Original article

The costs and effectiveness of two psychosocial treatment programmes for personality disorder: a controlled study

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Abstract

This paper examines the costs and cost-effectiveness of psychosocial treatment for personality disorder in a controlled study. Using well-validated cost and outcome measures three groups are compared: the One-Stage group (n = 32) received 12 months of inpatient treatment; the Step-Down group (n = 29) received 6 months of inpatient treatment followed by 12 months of outpatient therapy; and the control group of 47 people used routinely available services. Both specialist programmes were more effective than routine psychiatric services but more costly. Using an extended dominance approach the incremental cost-effectiveness ratio showed that achieving one extra person with clinically relevant outcomes required an investment in the Step-Down programme of around £3400 over 18 months. Small sample sizes and non-random allocation to programmes are limitations of this study but the costs and effectiveness findings consistently point to advantages for the shorter residential programme followed by community-based psychotherapeutic support.

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1. Introduction

This paper examines the costs and cost-effectiveness of three treatment modalities in UK for patients suffering from severe personality disorders. There is almost no costs-related research undertaken on this patient group. For example, recent cost-of-illness studies found the direct treatment costs for depression in the UK in 2000 to be £370 million [23] and £199 million for bipolar disorders [10], yet there has been no such study for personality disorder published since 1995 [22]. Only two UK studies reporting cost information at the individual level were found. A follow-up of 303 general practice attenders found people with personality disorder to be nearly twice as costly to support (mean = £3094 per annum) as those without (mean = £1633 per annum), although a diagnosis of personality disorder on its own was not a significant predictor of costs [20]. A study of partial hospitalisation for people with borderline personality disorder found 18-month treatment costs of $27,300 (health services only) compared to $31,000 for those receiving general psychiatric care [3].

We do know, however, from studies of resource use that patients with personality disorder place large burdens on health and social care resources. Prevalence rates are high, at between 10 and 13% of the adult population, and between 36 and 67% of psychiatric hospital populations [19]. People with personality disorder have been found to make more extensive use of psychiatric services than patients without personality disorder [5]. One Australian study found that almost a third of people requiring high levels of input from hospital and community-based psychiatric services had personality disorder as either a primary or comorbid diagnosis [16].

There is, however, some evidence to suggest that effective treatment may reduce service use, and therefore costs, over time [2,3]. Analysis of health service use data from the current study supports this finding; inpatient psychosocial treatment at the Cassel Hospital reduced patients’ subsequent use...
of medical, surgical and psychiatric services [9]. In this paper we extend those analyses to include the use and costs of other community-based services and accommodation supports. This enables a full understanding of the costs and cost-effectiveness of these treatment modalities.

1.1. Treatments under study

In this study two state-funded specialist models were compared with treatment as usual (TAU) as delivered within a general psychiatric service. The specialist services were provided at the Cassel Hospital in Richmond, London. This is a tertiary facility internationally renowned for its specialist psychosocial approaches and recently cited as a notable practice site for the treatment of personality disorder [19]. It offers two treatment programmes to patients from all over Britain; a ‘One-Stage’ psychosocial inpatient programme and a ‘Step-Down’ programme.

- The One-Stage programme entails an 11–16 months stay in a therapeutic community milieu including: twice-weekly individual psychoanalytically oriented psychotherapy; unit meetings with unit staff five times a week, community meetings twice each week, weekly small group psychotherapy; a structured programme of activities aimed at the acquisition of interpersonal skills, re-socialisation, and rehabilitation; psychotropic medication.

- Following a 6-month residential treatment with the same components as the One-Stage programme, the 12–18 months of outpatient follow-on treatment in the Step-Down programme includes including twice-weekly small group analytic psychotherapy, twice-weekly individual and group meetings in the community with a psychosocially-trained outreach nurse, active networking with primary and secondary care workers, team meetings to discuss the patients’ progress, and meetings with a senior psychiatrist to review progress.

The people receiving TAU were under the care of a general psychiatric care service. Their support comprised psychotropic medication, supportive outpatient and community contact with one or more care workers commonly at intervals of 2–4 weeks, hospital admission as needed, and a clinical review on average once a month. This group would reflect the likely outcome of non-specialist treatment in UK; a survey in 2002 found 28% of NHS Trusts still have no specialist personality disorder service [8,19].

There is no doubt that inpatient treatment is costly, often accounting for a high proportion of the total costs of care [17]. But how do the costs of specialist treatment compare with routinely available services? How do the costs of the two specialist programmes—the One-Stage and the Step-Down—compare? To provide evaluative information on the impact of expenditure we estimate an incremental cost-effectiveness ratio. This is a simple expression of the relative costs and effects of the treatment modalities from inception to the study through to 1 year after the expected termination of treatment.

2. Subjects and methods

2.1. Design and sample

Recruitment to the three-arm study began in January 1993 and continued until July 1997. Inclusion and exclusion criteria and other procedures have been detailed elsewhere [6]. In summary, consecutive admissions to the Cassel Hospital adult personality disorder unit were included if they were between the ages of 18 and 55, had a good command of the English language, and had an Axis II diagnosis of personality disorder. Patients were excluded if they had a previous diagnosis of schizophrenia, delusional disorder or organic brain damage, if they had a hospital admission of more than 2 years, or had been involved in criminal proceedings for violent crime.

Randomisation was not feasible in this study as the Step-Down programme still required quite intensive attendance at the outpatient facility. Therefore patients living in the greater London area were allocated to the Step-Down programme, whilst those from any other area in Britain were assigned to the longer inpatient programme (One-Stage group). Of the 64 patients who gave informed consent and were allocated to the One-Stage group 19 (30%) withdrew from the study without contributing any data, and a further 13 (20%) patients withdrew prior to the follow-up assessment. Fifty-five patients were allocated to the Step-Down group; 12 (22%) withdrew within a few days of agreeing to take part in the study and a further 14 (26%) dropped-out before the follow-up assessment.

Patients in the TAU group were identified over the same time period as the other two samples by senior psychiatrists working within the general psychiatric services of the North Devon Healthcare NHS Trust, and subsequently screened using the Personality Diagnostic Questionnaire version 4 for presence of at least one Axis II disorder [13]. Of the 73 patients that met the criteria, 14 (19%) did not sign the consent form, and a further 10 (14%) contributed no data after the baseline or post-discharge assessments.

The clinical outcome data used here were collected at baseline and a year after treatment (follow-up). For the One-Stage and TAU groups, the follow-up interviews were held approximately 24 months after entry-to-study, but the extended period of treatment for the Step-Down group meant these were held approximately 30 months after entry-to-study. Resource use data from the treatment and follow-up assessments are used to estimate costs for the whole study period.

All 108 patients for whom cost-related and outcome data were available at baseline, post-discharge and follow-up assessments are included in these analyses: 32 in One-Stage group, 29 in the Step-Down group, and 47 in TAU. People in this sample were similar to those who did not have costs data for all time periods on the baseline demographic, clinical and economic measures except that people who dropped-out were on average 3.4 years younger ($P = 0.045$).
About three-quarters of the sample were female, and the average age was 34 years. At baseline, about two-thirds of the patients in One-Stage and Step-Down groups were single compared to one-third of the TAU participants ($\chi^2 = 13.84, \text{DF} = 4, P = 0.008$).

### 2.2. Measures

Costs-related data were collected from each person using a variant of the Client Service Receipt Inventory (CSRI), adapted for this population and research context [4]. For the baseline interview, we were interested in assessing the extent to which patients differed in their use of those supports and services that were likely to be the major drivers of costs and outcomes. A ‘reduced list’ CSRI format was employed to record information on the use of accommodation supports, all hospital services, day activity and employment services, general practitioner (GP) contacts, drug and alcohol services, community-based psychiatrist, psychologist and psychiatric nurse, social worker, education classes, legal services, and police [17]. To facilitate the cost-effectiveness analysis, the total cost estimated from the full CSRI used at later assessments was adjusted to reflect the same scope of services. A comparison of the costs generated by the full and reduced list of services showed that the reduced list successfully captured 99% of the total support costs during the year after treatment.

At each time point, accommodation and service utilisation data were collected for a retrospective period of 12 months. For the One-Stage and TAU groups, this gave a continuous picture of service use throughout the study period. For Step-Down group, who had received 18 months of treatment, this meant that CSRI data were not collected for the period likely to be spent as an inpatient at the Cassel. Costs for this period were estimated as the actual number of inpatient days multiplied by the cost per inpatient day plus the costs associated with days not spent as inpatients. The latter were calculated on the basis of the accommodation type lived in for the majority of the subsequent 12 months plus group therapy and outreach nursing treatment costs.

Unit costs for each service and accommodation type were estimated. Combining these with patient’s data on the frequency and duration of service use (as collected on the CSRI) allowed estimation of the total service and accommodation costs for each person for the year prior to each interview. Particular attention has been paid to the costs of non-hospital accommodation, including domestic accommodation. As the study includes both residential and non-residential treatment programmes, a like-with-like comparison of costs would require us either to remove ‘hotel’ costs from the hospital costs or to include the costs of accommodation arrangements for people receiving non-residential treatment. The latter approach, taken here, is certainly easier but also conforms to the economic desiderata of taking a societal costs perspective. However, research resources did not allow collection of data relating to informal care inputs and as employment rates are very low among this sample, we indicate the scope of lost production costs through employment rates rather than calculate the cost implications.

Unit costs for the financial year 1998/1999 were used throughout the study so that the cost of each study members’ support package reflects prices and service configurations over the period in which most people received support. Unit costs based on national data were used where possible [18]. For services specific to this study, such as inpatient and outpatient services at the Cassel Hospital, unit costs were estimated from first principles as their closest approximation to long-run marginal opportunity costs using widely accepted methods derived from economic theory [1]. To adjust the prices presented in this paper to 2002–2003 levels, the Hospital and Health Services Pay and Prices index gives a multiplier of 1.178.

The diagnostic and outcome measures included the Structured Clinical Interview for DSM-III-R [21]; the Symptom Checklist-90-R [11] and the Global Assessment Scale (GAS) [12]. The Symptom Checklist-90-R yields two total scores, the General Severity Index (GSI), and the Positive Symptom Total (PST). These measures and the outcome results are discussed in more detail elsewhere [7,8].

### 2.3. Data analysis

Clinical outcome, employment circumstances, service and accommodation utilisation rates, and costs are described for the baseline and whole study period (post-discharge and follow-up assessments). Differences in means between groups were explored by ANOVA and Student’s $t$-tests, and Chi-square tests were used for categorical data. Data were analysed using SPSS for windows, version 11.0. Where appropriate, results from skewed cost data were confirmed by estimating bootstrapped confidence intervals using the STATA software package.

### 3. Results

#### 3.1. Clinical outcome

The Step-Down treatment programme has been shown to have greater psychosocial benefits for patients than either the One-Stage programme or TAU [6,7]. The three samples were well matched on most socio-demographic variables [7] and there were no differences between any of the groups on pre-treatment scores for the GAS, GSI or PST. Table 1 shows both the baseline and the improvement score between baseline and the follow-up assessment for each group.

In summary, all three groups had improved in their functioning over time, with people in Step-Down group showing the greatest improvement and those in the TAU group the least improvement.

- The Step-Down group improved more than the TAU group on all three measures:
\[ t = -2.287, \text{DF} = 41.4, P = 0.027 \] for the GAS;
\[ t = 4.286, \text{DF} = 45.8, P = 0.000 \] for the GSI;
\[ t = 4.570, \text{DF} = 43.7, P = 0.000 \] for the PST.

- The Step-Down group also improved significantly more than the One-Stage group on the PST \((t = -2.696, \text{DF} = 53.5, P = 0.010)\), and slightly more on the GSI \((t = -1.960, \text{DF} = 59, P = 0.055)\).

- The One-Stage group improved more than the TAU group on all three outcome measures:
  \[ t = -2.043, \text{DF} = 77, P = 0.044 \] for the GAS;
  \[ t = 2.387, \text{DF} = 77, P = 0.019 \] for the GSI;
  \[ t = 2.039, \text{DF} = 77, P = 0.045 \] for the PST.

3.2. Employment and income sources

A year after the end of treatment, only two or three more people in the specialist treatment programmes (One-Stage and Step-Down) had found open employment when compared to the baseline figures. Table 2 shows that the number of people in open employment had decreased slightly in the TAU group, suggesting a few people had poorer occupational functioning, but the increase in weekly wages may suggest more intensive participation for those who were working. The numbers of employed people are too small to present statistical findings for these comparisons. Changes in employment rates are broadly reflected in the changes in the proportions of people claiming social security benefits. Both findings suggest that there may be potential for wider economic benefits from specialist treatment.

3.3. Accommodation arrangements and service use

The use of various accommodation arrangements in the year prior to the baseline and follow-up interviews is shown in Table 3. The Table shows, for example, that 94% of people in One-Stage group had spent some part of the year prior to the baseline interview in domestic accommodation. In addition, nearly one in five people who had spent some time in specialist (usually staff-supported) accommodation facilities and one in four had been in psychiatric hospital for more than 42 days of that year. Only 15% of the TAU group had been living in domestic housing for at least 100 days in the year before the baseline interview, compared to 41% of One-Stage group and 50% of Step-Down group \((\chi^2 = 11.63, \text{DF} = 2, P = 0.003)\). Generally, in the year following treatment, all groups spent less time in specialist accommodation facilities or hospital.

Table 4 shows the service utilisation rates (reduced list only) for the three groups in the year prior to the baseline interview, during the treatment period and for the year after.
service use at baseline and for the year after treatment

<table>
<thead>
<tr>
<th>Service Type</th>
<th>Baseline: N (%) group using</th>
<th>Treatment period: N (%) group using</th>
<th>Follow-up: N (%) group using</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital services</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Psychiatric inpatient</td>
<td>5 (16%)</td>
<td>2 (7%)</td>
<td>14 (30%)</td>
</tr>
<tr>
<td>Non-psychiatric inpatient</td>
<td>2 (6%)</td>
<td>5 (17%)</td>
<td>13 (28%)</td>
</tr>
<tr>
<td>Non-inpatient hospital services</td>
<td>30 (84%)</td>
<td>26 (90%)</td>
<td>42 (89%)</td>
</tr>
<tr>
<td>Legal services</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Police</td>
<td>1 (3%)</td>
<td>4 (14%)</td>
<td>15 (32%)</td>
</tr>
<tr>
<td>Lawyer</td>
<td>4 (13%)</td>
<td>7 (24%)</td>
<td>19 (40%)</td>
</tr>
<tr>
<td>Mental health services</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Psychiatric inpatient</td>
<td>14 (44%)</td>
<td>10 (34%)</td>
<td>11 (23%)</td>
</tr>
<tr>
<td>Non-psychiatric inpatient</td>
<td>4 (13%)</td>
<td>5 (17%)</td>
<td>2 (4%)</td>
</tr>
<tr>
<td>Community psychiatric nurse</td>
<td>7 (22%)</td>
<td>10 (34%)</td>
<td>28 (60%)</td>
</tr>
<tr>
<td>Private psychotherapist</td>
<td>8 (25%)</td>
<td>7 (24%)</td>
<td>2 (4%)</td>
</tr>
<tr>
<td>Other counselling services</td>
<td>0</td>
<td>5 (17%)</td>
<td>0</td>
</tr>
<tr>
<td>Community-based services</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>GP</td>
<td>29 (91%)</td>
<td>27 (93%)</td>
<td>47 (100%)</td>
</tr>
<tr>
<td>Social Worker</td>
<td>6 (19%)</td>
<td>7 (24%)</td>
<td>21 (45%)</td>
</tr>
<tr>
<td>Education classes</td>
<td>5 (16%)</td>
<td>7 (24%)</td>
<td>12 (23%)</td>
</tr>
<tr>
<td>Employment services</td>
<td>0</td>
<td>2 (7%)</td>
<td>8 (17%)</td>
</tr>
<tr>
<td>Voluntary services</td>
<td>7 (22%)</td>
<td>3 (10%)</td>
<td>19 (40%)</td>
</tr>
</tbody>
</table>

* Psychiatric inpatient stays of less than 42 days are included here as it is assumed that costs of accommodation elsewhere were maintained during this period.
* Community-based mental health services.

During the treatment period, service use rates for the TAU group were similar to those found for the year prior to the baseline interview and, with the exception of the community psychiatric nurse and hospital services, Table 4 indicates some reduction in utilisation rates for the follow-up period. For the One-Stage and Step-Down groups, there appears to be a larger reduction in use of community mental health services and non-inpatient hospital services over time. However, as part of their treatment, everyone in specialist treatment also used inpatient services at Cassel and most of the Step-Down group used the Cassel outreach nurse (n = 21, 72%) and outpatient group therapy (n = 26, 90%) suggesting some service substitution. Utilisation rates for mental health services appear to rise in the year after treatment ended but not to the levels seen at baseline.

As in other studies of this patient group we found the frequency with which services were used to be quite high prior to treatment. For example, during the year prior to the baseline interview patients had an average of 13.6 outpatient appointments (range 0–133), 23.3 attendances at day hospitals (range 0–260), 13 GP appointments (range 0–150), and 5.8 social worker appointments (range 0–54). However, these figures were considerably lower after treatment: 7.8 outpatient appointments, 5.6 attendances at day hospitals, 1.3 contacts with a GP, and 0.5 contacts with a social worker.

3.4. The costs of treatment and support

Over the baseline period, accommodation arrangements (in domestic or specialist housing or prolonged hospital residence) accounted for just over two-thirds of the total support costs for all three groups. Hospital services absorbed between 13% (TAU) and 22% (One-Stage) with other community-based services absorbing between 11% (One-Stage) and 18% (TAU). Over the treatment period, costs accruing for treatment at Cassel accounted for 82% of the total cost of support for the One-Stage group and 24% of the costs of support for the Step-Down group. At the follow-up, the generally lower utilisation rates of hospital, mental health and other community-based services mean that together these cost categories account for only between 11% (Step-Down) and 19% (One-Stage and TAU) of total costs.

The mean total costs per person at each stage of the study period are shown in Table 5. For patients in the One-Stage and Step-Down groups, paired t-tests show that costs are higher during the treatment period than at pre-treatment (t = –14.72, P < 0.000) and then fall back to below the baseline level in the year following treatment (t = 5.02, P < 0.000). For those receiving TAU, the costs pre-treatment and over

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**Note:** The table and text reference Table 4, which is not provided in the image. The text above assumes the continuity of data from Table 4 as indicated in the context.
the treatment period are similar but follow-up costs are significantly lower than baseline costs ($t = 3.20, P = 0.002$). Comparing the groups at each time period, TAU group costs at baseline are lower than either the One-Stage group ($P = 0.066, CI = 452, 7473$) or the Step-Down group ($P = 0.004, CI = 2107, 10,273$). TAU costs were also lower than either the One-Stage or Step-Down groups over the treatment period (respectively: $P < 0.000, CI = 22,151, 30,109$; $P < 0.000, CI = 24,727, 32,627$). Costs for the One-Stage group and Step-Down group are similar at baseline ($P = 0.346$) and although the observed treatment period costs for the Step-Down group are higher than for the One-Stage group the difference is not significant ($P = 0.389$). Follow-up costs for all groups are similar ($P > 0.116$). Costs over the entire study period (entry-to-study to follow-up) are not different between the One-Stage and the Step-Down groups but TAU costs are lower than both the One-Stage group ($P < 0.000, CI = 26,763, 34,649$) and the Step-Down group ($P < 0.000, CI = 24,843, 36,666$).

3.5. Costs and outcomes

Put alongside each other, the cost and outcome results suggest that both the Step-Down and One-Stage programmes generate better outcomes for the patients than routinely available services (TAU) but these groups also receive more expensive treatment. No significant cost difference was found between the two specialist programmes but the Step-Down group improved more in terms of their outcomes than the One-Stage Group, particularly in their positive symptoms.

To bring together the costs and outcome findings we calculated an incremental cost-effectiveness ratio (ICER). This gives the additional cost of one treatment modality over another of achieving a one-point change in the outcome scores. This is calculated as the ratio of the between-group difference in the change in costs (costs for whole study period less the baseline costs) and the difference in improvement scores between groups.

In this study the three groups being compared have been ranked in terms of their cost (least expensive to most costly), and each treatment modality considered for exclusion where it is more expensive and less effective than the previous one [15]. Using this extended dominance approach the groups were ranked as TAU, Step-Down and One-Stage. The One-Stage programme was excluded as being more costly (although this was not a significant difference) and less effective than the Step-Down approach.

An ICER was calculated for each outcome measure in turn (Step-Down showed significant improvements for all measures compared to TAU): £3405 for each additional point gained on the GAS (range 1–100) in the Step-Down programme compared to TAU; £30304 for a one-point change in the GSI (range 1–4); and £1131 for the PST (range 0–90).

4. Discussion

This study has a number of strengths. First, we combine data on the use of accommodation and other health and social care supports with cost data, allowing the full cost implications of specialist treatment for personality disorder to be calculated. Second, a ‘TAU’ group was incorporated in the study design so that the two specialist treatment programmes based at Cassel Hospital could be compared with each other but also against a group of people using mainstream services. Finally, this study linked the cost information with concurrent measures of need. This allowed the costs data to be interpreted in light of patients’ needs and outcomes.

Both specialist programmes generated better outcomes for the participants than TAU, with the Step-Down programme being the most effective. Over the whole study period, support for the TAU group was the least expensive, with the intensive One-Stage inpatient programme being the most costly. This ranking led to an incremental cost-effectiveness ratio being calculated for the Step-Down programme over TAU. The cost of achieving the additional outcomes generated by the Step-Down programme appears high in some instances; around £30,300 for one additional point of improvement on the GSI, but as the range for this measure is small (0–4) this represents a large improvement. For the GAS and PST, scales which have a wider range of possible scores, we also calculated the number of people achieving a clinically significant change in outcome [14]. When calculated on this measure, the ICER (the cost of one extra person achieving this outcome in the Step-Down programme over the TAU) was £2660 for the GAS and £2993 for the PST.

It is important to remember the time scales for this project; the longer treatment period for the Step-Down group constitutes a central part of the treatment programme. This does have implications for the full study period, giving an extra 6 months from entry-to-study to the follow-up interview compared to the One-Stage or TAU groups. It could be argued that this longer period means that the natural progression of the disorder may have influenced the outcome results, how-

<p>| Table 5 |</p>
<table>
<thead>
<tr>
<th>Mean costs per person</th>
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<tbody>
<tr>
<td><strong>Mean costs per person for...</strong></td>
</tr>
<tr>
<td>Total cost for year prior to baseline interview</td>
</tr>
<tr>
<td>Total cost over treatment period</td>
</tr>
<tr>
<td>Total cost for year after treatment</td>
</tr>
<tr>
<td>Total cost over entire study period$^a$</td>
</tr>
</tbody>
</table>

$^a$ From entry-to-study to follow-up interview.
ever, severe personality disorder is a chronic and often treatment-resistant disorder, and there is no evidence to suggest that the 6-month delay in rating would make any substantial difference. Previous analysis of the outcome data have shown a significant time effect in the GSI and GAS score for the treatment groups with outcomes improving more sharply in the Step-Down programme relative to lower or lack of change in the One-Stage or TAU ([8], p1466). Treatment and support costs were estimated over the period from entry-to-study to follow-up interview, so our analyses incorporate the cost implications of that extended period as well as the intensity of treatment for each group. Thus the extra investment required for the additional outcomes generated by the Step-Down programme occur over a 30-month period.

There are three main limitations to this study. First, we must be aware of the small samples in this study. We have tried to overcome this as far as possible with the choice and careful use of statistical techniques, however the large difference in mean costs for the full study period found between the Step-Down programme and TAU (the groups used in the ICER calculations) suggest that the study was more than adequately powered to find a valid cost difference. Sample sizes were also sufficient to compare the baseline costs between the specialist treatment groups and TAU. The second limitation is that differential attrition between groups over the follow-up period constitutes a threat to the internal validity of the study. Only with the completion of more studies can the impact of this be understood.

Finally, patients were not allocated randomly to the treatment groups but rather by their geographical location. While the baseline analysis showed no difference between groups in the patients’ characteristics or needs, the service profiles were different with lower baseline costs for the TAU group. This disparity in baseline costs is not uncommon, even in randomised controlled trials, and we have taken it into account in our ICER calculations. However, viewing the cost results over time is instructive. The TAU group comes from a single locality so its specific system of care (for example, service availability and access, and professional preferences) may be responsible for the cost difference. Each of the three treatment modalities reduced the support costs in the year after treatment but again it is the Step-Down programme that appears most advantageous with the largest cost reduction over time, followed by One-Stage group, and the smallest reduction occurred for the TAU group. If regional differences in service provision continued during the follow-up period, the fact that costs are no longer different implies that the treatment at the Cassel Hospital generated a greater reduction in down-stream service use and costs than TAU. This provides further evidence in support of implementing the Step-Down programme rather than the types of treatment and support received by the other two study groups. Of course, if availability and access to services is generally better than in the control area selected for this study then the differences in costs and outcomes between people using treatment in the Cassel Hospital and routinely available services is likely to be smaller than indicated here.

5. Conclusion

Recent UK Guidance documents emphasise the need to develop service models to meet the needs of patients with personality disorder [19]. The Guidance encourages Trusts to develop specialist personality disorder teams and where there is a high concentration of morbidity, to consider developing day treatment units but states that there are no plans to extend the level of specialist inpatient or residential facilities.

The Guidance does, however, note that `the current state of research on treatment discourages prescriptive statements about the type of treatments which patients should be offered by specialist services’ ([19], p33). Our search of the literature also revealed that very few studies had explored the costs of treating or supporting people with personality disorder and none that had evaluated the cost-effectiveness of different treatment models. The findings from this study, therefore, provide some of the first evidence on the costs and effectiveness of specialist treatment centres and should feed into commissioning decisions about how best to ensure people with personality disorder have access to a range of treatment options.

References


