POLICY

Centre for Mental Health

# Under the radar

## Women with borderline personality disorder in prison

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a **better** way

## Summary

Women in prison are particularly vulnerable to mental health problems and self-harm (Corston, 2007). It is estimated that around a fifth of women in custody fulfil criteria for borderline personality disorder (BPD) (Singleton *et al.*, 1998), making it a significant issue for the prison health service and an expensive drain on limited prison management resources. Despite the principle of 'equivalence of care' in prison health care, guidelines for the management of BPD (NICE, 2009) are rarely observed in prisons.

In addition to health care deficits, the prison environment can be traumatic for women with BPD due to the hostile, punitive environment and the experience of incarceration (Wolff & Shi, 2009). Family environments are significantly disrupted for all women on custodial sentences, with children frequently relocated and one in ten sent into social care (Caddle & Crisp, 1997).

Women with BPD often have unstable family environments prior to being taken into custody, compounding the effect of this disruption (Whisman & Schonbrun, 2009). Looking ahead to future generations, this upset to family life may contribute to the effects of 'transgenerational transmission' of criminal behaviour and mental health problems (Feldman *et al.*, 1995; Warren & South, 2009).

We recommend:

- Increased screening and appropriate diversion should be implemented to avoid custodial sentences where possible for women with BPD.
- Prison staff could benefit from increased training to raise awareness and improve the quality of care in prison.
- Where custodial sentences are necessary, evidence-based therapeutic interventions should be available to support women with BPD in prison.
- Where appropriate, evidence-based family interventions should be made available.

This policy paper is based on a review of relevant academic literature and policy relating to borderline personality disorder within the women's prison estate. The main findings were complemented by interviews with two women who have been in prison and who have a diagnosis of borderline personality disorder. The interviews were semi-structured, giving the women the opportunity to talk about the full range of their experiences and opinions. These interviews were digitally-recorded, and then transcribed and anonymised before inclusion in this report.

## Introduction

Since the NHS took over health care in prisons between 2003 and 2006, there has been an important guiding principle: that health care in prisons should be equivalent to that in communities. This has been achieved for some health conditions, but mental health problems are difficult to treat in prison due to the differences in environment, referral pathways, lower resources, greater complexity of needs and the lack of continuity of care (Birmingham *et al.*, 2006; Niveau, 2007), and good treatment is not universally available.

Women coming into prison are almost twice as likely to have recently received help for mental health problems than men, are more likely to need help in prison for mental illness, are more likely to use prison health services and to take medication, and are much more likely to self-harm (Singleton *et al.*, 1998; Corston, 2007). Younger women have particularly complex, multi-faceted needs: Douglas and Plugge (2006) report that 40% of under 17-year-olds in women's young offender institutions (YOIs) have previously been looked after by local authorities, and 90% have left school before the age of 17. This means that in order to achieve equivalence of care, women's prisons should take account of the differences in women's health problems compared to men and tailor their services accordingly.

A fifth of women in custody fulfil criteria for a borderline personality disorder (BPD) (Singleton *et al.*, 1998). Borderline personality disorder is a debilitating and distressing condition (Perseius *et al.*, 2005), and research suggests that prison itself may make it worse (Wolff & Shi, 2009).

There are clear guidelines about the best practice in treating women with a BPD diagnosis (NICE, 2009), which are equally applicable in prison. Specialist dangerous and severe personality disorder (DSPD) services for women in HMP and YOI Low Newton have rigorously followed these guidelines in the development of the Primrose Programme (Travers & Reeves,

2005) (See Box 1). However, this service only accommodates twelve women at a time who are deemed to be a significant danger to society. Women in other prisons receive treatment that falls short of this standard, and receive far less than the financial resources given to those in DSPD services (Barrett *et al*., 2009). This paper gathers evidence from health, prison and psychiatric research about women with BPD in prisons.

**Box 1: Women's DSPD pilot**

The Primrose Project, based at HMP/YOI Low Newton, is a collaborative pilot programme serving the needs of women who primarily pose a risk of serious harm to the public emanating from their complex clinical presentations. The issues affecting service provision for women may be different from those of men; therefore, the Department of Health states that the project has drawn on best practice to develop a hybrid model of intervention. Unlike the DSPD programme for male offenders, the 12 places allocated to the Primrose pilot are housed on the wings and are not segregated from the rest of the prison (Department of Health, 2006).

When considering the provision of services for prisoners with personality disorders, political debate and policy decision making seem to be disproportionately skewed towards those offenders who pose the greatest risk to society. A recent report by the Centre estimates that up to £60 million is spent annually on containing and treating prisoners in services for Dangerous and Severe Personality Disorder (DSPD) in only a small number of prisons and high security hospitals (Rutherford, 2010), yet DSPD is a non diagnostic term without a clinical meaning (Buchanan & Leese, 2001). An economic evaluation argues that these services are more costly than prisons and result in a deterioration in outcomes (Barrett *et al*., 2009).

Under 0.5% of prisoners have access to the specialist interventions offered by DSPD units due to the nature and degree of their condition, yet research suggests that 78% of male remand, 64% of male sentenced and 50% of female prisoners have a diagnosis of personality disorder (Singleton *et al*., 1998).

Although significant resources are directed towards interventions for male prisoners in dangerous and severe personality disorder services very little resource is used to help women prisoners with debilitating conditions such as borderline personality disorder.

## What is borderline personality disorder?

The term personality disorder has been used to describe people who have "an enduring pattern of inner experience and behaviour that deviates markedly from the expectations of the individual's culture" (DSM-IV, 1994). There are twelve different types of personality disorder (Sainsbury Centre, 2009a). Borderline personality disorder (BPD) is a diagnosis used to describe people who show "a pervasive pattern of instability of interpersonal relationships, self-image, and affect, and marked impulsivity, beginning by early adulthood and present in a variety of contexts" (DSM-IV, 1994).

*"It was like as if someone had injected me with ... I don't know speed or something, and I was just getting out of control. I was told 'if you don't come off the ladder you're going to fall off the top, you're going to run out of rungs'."*

Many people with BPD experience a life full of emotional pain and distress (Perseius *et al*., 2005). The reality of the symptoms described in the diagnostic manual is that these difficulties often lead to self-harm and self-mutilation, associated with the complexity of expressing difficult emotions (Nehls, 1999). A systematic review found that over half of people with BPD also fulfilled criteria for drug or alcohol dependence (Trull *et al*., 2000).

Many people with borderline personality disorder have experienced some form of childhood trauma, especially physical abuse (71%), sexual abuse (68%), and witnessing serious domestic violence (62%) (Herman *et al*., 1989). This leads to some of the underlying cognitions behind borderline personality disorder, for instance feeling that the world is hostile (Silk *et al*., 1995).

Treatment for BPD in the community has changed in recent years following publication of government policy implementation guidance (Department of Health, 2003). This has been further reinforced by new evidence-based guidelines, recommending longer treatment courses, a reduction in medication prescription and continuity of care (NICE, 2009).

## Borderline personality disorder and women in prison

BPD is very common in prison, with a recent estimate at 30% for men and women in the US (Black *et al*., 2007). A decade before, Jordan *et al*., (1996) estimated that 28% of female prisoners met criteria for BPD in the US, suggesting this figure is stable. BPD has a high co-morbidity with other mental health diagnoses and risk factors such as substance use and self-injury.

Women represent one-twentieth of the prison population, with the current figure at 4,420 (5.4%), of whom one-fifth are on remand (Prison Service, 2010). There was a rapid increase in numbers of women in prison from 1,180 in 1992 to 3,340 in 2002 (Councell, 2003) since which time the figure has been relatively stable. There are still concerns that there are too many women in custody (Corston, 2007; MoJ, 2007).

*"... to tell the truth, the first time, I don't even remember going into prison, I was so ill. It was only ... talking to xxx, that she said 'yeah you've been in prison twice'. I said, Oh!"*

The female population in custody has different demographic characteristics to the male population, with 19% being foreign nationals, and 29% being of an ethnic minority compared to 13% and 27% respectively for men (Prison Service, 2010). Half the women in prison have experienced domestic violence, and women are twice as likely as men to have experienced some form of mental illness in the year preceding their admission to custody (Singleton *et al.*, 1998). Sixty-five per cent of imprisoned women have substance use problems, compared to 70% of men (Social Exclusion Task Force, 2009). Worryingly, 83% of women in prison have a longstanding illness, compared with 32% of the general female population, and many are on prescription medication (HM Chief Inspector of Prisons, 2009).

The Corston Report suggested an agenda of radical change to provision for custodial sentences for women. The Government has responded by addressing sentencing recommendations, alternative custodial arrangements, life skills/learning, hygiene and self-harm programmes (Corston, 2007). The report also highlighted that while services in the community are targeting women who are at risk of offending, for instance by providing 'one stop shops' (www.justice.gov.uk) and by monitoring those with mental ill health, that ethos has not translated to prisons.

The Corston Report did not mention BPD itself, but it included many vignettes about self-harm without recognising it as a key indicator of BPD (See Box 2). Despite only representing 5% of the custodial population, women represent half of all self-harming incidents in prison (Home Office, 2009).

**Box 2: Key indicators of borderline personality disorder**

*"If a person presents in primary care who has repeatedly self-harmed or shown persistent risk-taking behaviour or marked emotional instability, consider referring them to community mental health services for assessment for borderline personality disorder."*

(NICE, 2009)

In 2009, the Bradley Report raised concerns about the provision of mental health care in the criminal justice system, particularly highlighting that there is no formal provision of services for people with personality disorder in prison (Bradley, 2009). This is not equivalent to the community, where specialist services for personality disorder have been in development since 2003 (Department of Health, 2003). The report recommended that the Department of Health, the National Offender Management Service (NOMS) and the NHS develop a strategy for managing personality disorder at all levels of service, from custody to probation and in the community (Bradley, 2009). As the new strategy takes hold (Department of Health, 2009), it is a good time to address borderline personality disorder within the general context of female offender mental health.

## What is the impact of prison on women with BPD?

It has been recognised that people with BPD have frequently experienced some form of trauma during childhood, such as sexual abuse (Herman, *et al.*, 1989). The prison environment is hostile and punitive, having been designed primarily for the male prisoner (Corston, 2007). Prisons are predominantly staffed by men, with only 35% of prison service staff being female (Fawcett Society, 2008).

Women who have experienced abuse are more likely to feel traumatised by routine prison procedures such as body searches (Moloney *et al.*, 2009). This was found in a study of 800 male and female prisoners in a US study, where the greatest feelings of unsafety in prison were expressed by women with depression, anxiety, post traumatic stress disorder (PTSD) or recent victimisation (Wolff & Shi, 2009).

“*Well it's a bloody awful place. It smells like horse piss as soon as you walk in that health care department ... They've got so many psychiatric patients in there ... They just leave you in a cell with a hatch open and keep you in there most of the day ... When you go on the blocks most of them are mentally ill and they're all on drugs. They're all trying to nick your drugs. They're a nightmare. It's a horrible place.*”

The reaction of emotionally vulnerable women in prison may be to re-experience many of the features of childhood sexual abuse, namely traumatic sexualisation, betrayal, powerlessness and stigmatisation (Heney & Kristiansen, 1998; Dirks, 2004). This poses a threat to their mental and physical wellbeing, and may cause them to adopt maladaptive strategies to address the trauma of being in prison such as substance use, violence, self-injury and suicide (Heney & Kristiansen, 1998; Zlotnick, 1997).

Avoiding trauma in people with a personality disorder is important, as it directly affects their general and mental health. One study found that any type of recent victimisation was significantly associated with serious mental disorder for 48.1% of male prisoners and 47.2% of female prisoners (Wolff & Shi, 2009). Poorer health increases the disruption and ill-effects of prison for women with BPD and also raises the cost to the prison estate. People with BPD cost health services three times as much when they develop other health problems as those without BPD (Rendu *et al.*, 2002).

“*I was self-harming quite, quite a lot. And anybody who self-harms goes straight to the hospital wing, which is horrible ... just sitting there until somebody opens the cell door ... I think that that was where the self-harm got worse ... basically if you didn't go to work you'd get locked in your cell all day. It goes round in circles. Because you'd self-harmed as a punishment you'd get locked up, so you self-harm even more to get out of the cell, but they won't have you at work because you've self-harmed.*”

### Family issues

Women's pathways to custody differ greatly from those of men, as the majority of offences are non-violent or property related and as such rarely pose a threat to public safety (Moloney *et al.*, 2009). Women's offending patterns are more likely to be directly affected by their families, with property crimes such as petty theft being associated with family poverty (Taylor, 2004).

“*Didn't see my son and daughter for six months which broke my heart and killed me.*”

When mothers are imprisoned the impact is highly disruptive on their families, as female prisoners are often the only carers of their children, frequently resulting in custody being taken by grandparents or other female relatives (Caddle & Crisp, 1997; Home Office, 2004). This is not the case for men, whose children are usually cared for by their female partners during their incarceration (Taylor, 2004). Fathers take custody of female prisoners' children in just 9% of cases in the UK, only marginally higher than the number taken into care, at 8% (Caddle & Crisp, 1997). Around two-thirds of women in prison have dependent children under 18, and 40% of those are children under 10 years.

Women with BPD have potentially difficult family situations. This may be dependent on the severity of BPD symptoms, as men and women with increasingly severe symptoms experience more marital distress, commit more domestic violence and have more disruption in their marriages (Whisman & Schonbrun, 2009). Imprisoned women with more anti-social and borderline traits also show greater

parenting deficits based on the Parenting Stress Questionnaire (Warren & South, 2009). Women with anti-social personality disorder also report difficulties with child attachment, feeling competent as a parent and their degree of child contact. This may be a part of the 'transgenerational transmission' of BPD (Warren & South, 2009).

*"All the effort I was making for people, you know. I send them cards and I write letters to them and they couldn't even be bothered. It's like, 'oh she's a loon and she's in prison. No, we don't want to flipping know'. I just thought ... what do I do now?"*

## The impact on children

There are no studies specifically examining the relationship between incarceration of women with BPD and the effect on their children. By drawing conclusions from what is known about the effects of having a mother with BPD, we can see that these children are more vulnerable to separation and family disruption. It is known that 80% of these children show a disorganised attachment pattern (Hobson *et al.*, 2005). Disorganised attachment is characterised by a confused relationship with the parent, usually caused by finding them frightening. Children may be dazed and avoidant at a young age, but at a later age begin to take on 'parenting' roles and 'look after' the parent. In terms of the repercussions on the child, some studies show that this may lead to aggressive behaviour (Lyons-Ruth, 1996).

There are a few studies on the children of women with borderline personality disorder, and their findings show the effects of this diagnosis on parenting style. Children aged 4-18 years whose mothers have this diagnosis are more likely to experience traumatic events such as maternal suicide attempts, parental substance abuse, changes in custodial arrangements, moving schools and changes to household membership (Feldman *et al.*, 1995).

The children of mothers with BPD have a higher prevalence of psychiatric diagnoses, specifically attention deficit hyperactivity disorder (ADHD) and disruptive behaviour disorders, than children of women with other psychiatric problems (Weiss *et al.*, 1996). They also show greater anxiety, depression and low self-esteem than children of mothers without any psychiatric diagnosis (Barnow *et al.*, 2006). Behaviourally, these children also show more attention deficits, delinquent behaviour and aggression between ages 11 and 18 years (Barnow *et al.*, 2006). These same risk factors are also increased for the children of incarcerated mothers in general. All of these children are similarly exposed to households characterised by dysfunction, with the incarceration of the mother providing an added trauma in addition to existing risk factors such as substance and domestic abuse in the home (Greene *et al.*, 2000). Drawing these results together, it seems that separation from an incarcerated mother may exacerbate negative outcomes for children whose mothers have a BPD diagnosis.

Drawing more generally on what is known about the link between criminality and parental incarceration, there are five main factors to consider (Cunningham & Baker, 2004).

1. **Unhealthy coping strategies:** Children with an incarcerated mother have great anxiety, shame and experience more violence and poverty. While coping strategies can help them to deal with these situations, those strategies are often unhealthy, such as denial, anger, self-blame, emotional numbness and alcohol or substance use. These in turn lead to greater problems in the future, and perhaps to criminality.
2. **Rationalisation:** Children refuse to accept negative criticisms of their mother and instead blame the people expressing those criticisms. They may go further and think that those people are malicious, that crime is sometimes noble or justified, or that their mother is a victim of a 'system'. In some cases this may lead to a belief that going to prison is part of their family identity, and confers a 'badge of honour'.
3. **Poverty:** Children in poverty can have greater stress and strain, live in neighbourhoods with higher crime, have poor nutrition, and have a stronger sense of injustice.
4. **Lack of supervision:** Children with a mother in prison often lack parental guidance which may lead to educational under-achievement, early pregnancy, job difficulties and difficult or abusive relationships. Seeking a guidance figure, children may turn to dominant community figures on the street, leading

to substance use and involvement in the sex trade. These factors contribute to the likelihood of criminal behaviour.

5. **Associated stigma:** Children of incarcerated parents suffer the stigma of criminality, with staff in the criminal justice system being prone to bias in decision making about the child. Some may believe that "the apple does not fall far from the tree" and impose higher sanctions for criminal behaviour, rather than giving them community or social service provision.

The potential economic burden of these intergenerational effects could be mitigated by effective early intervention and parenting programmes. A recent report (Sainsbury Centre, 2009b) estimates that the total cost of crime attributable to people who had conduct problems in childhood is approximately £60 billion a year in England and Wales.

## Strategies for intervention

In order to tackle a complex mental health problem, it first needs to be identified in a timely fashion, and then treated appropriately, for an effective period of time. In the criminal justice system, mental health diagnoses are identified either at the arrest, court or prison reception stage, but many mental health problems are missed due to inadequate screening procedures (Shaw & Humber, 2007). Black *et al.* (2007) conclude that correctional facilities need to systematically screen for BPD specifically, such is the impact of the diagnosis on other mental health needs in prison.

The Corston Report recommended increased attention to health care, mental health and self-harm, but the report does not specifically address BPD. Programmes such as Carousel, which combines group therapy with individual counselling and other activities, were mentioned. The Government has subsequently implemented the CARE (choices, actions, relationships and emotions) programme for self-harm at HMP Downview with the intention of widespread use. However, these programmes are inconsistent with NICE guidelines for BPD. Simple additions to prison procedure, such as care in transition periods, could greatly reduce the risk for women prisoners with BPD. The current lack of specific provision for BPD means that evidence-based practice for women with this diagnosis is ignored, despite the high prevalence in the prison population. The following interventions would help to tackle this problem.

### Screening

The aim of prison mental health services is to screen for mental health problems at all levels of the system: from reception screening and induction or 'first night' centres onwards (Department of Health, 2005). The early detection stage is extremely important as this determines the level of care provided in prison. Screening tools used at reception have been criticised, with many instances of psychiatric morbidity being missed (Birmingham, 1997). This suggests that comprehensive screening at the court stage would make a dramatic difference (Shaw *et al.*, 1999; Bradley, 2009).

A screening programme for BPD at the stage of court trial would be able to target the 57,875 women who were charged with indictable offences in 2008 (Home Office, 2010). Of these, 14.8% are found guilty, leading to 16,440 women starting a period in custody (Home Office, 2010). Of these, 12,676 are first receptions into prison, suggesting that a high number of those screened at reception will not have been screened before. This may benefit women who have not been diagnosed outside the criminal justice system and therefore have not previously received any support for their diagnosis and mental health needs. In this way, the prison service can play a major role in increasing the number of women receiving help for BPD.

In order to screen and treat women with BPD appropriately, prison health care staff should not be exempt from NICE guidelines, which state that "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" (NICE, 2009).

### Staff training and recruitment

It has been widely recognised that looking after people with a personality disorder can be difficult, and some people are better suited to it than others (Bowers *et al.*, 2003). By providing specialist training and setting up a supportive

system for staff, most will find it easier to cope with and will be able to provide a better service. This will also save money in staffing costs, as positive attitudes towards people with personality disorder lead to improved general health and job performance, decreased burnout, and favourable perception of managers in prison staff (Bowers *et al.,* 2006).

There are already programmes designed to train staff who are working with people with personality disorders. For example, the University of East London provides a part-time postgraduate certificate entitled *Working with People with Personality Disorders* which is aimed at staff working in statutory or voluntary sector mental health services.

The provision of support for staff working with individuals with a personality disorder is recommended to include the following (Duff, 2003):

1. Specialised induction
2. Mentorship
3. Personal development plans and teaching programmes linked to organisational developmental plans
4. Support and supervision systems
5. Debriefing

In addition, Duff (2003) recommended that staff increase their self-awareness of their vulnerabilities and blind-spots. They should also be more aware of people with a personality disorder diagnosis, of their perspectives and positive attributes, and be able to build on their existing skills. It is important for staff to have awareness of potential complications within the team due to the difficulties of working with people who have a diagnosis of personality disorder.

## Transitions

Transition periods in prison custody are high risk, with increased likelihood of suicide for all prisoners (Shaw & Humber, 2007). Prisons protect new prisoners from harm by the use of a 'first night' centre and an induction wing which are designed to ease transitional periods. Care is still lacking in transitions back to the community, however, especially for prisoners with mental health difficulties. Rapid engagement with community mental health services significantly reduces risk during this period (Shaw & Humber, 2007).

Equally, a specific NICE target for treatment of BPD is to take added care in transition periods. NICE guidelines say that extra care should be taken when a person with BPD has to make a transition between different sources of care due to the incurred emotional difficulty with this process. The guidelines recommend that:

1. Such changes are discussed carefully beforehand with the person (and their family or carers if appropriate) and are structured and phased.
2. The care plan supports effective collaboration with other care providers during endings and transitions, and includes the opportunity to access services in times of crisis.
3. When referring a person for assessment in other services (including for psychological treatment), they are supported during the referral period and arrangements for support are agreed beforehand with them (NICE, 2009).

We suggest that these detailed arrangements are made for women with BPD, in addition to the measures already taken as part of prison policy.

## Therapeutic interventions in prison

Treatment programmes for BPD should be based on psychotherapeutic principles. There is a list of suggested therapeutic approaches in the NICE guidelines which includes dialectical and cognitive behavioural therapy-based programmes, mentalisation-based therapy and part hospitalisation, cognitive analytical therapy and psychodynamic therapies (NICE, 2009). Dialectical behavioural therapy, which focuses on acceptance and behaviour change, is the only treatment that has shown consistent benefits for people with a borderline personality disorder diagnosis, according to a Cochrane systematic review (Binks *et al.*, 2006).

In the Carousel programme, group therapy is combined with individual counselling, physical exercise, relaxation, educational activity and art therapy. Some of this programme conforms to the guideline and therefore may be beneficial, but it is currently lacking an evidence base. NICE guidelines also suggest that psychotherapeutic interventions are embedded within a programme of strategies for associated co-morbidities such as substance use and eating disorders (NICE, 2009). It is also stipulated in the guidelines that therapy should last for not less than three

months. In remand prisons and with short sentences this may be difficult (the average sentence is just 9.6 months), requiring in-reach/bridge services to continue treatment in the community.

Women with BPD frequently have co-morbid mental health problems, including eating disorders or substance use issues, and according to NICE guidelines these should be treated under the same umbrella as BPD. A practical strategy is to have a care co-ordinator facilitating access to BPD treatment in a way that complements substance use programmes. This strategy needs to be introduced into prisons to enable women to address multiple needs affecting their mental health.

### Alternatives to prison

By diverting women with BPD from custody, the problem of inadequate mental health care provision in prison may be avoided. There are several different schemes that enable women, specifically, to be diverted at any point in the criminal justice process. This can include diverting women with a severe mental illness to hospital under the Mental Health Act (1983) rather than keeping them in the criminal justice system.

There are also broader schemes supporting prisoners with a variety of mental health problems and linking them to community services. A review of existing diversion schemes found that only 2-3% of female offenders coming through the criminal justice system were being diverted (Hunter *et al.*, 2005), which grossly excludes the 50% of female prisoners with a personality disorder diagnosis.

The Primrose Service is the only service designed specifically for the diversion from prison of women with a personality disorder diagnosis. But it has just 12 beds, and it is housed within the prison system rather than a secure hospital.

The Bradley Report recommended that the Government should evaluate the existing treatment options for personality disorder in prison including therapeutic communities, and also that the DSPD units should be assessed to see if they are adequately addressing prisoners' needs. It also recommended that the Department of Health, NOMS and the NHS should develop a personality disorder strategy that would cover management from custodial to community services for women who are serving short sentences (Bradley, 2009).

### Parenting interventions

Given the considerable costs of crime attributable to conduct disorders (Sainsbury Centre, 2009b), and the links made between mothers with BPD, incarceration and intergenerational risk factors for crime, evidence-based parenting programmes may be a cost-effective intervention that could have longitudinal benefits. The Centre (Sainsbury Centre, 2009b) estimates that these programmes cost as little as £600-£900 per person for group-based therapies and up to £4,000 per person for individual interventions. The brevity of parenting programmes also means that they could potentially be delivered for women who are serving short sentences.

## Recommendations

**Recommendation 1: Where appropriate, alternatives to custody should be sought at all stages of the criminal justice system for women with a diagnosis of borderline personality disorder.**

Prison can be especially traumatic for women with a diagnosis of borderline personality disorder, due to their personal histories of abuse and victimisation.

Staff should be vigilant to symptoms of BPD at all stages of the criminal justice pathway, leading to professional assessment and diversion to appropriate services.

**Recommendation 2: Prison staff should be aware of self-harm as a key symptom of borderline personality disorder. This is consistent with the NICE guidelines for this condition (NICE, 2009).**

Prison staff should be given training to recognise the symptoms of borderline personality disorder, and equipped with the basic understanding and skills to manage sensitively those who self-harm.

**Recommendation 3: Where possible, interventions consistent with NICE guidelines should be offered to women with BPD in the criminal justice system.**

The NICE guidelines recommend that evidence-based psychological therapies are used in the treatment of people with a diagnosis of borderline personality disorder. The minimum period of treatment suggested in the guidelines is three months.

Women with a diagnosis of borderline personality disorder who are serving long sentences should be given access to psychological therapies to help them to manage their condition.

Where women are on shorter sentences, therapies should still be offered and continued after release. Adequately provisioned mental health in-reach services may provide an effective solution.

**Recommendation 4: 'Meet and greet' care should be provided on discharge to improve links between prison and community services.**

People with a borderline personality disorder diagnosis benefit greatly from well-managed transitions between different health care providers. A 'meet and greet' procedure would avoid disruption in the provision of services. This is often ignored due to the absence of adequate hand-over procedures between community mental health teams and prison health care.

Prison health care staff should liaise with prisoners' local community mental health teams to prepare for release.

**Recommendation 5: An adequate number of trained therapists with dialectical behavioural therapy (DBT) skills should be commissioned.**

The Government is committed to delivering an increase in access to evidence-based psychological therapies (Department of Health, 2010). Currently, Improving Access to Psychological Therapy (IAPT) services are being introduced across England. This roll-out includes the provision of training for psychological therapists. This training should be expanded to include dialectical behavioural therapy.

**Recommendation 6: More research needs to be undertaken to understand the impact of custody and family separation on women with a diagnosis of borderline personality disorder.**

The lack of contact with their children and the uncertainty surrounding their custody arrangements is a source of great distress to all parents in prison, but particularly for women. There is little specific research available in the context of women with this diagnosis.

**Recommendation 7: Family-based and parenting interventions should be provided to incarcerated women with a borderline personality disorder.**

Children of incarcerated women with a borderline personality disorder diagnosis are particularly at risk of conduct problems and future offending behaviour.

Women with a borderline personality disorder diagnosis tend to have more disrupted families, and so require greater support to maintain a stable family unit.

By seeking suitable diversion at an earlier stage within the criminal justice pathway, family units can be maintained and the risk of disruption to children's lives can be minimised.

Where incarceration is the only option, social services should be sensitive to the beneficial effects of family interventions. All options should be sought to maintain the integrity of the family unit. This may include the provision of parenting and lifestyle interventions both in prison and on release into the community.

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## Under the radar

**Women with borderline personality disorder in prison**

Matt Fossey and Georgia Black

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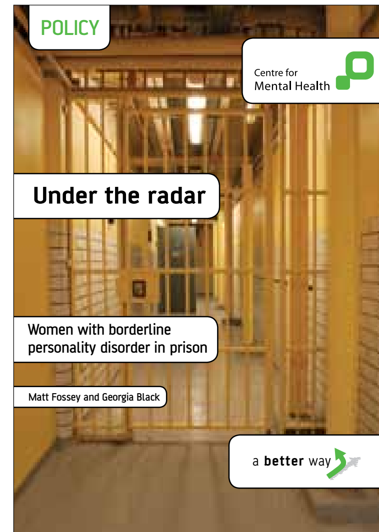


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