</li> <li>• develop systems of communication and protocols for information sharing among different services, including those in forensic settings, and collaborate with all relevant agencies within the local community including health, mental health and social services, the criminal justice system, CAMHS and relevant voluntary services</li> <li>• be able to provide and/or advise on social and psychological interventions, including access to peer support, and advise on the safe use of drug treatment in crises and for comorbidities and insomnia</li> <li>• work with CAMHS to develop local protocols to govern arrangements for the transition of young people from CAMHS to adult services</li> <li>• ensure that clear lines of communication between primary and secondary care are established and maintained</li> <li>• support, lead and participate in the local and national development of treatments for people with borderline personality disorder,</li> </ul>	<p>1.5.1.1</p>	<p>✓</p>

<p>including multi-centre research</p> <ul style="list-style-type: none"> <li>• oversee the implementation of this guideline</li> <li>• develop and provide training programmes on the diagnosis and management of borderline personality disorder and the implementation of this guideline (see recommendation 1.5.1.2)</li> <li>• monitor the provision of services for minority ethnic groups to ensure equality of service delivery.</li> </ul> <p>The size and time commitment of these teams will depend on local circumstances (for example, the size of trust, the population covered and the estimated referral rate for people with borderline personality disorder).</p>		
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2.2.5 Ten of the recommendations in the guideline have been identified as key priorities for implementation, and three of these are also among the six recommendations considered to have significant resource impact.

2.2.6 The remaining seven key recommendations that have not been considered to have a significant resource impact are:

- Recommendation 1.1.3.1 – autonomy and choice. It was considered that healthcare professionals working in partnership with people with borderline personality disorder to develop autonomy and encourage choice would not lead directly to a significant increase in resource use, although raising an awareness of this may be required through training.
- Recommendation 1.1.4.1 – developing an optimistic and trusting relationship. This recommendation was not considered for costing because it relates to the patient–professional relationship and could not be isolated from the overall treatment plan. Training of mental health professionals will need to highlight

the importance of trusting and optimistic relationships to those with a diagnosis of borderline personality disorder.

- Recommendation 1.1.7.1 –managing endings and transitions. Managing endings and transitions forms part of all care pathways for people with borderline personality disorder, although on its own this recommendation cannot be costed. Training of mental health professionals will need to highlight the importance of managing endings and transitions of borderline personality disorder patients.
- Recommendation 1.3.2.1 – care planning in community mental health teams. As with recommendation 1.1.7.1, this forms part of the care pathway for people with borderline personality disorder and awareness of this will need to form part of the training of mental health professionals.
- Recommendation 1.3.4.3 – the role of psychological treatment. The guidance recommends that psychological treatment is structured but is also adapted to the person’s needs.
- Recommendation 1.3.4.4 – the role of psychological treatment (brief interventions). The guidance recommends that interventions should be no shorter than 3 months. However, clinical opinion was that current treatment programmes for BPD would never be less than 3 months, so this recommendation will not involve a change in practice. When recommendations 1.3.4.3 and 1.3.4.4 are taken together, the resources required to provide structured treatment adapted to the individual patient’s needs rather than brief interventions will depend on current local service provision and needs to be assessed locally.
- Recommendation 1.3.5.1 - the role of drug treatment. It is not possible to link prescribing information to diagnosis.

2.2.7 We have limited the consideration of costs and savings to direct costs to the NHS that will arise from implementation. We have not included consequences for the individual, the private sector or the not-for-profit sector.

### **3 Recommendations with possible significant cost implications**

#### **3.1 Access to services**

##### **Recommendation**

- 3.1.1 People with borderline personality disorder should not be excluded from any health or social care services because of their diagnosis or because they have self-harmed. [Recommendation 1.1.1.1]

##### **Background**

- 3.1.2 Ten published studies were used in the preparation of the full guidance to inform about the experience of service users with a diagnosis of borderline personality disorder. Crawford et al. (2007) reported that patients with a diagnosis of borderline personality disorder have experienced exclusion from services.
- 3.1.3 Despite the 2003 publication of Department of Health guidance on personality disorders, mental health professionals were of the view that patients with a diagnosis of borderline personality disorder continue to be excluded from some services and that levels of service provision vary considerably around England.

##### **Discussion**

- 3.1.4 As it has not been possible to establish a baseline for the current provision of services, or a number of borderline personality disorder patients receiving treatment within services, it has not been possible to evaluate the likely increase in demand on services by implementing this recommendation.
- 3.1.5 If the 0.7% prevalence estimate of borderline personality disorder in adults (Coid et al. 2006) is correct, the number of potential referrals to specialist services for assessment could be around 280,000 in England.

- 3.1.6 Coid and colleagues' study is based on private households (Coid et al. 2006). It might be assumed that the number of actual referrals to specialist services will be lower than the potential 280,000 estimate based on prevalence, as not all those with borderline personality disorder will present to services or they may not present for treatment of their borderline personality disorder.
- 3.1.7 Between 90 and 97% of people with borderline personality disorder will have a comorbid condition (Pfohl et al. 1986) and some may already be accessing services where required.
- 3.1.8 Depending on current local approaches to the diagnosis and treatment of borderline personality disorder the increase in demand by providing access to services for patients will vary considerably across England.

## **3.2 *Training, supervision and support***

### **Recommendation**

- 3.2.1 Mental health professionals working in secondary care services, including community-based services and teams, CAMHS and inpatient services, should be trained to diagnose borderline personality disorder, assess risk and need, and provide treatment and management in accordance with this guideline. Training should also be provided for primary care health professionals who have significant involvement in the assessment and early treatment of people with borderline personality disorder. Training should be provided by specialist personality disorder teams based in mental health trusts (see recommendation 1.5.1.1). [Recommendation 1.1.9.1]

### **Discussion**

- 3.2.2 The impact of implementation of this recommendation will depend on local circumstances.

- 3.2.3 There is likely to be a large increase in demand for the training from specialist personality disorder teams based in mental health trusts to meet the guidance, perhaps to a greater extent from the primary care sector due to the wider prevalence of borderline personality disorder in the community that have not presented to services.
- 3.2.4 The resources required to train and support professionals will depend on local circumstances. Training may need to be targeted for different professional groups from psychologists to mental health support workers. There could be a one-off non-recurrent cost to train existing staff followed by lower ongoing costs for new staff and continuing professional development.

### **3.3 *Assessment and management by community mental health services***

#### **Recommendation**

- 3.3.1 Community mental health services (community mental health teams, related community-based services, and tier 2/3 services in CAMHS) should be responsible for the routine assessment, treatment and management of people with borderline personality disorder. [Recommendation 1.3.1.1]

#### **Discussion**

- 3.3.2 Existing guidance for comorbid conditions in patients with borderline personality disorder recommends that this is the route taken to assess, treat and manage people with those conditions, including self-harm (NICE clinical guideline CG16).
- 3.3.3 Expert opinion suggests that all community mental health teams assess people with borderline personality disorder and, therefore, that some expertise already exists. However, a diagnosis of borderline personality disorder is not necessarily followed up with treatment. As stated in recommendation 1.1.1.1, patients should

not be excluded from services as a result of a diagnosis of borderline personality disorder.

- 3.3.4 Expert opinion suggests that with training and support there is no need to recruit more professionals to add capacity to these services, although implementation of this guidance may result in a redeployment of resources in mental health settings.

### **3.4 *Providing information about psychological and drug treatments***

#### ***Psychological treatments***

##### **Recommendation**

- 3.4.1 Before offering a psychological treatment for a person with borderline personality disorder or for a comorbid condition, provide the person with written material about the psychological treatment being considered. For people who have reading difficulties, alternative means of presenting the information should be considered, such as video or DVD. So that the person can make an informed choice, there should be an opportunity for them to discuss not only this information but also the evidence for the effectiveness of different types of psychological treatment for borderline personality disorder and any comorbid conditions.  
[recommendation 1.3.4.2]

##### **Background**

- 3.4.2 The full guideline describes a number of psychological treatments for the treatment of borderline personality disorder and their effectiveness. The list is not exhaustive and the brief psychotherapeutic intervention described in the full guideline has been excluded here because brief interventions are specifically not recommended by the guidance:

- dialectical behaviour therapy

- mentalisation-based therapy and partial hospitalisation
- cognitive behavioural therapy
- problem-solving therapy
- schema-focused cognitive therapy
- cognitive analytical therapy
- interpersonal therapy
- psychodynamic interpersonal therapy
- psychodynamic/psychoanalytical psychotherapy.

## **Discussion**

- 3.4.3 During discussions with healthcare professionals it was suggested that there may already be written material to describe to a patient the therapy option that has been discussed for treating their condition. If this does already exist then costs should be limited to printing and distribution. However, we are not aware of any printed materials for the therapies listed above other than from internet-based help groups.
- 3.4.4 Anecdotal evidence based suggests that visual materials are not currently available for describing therapies to those with reading difficulties. This would require production of the material and manufacture into an appropriate format – for example, DVD and the provision of facilities for viewing so that patients can discuss the treatment with practitioners.
- 3.4.5 The possible costs associated with the provision of written and visual material for psychotherapeutic interventions need to be determined locally. In accordance with recommendation 1.1.1.4, written and visual materials should be made available in a range of languages. The appropriate languages will need to be assessed locally.

## ***Drug treatments***

### **Recommendation**

- 3.4.6 When considering drug treatment for any reason for a person with borderline personality disorder, provide the person with written material about the drug being considered. The material should include evidence for the drug's effectiveness in the treatment of borderline personality disorder and for any comorbid condition, and potential harm. For people who have reading difficulties, alternative means of presenting the information should be considered, such as video or DVD. So that the person can make an informed choice, there should be an opportunity for the person to discuss the material. (Recommendation 1.3.5.5)

### **Background**

- 3.4.7 The guideline recommends that drug treatment should not be used specifically for the treatment of borderline personality disorder (see recommendation 1.3.5.1). In addition, the guideline does not recommend the use of antipsychotic drugs for the medium and long-term treatment of borderline personality disorder. Drug treatment may be used in the overall treatment of comorbid conditions and for short term use when those with a diagnosis of borderline personality disorder present during a crisis (see recommendation 1.3.5.2).
- 3.4.8 For these reasons, the recommendation to provide information on drug treatment will not apply to everyone with borderline personality disorder.

### **Discussion**

- 3.4.9 There are no drug therapies licensed in the UK for the treatment of borderline personality disorder, so the patient information leaflets supplied with drug treatments will be inadequate for the purposes

of this recommendation. There would, therefore, be a cost for both the production and the distribution of the material.

3.4.10 Our discussions suggest that visual materials for drug therapies are not available for people with reading difficulties. The costs of producing such material would need to cover writing, filming, manufacture into an appropriate format (for example, DVD), and providing facilities for viewing so that patients can discuss the treatment with practitioners.

3.4.11 The possible costs associated with providing written and visual material about drug treatment should be determined locally and should also take account of the range of languages spoken in the area.

### **3.5 *The role of specialist personality disorder services within trusts***

#### **Recommendation**

3.5.1 Mental health trusts should develop multidisciplinary specialist teams and/or services for people with personality disorders. These teams should have specific expertise in the diagnosis and management of borderline personality disorder and should:

- provide assessment and treatment services for people with borderline personality disorder who have particularly complex needs and/or high levels of risk
- provide consultation and advice to primary and secondary care services
- offer a diagnostic service when general psychiatric services are in doubt about the diagnosis and/or management of borderline personality disorder

- develop systems of communication and protocols for information sharing among different services, including those in forensic settings, and collaborate with all relevant agencies within the local community including health, mental health and social services, the criminal justice system, CAMHS and relevant voluntary services
- be able to provide and/or advise on social and psychological interventions, including access to peer support, and advise on the safe use of drug treatment in crises and for comorbidities and insomnia
- work with CAMHS to develop local protocols to govern arrangements for the transition of young people from CAMHS to adult services
- ensure that clear lines of communication between primary and secondary care are established and maintained
- support, lead and participate in the local and national development of treatments for people with borderline personality disorder, including multi-centre research
- oversee the implementation of this guideline
- develop training programmes on the diagnosis and management of borderline personality disorder and the implementation of this guideline (see recommendation 1.5.1.2)
- monitor the provision of services for minority ethnic groups to ensure equality of service delivery.

The size and time commitment of these teams will depend on local circumstances (for example, the size of trust, the population

covered and the estimated referral rate for people with borderline personality disorder). [recommendation 1.5.1.1]

## **Discussion**

- 3.5.1 The Department of Health has initiated some pilot projects to develop services for people with personality disorders, including borderline personality disorder. Initial information about these pilots indicates that different areas are using different levels of resources.
- 3.5.2 The change in resources required will depend on how developed services are already and what further needs to be done to implement specialist disorder services. Additional resources may not always be required: it could be that existing resources are adapted and restructured to provide a specialist disorder service. This possibility should be assessed locally.

## **3.6 *Benefits and savings***

- 3.6.1 It has not been possible to quantify the benefits and savings that might accrue to the NHS as a result of implementing this guidance. However, two areas emerge as providing benefits and possible cost savings.
- 3.6.2 Diagnosis and access to services. The evidence tables presented in the full guidance (appendix 15) suggest increasing awareness, diagnoses and providing the necessary treatment for people with borderline personality disorder could lead to a reduction in the use of other NHS resources by reducing the number of self-harm events. These events might lead to a reduction in the number of A&E attendances and periods of hospitalisation.
- 3.6.3 Hospital episode statistics give the number of admissions for patients with a diagnosis of F60.9 (personality disorder unspecified) in England for 2006–07 as 1062, of which 738 were emergency admissions. The mean length of stay in hospital was 42.6 days, although the median was 10 days, with a total of 42,130 bed days

attributed to these patients<sup>2</sup>. These data do not show the true extent of borderline personality disorder because the reasons for admission may have been coded differently. The national average unit cost of a bed day for adult acute care in mental health services for 2006–07 was £259<sup>3</sup>.

3.6.4 Improved service organisation may result in fewer visits to primary care and fewer episodes of crisis intervention.

## **4 Impact of guidance for commissioners**

4.1.1 This guidance covers care provided within primary, community, secondary and specialist health care services within the NHS. Specifically, it includes:

- care in general practice and NHS community care
- hospital outpatient, day and inpatient care, including secure hospitals
- primary/secondary interface of care
- the transition from child and adolescent services to adult services
- care in prisons and the transition from health services to NHS services.

4.1.2 It is expected that expenditure on the recommendations in this guidance will fall into programme budgeting category 205X 'other mental health disorders'.

4.1.3 Mental health services are currently excluded from 'Payment by results'.

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<sup>2</sup> Data is for all personality disorders as a further breakdown is not available.

<sup>3</sup> NHS Reference Costs (2006/07) Service code MHIPA2  
National costing report: Borderline personality disorder  
(January 2009)

## **5 Conclusion**

### **5.1 *Total national cost for England***

- 5.1.1 It has not been possible to establish the current baseline provision of services for people with borderline personality disorder or the cost of service provision where it currently does not exist. Therefore, it has not been possible to quantify costs or savings arising from implementation for England and it will be necessary for commissioners and providers implementing this guidance to establish costs at the local level.

## Appendix A. References

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## Appendix B. Related NICE guidance

Antisocial personality disorder: treatment, management and prevention. NICE clinical guideline 77 (2009). Available from [www.nice.org.uk/CG77](http://www.nice.org.uk/CG77)

Anxiety: management of anxiety (panic disorder, with or without agoraphobia, and generalised anxiety disorder) in adults in primary, secondary and community care. NICE clinical guideline 22 (2004). Available from [www.nice.org.uk/CG22](http://www.nice.org.uk/CG22)

Bipolar disorder: the management of bipolar disorder in adults, children and adolescents, in primary and secondary care. NICE clinical guideline 38 (2006). Available from [www.nice.org.uk/CG38](http://www.nice.org.uk/CG38)

Depression: the management of depression in primary and secondary care. NICE clinical guideline 23 (2004). Available from [www.nice.org.uk/CG23](http://www.nice.org.uk/CG23)

Drug misuse: opioid detoxification. NICE clinical guideline 52 (2007). Available from [www.nice.org.uk/CG52](http://www.nice.org.uk/CG52)

Drug misuse: psychosocial interventions. NICE clinical guideline 51 (2007). Available from [www.nice.org.uk/CG51](http://www.nice.org.uk/CG51)

Eating disorders: core interventions in the treatment and management of anorexia nervosa, bulimia nervosa and related eating disorders. NICE clinical guideline 9 (2004). Available from [www.nice.org.uk/CG9](http://www.nice.org.uk/CG9)

Obsessive–compulsive disorder: core interventions in the treatment of obsessive-compulsive disorder and body dysmorphic disorder. NICE clinical guideline 31 (2005). Available from [www.nice.org.uk/CG31](http://www.nice.org.uk/CG31)

Post-traumatic stress disorder (PTSD): the management of PTSD in adults and children in primary and secondary care. NICE clinical guideline 26 (2005). Available from [www.nice.org.uk/CG26](http://www.nice.org.uk/CG26)

Schizophrenia: core interventions in the treatment and management of schizophrenia in primary and secondary care. NICE clinical guideline 1 (2002). Available from [www.nice.org.uk/CG1](http://www.nice.org.uk/CG1)

Self-harm: the short-term physical and psychological management and secondary prevention of self-harm in primary and secondary care. NICE clinical guideline 16 (2004). Available from [www.nice.org.uk/CG16](http://www.nice.org.uk/CG16)

Violence: the short-term management of disturbed/violent behaviour in in-patient psychiatric settings and emergency departments. NICE clinical guideline 25 (2005). Available from [www.nice.org.uk/CG25](http://www.nice.org.uk/CG25)

Zaleplon, zolpidem and zopiclone for the management of insomnia. NICE technology appraisal guidance 77 (2004). Available from [www.nice.org.uk/TA77](http://www.nice.org.uk/TA77)

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