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(1) A Clear Model of Change

1.1 CARE aims to enable women with a history of violence and complex needs[1] to better understand and reduce the risk they pose to themselves and others and to live a more satisfying and pro-social life.

1.2 The programme combines 30 group work sessions, with ten individual narrative therapy sessions and up to two years mentoring and advocacy support. The treatment methods used include narrative therapy, cognitve behavioural therapy, psyco-education, grounding skills, emotion approach coaching, mindfulness training, assertion training, pro-social modelling and mentoring and avocacy.

1.3 CARE aims to reduce violence and aggression. Given the complex and inter-related needs of women, and their pathways to offending, by addressing needs related to violence CARE also responds to and addresses a complexity of needs including substance misuse, self-harm and suicidal behaviour, mental health and personality disorder and poor response to treatment. This integrated approach is supported by the literature on women and offending and recent reviews which advocate a holistic approach. This is described in more detail in the Theory Manual and the relationship between complex needs and violence and offending is described within the model at the end of this section.

1.4 CARE's model also describes how the needs addressed in the programme stem from early experiences of trauma, neglect, abuse and failures of attachment, and manifest in violent offending and complex needs. These behaviours contribute to women's growing social exclusion as they find it difficult to engage with and sustain links with services that they depend on but distrust.

1.5 For these women, engaging in and benefiting from treatment is very threatening and difficult and CARE has been designed to help identify, understand and work with these issues. The content of the programme, the sequencing of learning, the treatment methods, level of exposure and personal demands on group members have been carefully chosen and sequenced. The aim is to enable women to safely engage, to grow and to learn in an environment that does not cause them harm or exacerbate their needs. There is a strong focus on developing motivation and empowering participants. Although the model of change is trauma-informed the programme is not trauma focussed but aims to build emotion management skills and coping skills to replace

[1] The Assessment and Evaluation Manual and Theory Manuals describe the risk, needs and responsivity criteria used to confirm the appropriateness of CARE for a woman. This includes evidence of medium or high risk of reoffending and violence and presence of at least two complex needs.

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previously avoidant and anti-social strategies. It also builds pro-social support and links to other services and activities. In this way CARE offers hope as well as understanding and new skills.

1.6 In brief, the programme

- enables participants to develop insight into their risk and needs
- enhances belief that change is possible and provides the motivation to work towards and maintain that change
- develops a range of pro-social skills for managing emotions and coping
- provides significant social and resettlement support

1.7 CARE can be undertaken as a programme in itself or as a foundation programme that creates new opportunities and choices for women in both custodial or community settings. It acts as a springboard to a broad range of treatment, support and professional services.

1.8 CARE addresses five key treatment areas. The treatment targets which fall within these areas are described in the model at the end of this section and in more detail in Section 3, the Theory Manual and Assessment and Evaluation Manual. The sequencing and main phases of CARE are described more fully in Section 6 and the Theory Manual.

The five treatment areas are:

1.9 Awareness – CARE aims to help participants become more aware of their thoughts, feelings, beliefs, physiological states and actions and how these relate to their risk to others and themselves. This work is threaded throughout the intervention. The pacing and increase of exposure to personally challenging material is gentle and gradual, to ensure women remain engaged. Early work uses scenarios and third parties, building up to exercises which require greater personal disclosure and application to self. The use of personal portfolios, a range of diaries, course work, feedback and reviews, and skills practice all support the development of self-awareness. Psycho-educational exercises increase insight into a range of issues including physiology, emotions, inter-personal boundaries and human rights and needs. Mindfulness training helps the women notice their thinking and experiences and maintain focus and concentration. There is an ongoing emphasis on identifying facts and practising objective self-monitoring within and out of sessions. Self-awareness is targeted in the ten narrative therapy sessions which are spaced through the programme and enable the women to understand and map out problems in their lives but also their preferred ways of being, personal goals, hopes and the steps they can take towards a new life.

1.10 Motivation and Engagement – CARE's content and treatment methods are designed to respond to the complex and trauma related needs of woman, and to help them engage meaningfully and cope with the challenges of treatment. The approach places the individual

woman at the centre of the intervention, move at a considered pace and employ a facilitation style that is based on empowerment, respect, transparency and collaboration. Considerable emphasis is placed on developing safe, boundaried and effective therapeutic relationships within treatment sessions, training and supervision. Each woman is viewed as a unique individual and time is taken within individual, group and mentoring sessions to ensure her personal circumstances, background, personal beliefs and experiences are well understood. Individual narrative therapy sessions are used to understand and enhance motivation, identify risks and barriers and enable the women to have a vision of a new and successful life. These sessions further enhance the responsive nature of CARE and its ability to response to diversity and complexity.

1.10.1 CARE focuses on developing self-efficacy and stable self-esteem. The programme enables women to identify, record and enhance their strengths and capitalise on their experiences of skill and success. The treatment team regularly model skills and knowledge and share examples of success and learning.

1.10.2 Throughout group and individual sessions, and the two years of mentoring and advocacy CARE seeks to secure the support of others and builds networks which help the women monitor and sustain their motivation to change. These also aim to reduce and compensate for negative influences which may destabilise the woman and which may diminish her hopes and efforts for change.

1.11 Emotion Management – The life histories of many of the women on CARE mean they may frequently feel overwhelmed by and unable to process their emotional experiences, leading to panic, hostility, self-damage, aggression and violence. They are likely to be hyper-sensitive to possible rejection and to perceived threats. Suppression, avoidance and dissociation may be automatic coping strategies. CARE aims to enable participants to approach, understand and manage their emotions and thinking. A range of emergency first aid skills (using predominately cognitive-behavioural techniques) are provided and women are encouraged to regularly plan and carry out acts of self-care which self-sooth, self-monitor, develop well-being, health and pleasure. These skills help women tolerate the treatment environment, disclose and address personal issues and cope as treatment becomes more personally challenging. They also target high emotional and physical reactivity, intense emotions of anger and shame, hostile thinking, avoidance, rumination and suppression. The skills are practised repeatedly to ensure the women can use them when in more difficult and emotionally aroused circumstances and to prevent their escalation to violence.

1.11.1 A number of psycho-educational exercises also help the women recognise, describe and understand physiological and emotional experiences and their causes and consequences. Work includes understanding anger, shame, and the relationships between these emotions. Links are made with behaviour and relationships with others. Skills for recognising and understanding these

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emotions are introduced including steps for allowing more time, control and choice over how you react.

1.11.2 Emotion approach coaching is introduced and uses gradual exposure to enable the women to identify, describe and approach their emotions. The skills are practised regularly and include work on self-monitoring and the ability to objectively evaluate and describe situations. These skills are carefully facilitated, modelled by facilitators, and use a range of exercises and materials including mood boards, cards, scenarios and handouts which can be matched to learning styles and needs.

1.11.3 Mindfulness training is introduced from session eight to support self-monitoring, objectivity, work on maintaining concentration and focus, coping with stress, tolerating emotions and avoiding impulsive responses, hostile rumination and angry and resentful thinking. The complexity of the skills are increased throughout sessions with regular practice within groups and through assignments. This supports the women in planning for and maintaining goals, and increases their awareness and understanding of their emotions and physiological reactivity. A range of materials including books, CDs and DVDs are also available to help with this work.

1.11.4 Facilitators are trained to remain mindful of the high levels of physiological arousal that will be experienced in the room and to not underestimate how powerful feelings of anxiety and shame may be for women. They are given materials which are carefully sequenced and constructed but are asked to make judgements within exercises about how far to encourage each woman to disclose and approach her emotions.

1.12 Coping skills- CARE provides a range of skills to enable participants to better understand others, manage conflicts, respond more assertively, communicate more effectively, and encourage others to help and support them. Many of the women will use aggression and violence, self-harming and other unhelpful coping strategies including avoidance, dissociation, suppression and rumination. Skills for noticing and interrupting unhelpful coping strategies are therefore taught. CARE also helps women identify new and more helpful ways of thinking and behaving, develop goal attainment skills, communication skills and asking for help.

1.12.1 For many participants their ability to recognise and develop healthy, mutually respectful relationships will have been severely limited by their life experiences. CARE therefore focuses on understanding and managing the dynamics within relationships, communication skills and managing impulses and cognitive biases. Group sessions consider needs and expectations within relationships, build perspective taking skills and develop more objective and considered thinking around others' behaviour and motives. Later sessions encourage the women to identify principles for how they want to be treated within relationships, and their responsibilities around how they

should behave with others. This builds insight and skills for communication and disclosure which feed into later work on assertiveness and asking for help. The individual narrative therapy sessions look in more detail at the problems the women have had within relationships and how they would prefer their relationships to be. This includes looking at risks, needs and goals for the future. Mentoring and advocacy supports the development of strong positive relationships, through advocacy, pro-social modelling, development of support networks and motivation, mediation and problem solving, enhancing opportunities and recognising successes.

1.12.2 The second half of CARE focuses on developing and practicing coping and assertiveness skills, leading to a series of skills practice sessions where the women draw on all the skills and knowledge covered in CARE to role play real life situations and meaningful experiences. Assertive communication is taught in a structured, gradual and experiential way with increases in intensity and exposure according to the woman's needs and progress.

1.13 Social inclusion and resettlement- Many women offenders will have very limited access to social support and are unlikely to identify with many pro-social models. They will have, and are likely to face a range of barriers to effective resettlement including violence and other negative influences from peers, family or partners. They may have limited opportunities, a limited range of interpersonal skills and little hope that they can take advantage of what opportunities exist.

1.13.1 Initial assessment, referral to CARE and the first narrative therapy sessions begin to explore and understand the range of social inclusion and resettlement needs the women may have. This work includes identifying problems and goals, the presence and availability of support networks and the influence of peers. Group work, course work and individual narrative sessions continue this process throughout. Participants are introduced to the Mentoring and Advocacy Service in group session three, after which they are offered sessions during group work to build up their relationship with the service and access their help. The mentoring and advocacy service continues for up to two years providing advice and support, enabling the women to resolve their own problems and conflicts and to take up opportunities and services. The service also acts on behalf of the woman, advocating for her with other agencies and services around issues related to her successful resettlement or progress including training, accommodation, employment, finance, substance misuse, health and family issues. This provides the woman with strong pro-social models of effective problem solving and conflict resolution.

1.13.2 Post course, the woman is also supported with a further three narrative sessions which facilitate a positive ending from the group work element of the programme. She identifies further objectives with the multi-disciplinary delivery team and is supported within a post course review.

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1.14 The model below outlines the main features of CARE and the pathways to violence and aggression. The box on the left describes complex trauma which ultimately leads to the range of needs associated with offending and self-damaging behaviour. The blue boxes depict the motivation and engagement and self-awareness needs of women which act as facilitators for offending and barriers to change. The green boxes list the emotion approach and management problems, coping skills difficulties and resettlement and social inclusion needs which occur as a result of early life experience. These interact to enhance risk through destabilising and disinhibiting the women and enhancing their motivation to offend. The final box on the far right describes the consequences of this range of needs, highlighting violence and aggression within the spectrum of complex needs.

The needs encased within the pink box are the treatment targets for CARE.

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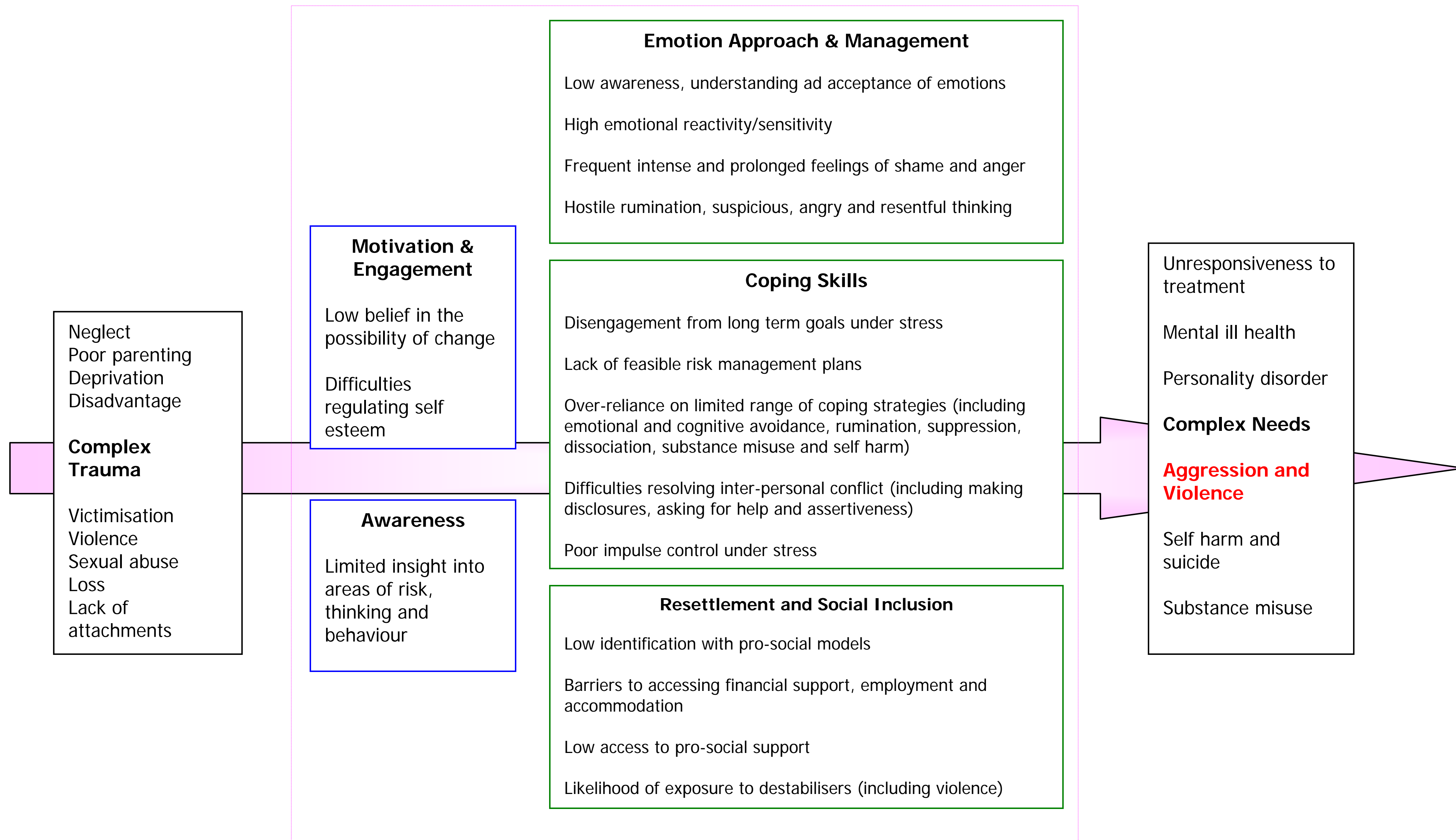

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(2) Selection of Offenders

2.1 CARE has been designed for women with a history of violence[2], who pose a moderate or high risk of reoffending and harm and who have other complex needs.

2.2 The referral and selection of offenders for CARE is described in detail in the Assessment and Evaluation Manual. In determining whether the programme is suitable for a woman the treatment team follow a set of inclusion criteria which cover risk, needs and the readiness and responsivity of the women.

2.2.1 **Risk**: A women will meet the risk criterion if:

1. She has an OGRS3 score of 40 or above; AND
2. She has a history of violence or aggression. The woman should have
    a. one or more current convictions for violence; OR
    b. one or more previous convictions for violence; OR
    c. one or more instances of violence or aggression while in prison, AND.
3. An HCR-20[3] assessment confirms she poses a medium or high risk of future violence, either whilst incarcerated or on release. This criterion will be evident from the presence, severity or combination of a number of risk factors for violence.
4. Caveats exist for cases that do not meet the risk criteria exactly: if there is evidence of unconvicted violence or aggression in prison or the community.

2.2.2 **Complex Needs:** A women will meet this criterion if there is evidence of two or more of the following:

1. History of substance misuse problems
2. History of self-harming behaviour or suicidal behaviour
3. Mental health difficulties
4. Personality Disorder
5. Past difficulties in accessing or benefiting from help or treatment.

Caveats exist for women from a minority ethnic background who may not have accessed services in the past and whose mental health problems and substance misuse problems may have gone undiagnosed.

Need criterion	**Potential sources of evidence**	**Guidance**
History of Substance Misuse problems	OASys: Drug Misuse and Alcohol use domains CARATS HCR-20 assessment – Item: H5: *Substance Use Problems*	This includes the use of alcohol, illegal drugs, prescribed drugs and other substances such as solvents or glue. There should be evidence that the offender's use of substances has contributed to their offending

[2] Within CARE violence is defined using the HCR-20 definition: "*actual, attempted, or threatened harm to person or persons. Threats of harm must be clear and unambiguous (e.g. "I am going to kill you"), rather than vague statements of hostility. Violence is behaviour which obviously is likely to cause harm to another person or persons. Behaviour which would be fear-inducing to the average person may be counted as violence (e.g. stalking).*" (Webster, Douglas, Eaves & Hart, 1997).

[3] The HCR-20 (Webster et al, 1997) is a set of structured professional guidelines for the evaluation of violence risk in individuals who have mental health problems or a diagnosis of personality disorder. Further information about the HCR-20 is included in the Assessment and Evaluation Manual.

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		behaviour, or has caused problems in other areas of their life, such as health, employment, relationships, etc.
History of self-harming or history of suicidal behaviour	Case file Medical records Self-disclosure ACCT	At least one instance of self-harm and/or suicide attempt, or ACCT monitoring It is acknowledged that self-harming and suicidal behaviour may serve different functions for an individual; however, in practice, it can sometimes be difficult to determine whether specific episodes of self-harm are in fact suicide attempts; therefore for the purposes of this assessment there is not a requirement to differentiate between the two.
Mental Health Difficulties	Medical records Case file OASys profile HCR-20 assessment -Items: H6:*Major Mental Illness* C3: *Active Symptoms of Major Mental Illness*	Current or past diagnosis for any DSM IV[4] Axis I or Axis II disorder. Selection agreed by CPA co-ordinator / responsible medical officer as beneficial to mental health, **or** OASys: Emotional Well-being domain: Any score of 1 or more on items 10.2 or 10.6
Personality Disorder	Medical records HCR-20 assessment – Item: H9:*Personality Disorder*	Current or past diagnosis for any DSM-IV or ICD-10[5] personality disorder.
Difficulties in accessing help	Case file Self-disclosure HCR-20 assessment -Items: H10:*Prior Supervision Failure* C5: *Unresponsive to Treatment* R4: *Noncompliance with Remediation Attempts*	Evidence of responding poorly or declining to engage with support aimed at reducing risk of offending or improving health, social, psychological or vocational well-being. For example, failing to complete previous offending behaviour programmes, not attending psychiatric appointments, declining offers of improving their education or vocational skills.

2.2.3 **Readiness and responsivity**

If a woman has current substance misuse or active mental health issues the extent of these are explored to determine whether she is more likely to benefit from the programme at a later date when these presenting difficulties are less severe. A woman may also not be ready to take part if she is expressing an unwillingness to participate or if there are practical barriers to her participation such as language difficulties. In these cases, the offender is deemed not to be ready yet to participate in CARE, and ways to build her readiness to participate later are specified.

CARE does not require high levels of motivation before the programme starts. The programme itself incorporates motivational elements. Therefore offenders can be suitable even if they have low levels of expressed motivation for treatment. As a minimum, participants must be willing to take part in the programme.

[4] Diagnostic & Statistical Manual of Mental Disorders: 4th Edition (American Psychiatric Association, 1994)

[5] International Classification of Diseases: 10th Edition (World Health Organisation, 1992)

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Denial of the individual's offending does not present a barrier to CARE as participants are not required to disclose or discuss their offending. However, participants will be expected to discuss current and past problems in their lives.

Other exclusion criteria:
Offenders should not commence the CARE programme if they will be released before completion of the group work phase. In practice this probably means that the woman should have at least nine months left to serve before anticipated release.

2.3 The selection process

There are four stages to the selection process:

1. discussion leading to referral
2. discussion to obtain informed consent to assessment and treatment
3. pre-course interview for HC-20 and psychometric assessment
4. a one to one narrative interview with a trained facilitator to confirm readiness for treatment.

CARE employs a triangulated approach to assessment to enhance the validity and reliability of the information that informs selection:

- **Self-report:** Information that comes directly from the offender, including self-report psychometric measures and the offender's own account of her history and needs
- **Structured assessment:** the HCR-20 which involves a review of collateral information, interviews and observation.
- **Observation:** behavioural feedback from staff and others.

2.4 Diversity

In general, Treatment Managers must make all reasonable adjustments to ensure CARE is accessible to all those who meet the selection criteria and could potentially benefit.

Guidance is provided in the Assessment and Evaluation Manual on accommodating a range of needs to ensure that CARE is as inclusive as possible, though not at the cost of offering treatment inappropriately or disrupting the treatment of others. This includes guidance on evaluating and managing issues around literacy, dyslexia, mental and physical health needs, learning disability, physical disability, language, substance misuse and psychopathic personality traits.

If the offender is from a Black or Minority Ethnic group, staff are required to be sensitive to her cultural background and possible expectations that the programme will not recognise cultural difference. Programmes are often managed and delivered by mainly white staff and this may increase the perception that programmes are best suited to white offenders. The Treatment staff should be prepared to facilitate open discussion about any such concerns and how they could be overcome.

2.5 De-selection

De-selection decisions are made on an individual basis and there are no automatic de-selection criteria; however treatment teams should monitor participants' behaviour and review ways to intervene or respond if a pattern of behaviour is beginning to emerge.

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In general, the decision by staff to de-select an offender from CARE should only be taken as a last resort when continued participation:

- presents an unacceptable risk of harm, or to the well-being of the individual offender or others.
- jeopardises the effective treatment of others
- no longer continues to be meaningful for the individual offender

Further guidance on de-selection is provided in the Assessment and Evaluation Manual.

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(3) Targeting a Range of Dynamic Risk and Protective Factors

3.1 CARE aims to enhance participants' awareness and understanding of their risk and needs, foster their hope that change is possible and worthwhile, develop the skills to support a new life and provide them with ongoing support to apply these skills and overcome barriers to change. In doing this CARE addresses five key treatment areas. These are:

1. Awareness
2. Motivation and engagement
3. Emotion management
4. Coping skills
5. Social inclusion and resettlement

3.2. Part Two of the CARE Theory Manual provides an explanation of how needs develop and combine to form pathways to violence and offending for women. It describes the links between complex needs and violence and the range of dynamic risk factors that mediate between these outcomes and a background of static factors that constitute complex trauma such as sustained victimisation and abuse, disadvantage, loss, poor parenting and lack of attachments. The CARE Theory Manual provides evidence of the presence of these mediating risk factors and complex outcomes in violent women offenders.

3.3 The mediating risk factors have been clustered under the five main treatment headings above and are tabulated below in terms of treatment need (how a woman is likely to present if they have the deficit/difficulty) and treatment goal (how we hope they may be at the end of treatment). These treatment needs are dynamic and act either as motivators, de-stabilisers or dis-inhibitors for offending. The social inclusion cluster also includes a range of protective factors. The table also lists the assessment tools identified for evaluating progress in each area.

3.4 The sequencing of these targets and the methods employed to address them is described in Chapter 6 of this Submission Document and in the Theory Manual.

Treatment need	Description of need	Treatment goal	Evaluation Measure
Awareness			
Limited insight into areas of risk, thinking and behaviour	The woman has limited or fluctuating insight into how her thoughts, feelings and behaviour influence her risk to others and to herself. She may not believe herself to be a risk, or may acknowledge this but believe it is out of her control. She may lack insight into the impact of her mental health, personality, substance use, medication and relationships on her behaviours. The woman may have limited insight into the thoughts, feelings and behaviours of other. She may also have limited awareness of how past and current experiences influence her	The woman is more aware of her thoughts, feelings, beliefs, physiological state and actions. She is able to identify and describe feelings, and has developed skills for objectively monitoring her internal word. She is able to make links between her thoughts, feelings and actions and also has a better understanding of how her internal experiences and behaviour link to her risk to others and herself. She has more understanding of how external factors such as drugs, alcohol and relationships impact on her behaviour. The woman also has a better understanding of the intentions, emotions and actions of others and how she makes judgements about others' motives and actions.	HCR-20 C1: Lack of Insight Self-report Facilitators' observations Treatment products Behavioural Monitoring
Motivation and Engagement			
Low belief in the possibility of change	The woman struggles to see how her life could change, or to identify what changes she would like. She has little faith in her own ability to bring about change, and may feel she lacks the opportunity or support. She may feel others will block, damage or disapprove of change which diminishes her efforts. Overall she has little hope that change can happen.	The woman is able to identify how she would like her life to be, and can identify specific goals and changes she would like to make. She believes that change is possible, has some faith that she has the skills and ability to bring about change and feels she has support which will help her begin and sustain the process of change. She has a better understanding of what affects her motivation and is able to monitor and enhance her own hope and commitment to change.	Beck Hopelessness Scale (BHS) Self-report Facilitators' observations Treatment products Behavioural Monitoring
Difficulties in regulating self-esteem	The woman has an unstable self-esteem, feels disempowered or has a low opinion of herself and her capabilities. She may rely on others to help her define her identity or she may feel 'empty' and unable to say who she is. She struggles to regulate her self-esteem and has few strategies for understanding, enhancing or maintaining her self esteem. These fragile self-feelings impact on her emotional experience particularly shame and depression.	The woman is able to recognise factors that have impacted on her self-esteem in the past and can identify potential factors in the future that may influence her self-esteem. She has begun to develop a more positive opinion of herself and is less vulnerable to fluctuations in how she views herself. She will have developed a range of strategies for maintaining her self-esteem, which are not reliant on others.	

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Emotion Management			
Low awareness, understanding and acceptance of emotions	The woman has little awareness or understanding of her emotions. She may find it difficult to differentiate between or describe some emotions. She may find some emotional experiences very difficult to tolerate and finds thinking and talking about her emotions intolerable. As an automatic response against feeling overwhelmed she may avoid, suppress or dissociate from feelings and experiences as a protective coping mechanism.	The woman will be able to verbalise a greater range of emotional experiences and will show an understanding of the factors that influence her emotions. She will recognise times when she is experiencing strong emotions and have developed strategies to tolerate negative emotions without resorting to previous harmful, problematic or unhelpful behaviours.	STAXI-2 Coping Styles Questionnaire (CSQ3) HCR-20 C4: Impulsivity HCR-20 C2: Negative Attitudes Self-report Facilitators' observations Treatment products Behavioural Monitoring Adjudications
High emotional reactivity/ sensitivity	The woman experiences sudden or frequent high levels of arousal and strong physiological reactions, often disproportionate to the nature of the trigger. This may be triggered by external events but may also be linked to previous experiences of trauma and abuse.	The woman is more aware of internal and external triggers which contribute to her emotional state and has developed a range of strategies to evaluate these and to reduce the frequency, intensity or duration of high levels of emotional arousal. She is more aware of the physiological cues of emotional arousal and has developed behavioural and cognitive strategies to calm and ground herself at times when she is experiencing strong emotions. She has over-rehearsed these skills so they are easily available at times of emotional crisis.	
Frequent, intense and prolonged feelings of anger and shame	The woman experiences strong and frequent feelings of anger and shame. These may be prolonged and intense. Often the anger serves to mask the feelings of shame. How she responds to these feelings can make it difficult for her to develop and use pro-social coping strategies and can impact on her relationships. These feelings can be precursors to violence and also to self-harm or suicide attempts.	The woman can differentiate between feelings including anger and shame and is more aware of factors which contribute to these emotions and how they impact on her sense of who she is and how she would like to be living her life. She will recognise times when she is experiencing anger and/or shame and have developed strategies to tolerate and cope with these emotions. She will have an awareness of how these impact on her relationships with others. She will have learnt to evaluate the function of these emotions in order to allow herself more time to reflect and use skills, giving herself choices about how she responds.	
Hostile rumination, suspicious, angry, resentful thinking about others	The woman has resentful, suspicious or hostile thoughts about others and the world around her. In particular she may attribute hostile intentions or rejection to others. She tends to dwell on these thoughts, which can be associated with feelings of anger, vengeance or shame. By ruminating on these she can increase their intensity and her belief in them.	The woman can identify times when she is ruminating or experiencing resentful, suspicious or hostile thoughts and when she might be incorrectly attributing hostile intent to others. She recognises that we can make automatic judgements of people and has developed cognitive strategies to re-evaluate these. She is more open to considering the views of others when they conflict with her own and has developed pro-social strategies for dealing with perceived conflict or rejection.	

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<table>
<tr><td colspan="4">Coping Skills</td></tr>
<tr><td>Over reliance on a limited range of coping strategies (including emotional and cognitive avoidance, rumination, suppression, dissociation, substance misuse and self harm)</td><td>When faced with problems, conflicts, difficulties or opportunities the woman has a limited range of coping strategies. Whilst the strategies she has may be protective and useful at times of severe threat they are limited, restrictive and provide few options for managing situations, coping with emotions and getting the best outcome. Her coping strategies may also lead her to avoid and suppress thoughts, emotions and experiences, or to over focus on issues and lead to rumination. The woman may also use self-damaging ways of coping such as self-harm and substance misuse.</td><td>The woman has a greater understanding of the limiting nature of the coping strategies she has previously used and the potentially harmful or unhelpful consequences of some of these. She is able to monitor her current use of coping strategies and evaluate how appropriate and effective they are. She will have developed a wide range of additional coping strategies and be able to identify when she can choose to use these.</td><td rowspan="3">Coping Styles Questionnaire (CSQ3)

HCR-20 H3 : Relationship Instability

HCR-20 C4: Impulsivity

HCR-20 R5: Stress

HCR-20 R1: Plans lack feasibility

Self-report

Facilitators' observations

Treatment products

Behavioural Monitoring

Incidents of self-harm and suicide attempts.

Substance misuse (e.g MDT)</td></tr>
<tr><td>Difficulties resolving interpersonal conflict (making personal disclosures, asking for help, assertive communication)</td><td>The woman finds problems within relationships difficult to identify, understand and resolve. She has difficulties sharing information and making personal disclosures. In certain situations, especially in significant relationships, she may use an overly passive or overly aggressive style. She finds it hard to ask for and to access help from others.</td><td>The woman can recognise past and current relationship problems and the factors that contribute to these. She has developed her ability to resolve interpersonal problems using pro-social means. She can recognise when she needs to ask for help from others and can identify appropriate sources of help. She is more comfortable when disclosing personal information about herself and asking for help. She can recognise times when she selects an overly passive or overly aggressive communication style and has developed her assertive communication skills. She remains aware of the context of relational conflicts and the need to prioritise the safety of herself and others.</td></tr>
<tr><td>Poor impulse control when under stress</td><td>When under pressure or stress the women tends to make more impulsive decisions and is more likely to act in an emotionally reactive way without fully considering the facts, the circumstances and preferred consequences.</td><td>The woman can recognise cognitive, behavioural or physiological signs of stress and distress and shows an awareness of potential stressors. She recognises when she has felt under pressure or stress in the past and how this has affected her thinking and behaviour. She can recognise when she has made impulsive decisions or behaved in an emotionally reactive way and can identify the consequences of this. She has developed her ability to objectively evaluate situations and explore the potential options and outcomes before making a decision. She will also have developed cognitive and behavioural strategies to reduce her tendency to react emotionally to a trigger.</td></tr>
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Disengagement with long term goals when under stress	When under pressure and stress the woman struggles to maintain her commitment to her long term goals and aims. She may see them as less important, may lose her motivation and focus, or disengages as she feels unable to achieve the things she has planned. This is likely to feed into her low belief in the possibility of change and a general sense of hopelessness.	The woman can recognise when she has lost sight of her long-term goals in the past and can identify the long-term consequences of this. She understands the benefits of long-term goals and factors that influence fluctuations in her level of commitment. She will have developed a range of feasible and achievable goals, which are stable over time and identified ways to monitor progress in reaching these goals. She will have developed strategies for dealing with setbacks in reaching her goals.	
Lack of feasible risk management plans	The woman has limited, unsafe or unrealistic plans for risk management and relapse prevention. This may be exacerbated by the real barriers she faces to accessing services and resources.	The woman will have developed achievable and appropriate plans across a range of areas of her life (e.g. employment, family, relationships, recreation) that reduce her risk of harmful behaviours to herself or others. She can identify steps that she will need to take in order to put these plans into action and can monitor her progress in achieving these. She shows an awareness of potential barriers and setbacks she may face and has a range of pro-social and adaptive strategies to deal with these.	x
Social inclusion and resettlement			
Low identification with pro-social models	The woman is unable to identify any, or limited credible pro-social models. She feels she has little in common with pro-social individuals. This is likely to be related to her (possibly real) fears of rejection and her sense of shame.	The woman can identify and relate to pro-social models, whose ways of living reflect her preferred way of living. She has a commitment to strengthening the qualities that she values and aspires to. She can recognise the extent to which others demonstrate these qualities and can identify a range of specific individuals who demonstrate these in a pro-social way.	HCR-20 R1: Plans lack feasibility HCR-20 R2: Exposure to Destabilisers

Barriers to accessing financial support, employment and accommodatio n	The woman finds it difficult to gain resettlement support including housing, education, training and financial advice. This might include disruption or obstruction from others around her, a lack of opportunity, disadvantage due to her past experience and skills or low self-belief and motivation. The stigmatising effect of being a woman in prison further impacts on her access to some services.	The woman can recognise times when she has had difficulty accessing resettlement support and the factors that contributed to this. She can identify possible sources of support that she may benefit from in the future and the potential barriers or setbacks she may face in accessing this. She will have developed a range of strategies to deal with these setbacks and maximise her ability to access appropriate support. She will make better use of the opportunities.	
Low access to pro-social support	The woman has limited access to pro-social support whilst in prison or in the community.	The woman is able to identify problem areas in which she would benefit from increased social support. She can identify potential sources of pro-social support and what steps she needs to take in order to develop the availability and strengthen the effectiveness of these. She will make good use of the opportunities afforded to her by the CARE mentoring and advocacy service.	
Likelihood of exposure to destabilisers (including violence)	The women's lifestyle increases the chances that she will be exposed to destabilisers i.e. situations/relationships where she may be vulnerable and which may trigger violence. These situations are unique to individuals but may include the presence of weapons, substances, certain groups of people, certain relationships e.g. with a perpetrator of domestic violence. She has limited coping strategies for responding effectively and safely when this happens.	The woman's life is more stable, and well supported. She is less likely to be exposed to destabilisers due to support networks around her, the choices she makes and skills she has developed. When faced with destabilising experiences she is better able to cope and can ask for help if needed.	

3.5 Progress during treatment is informed by:

- **Self-report:** statements made by the offender during treatment about her needs and progress.
- **Observation:** behavioural monitoring and feedback from staff and others. Facilitator assessments of progress in treatment are also included in this area, as are evaluations of participant's work products during treatment.

3.6 At the end of the group work element of CARE the women receive a post programme report written by their personal facilitator. This describes their progress during the group work phase including their preferred story, the skills and knowledge they have developed which support this new story and how they intend to identify and manage risks to their new life. They will also receive a post programme risk report which is written by a skilled practitioner who has an understanding of CARE and the individual's baseline assessment of risks and needs, but who was not directly involved in delivering treatment. This pulls together information from all of the assessment approaches. The Assessment and Evaluation Manual describes each of the evaluation measures, the rationale for their use and the role of post programme reports.

3.7 Additional needs to those addressed in the programme may be thrown up by the treatment needs analysis, individual narrative sessions, HCR-20 assessment, behavioural monitoring or mentoring and advocacy sessions. Where possible these needs can be addressed through the individual sessions or through assignment setting, or the individual mentor can create links to other services, agencies or create opportunities that can assist. As mentoring and advocacy support spans both custody and community and lasts for up to two years, additional needs can be identified and addressed at any point. The work of the independent mentor and advocate complements that of the offender manger who is involved either as part of the core CARE delivery team or at the review and objective setting stage. This high level of support and continuity is further supported by the multi-disciplinary management and delivery team which is linked into a broad range of services and processes within the prison.

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(4) Effective Methods

4.1 CARE is a holistic intervention which combines a number of treatment approaches delivered within individual sessions, group sessions and through individual contact with a specialist mentor and advocate. The methods are used in combination and together build the motivation, awareness and skills of participants. The section on sequencing describes how this blend of methods is developed. All of the treatment methods are discussed in more detail in the Theory Manual's section on treatment methods. The methods are:

- Narrative Therapy
- Mindfulness
- Cognitive behavioural therapy
- Emotion approach coaching
- Psycho-education
- Pro-social Modelling
- Mentoring and advocacy

4.2 Narrative therapy

4.2.1 There are ten individual narrative therapy sessions built into the start, beginning and end of the group work phase of CARE. Narrative therapy approaches are also used within some elements of exercises in group sessions, ongoing work on the preferred story portfolio, personal facilitators report and case review.

4.2.2 Narrative therapy has been chosen predominantly to enhance motivation and develop stable self-esteem and self-awareness. This is part of enabling the women to strengthen and maintain a pro-social and meaningful identity for themselves. The approach is collaborative, respectful, caring, exploratory and puts the woman at the centre of the therapy. Its client centred approach is responsive to diverse needs, ensuring that the language used to describe problem stories and preferred stories is that of the women themselves. Facilitators and therapists who work on CARE are all women.

4.2.3 Narrative therapy is particularly helpful when working with people with experiences of trauma, failure and rejection as it separates out the problems the person has from the person's identity and sense of self. This can help the participant view their life in a more objective manner and to cope with identifying the difficulties and problems they face. Narrative therapy also helps people identify moments of success and skill and develop a vision of how their lives could be different. This approach can be more effective than more direct and challenging techniques with women who have developed avoidant coping strategies, find it difficult to regulate their emotions, have little hope, feel overwhelmed by difficulties and are fearful of facing the problems they have in life.

4.3 Mindfulness

4.3.1 Mindfulness training is used within CARE to help participants engage in treatment sessions, develop self-awareness and cope more effectively with their emotions. It does this through:

- increasing the women's ability to maintain concentration and focus, thereby helping them keep their attention on the purpose and content of sessions
- helping women develop reflective thinking

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- enhancing the women's ability to notice and tolerate emotions
- helping the women notice when they are begin to ruminate and take steps to avoid hostile rumination and angry and resentful thinking
- employing a non-judgemental approach which supports self-monitoring and objectivity.

4.3.2 Mindfulness training enables individuals to develop awareness by learning to pay attention in a particular way, on purpose, in the present and without judgement. It has its roots in meditative practices and has been helpful in enabling people to cope with experiences with an attitude of acceptance rather than avoidance. The training is experiential and the approach in CARE is one of encouragement and invitation. It is not dependent on intellectual ability and is culturally neutral, so should be responsive to diverse needs. The approach further fosters an atmosphere of collaboration and safety, building a more effective therapeutic relationship.

4.3.3 The complexity of the training is increased throughout sessions with regular practice within groups and through assignments. This supports the women in planning for and achieving goals and increases their awareness and understanding of their emotions and physiological reactivity. A range of materials including books, CDs and DVDs responsive to different learning styles are available to help with this work.

4.4 Cognitive behavioural therapy (CBT)

4.4.1 CARE uses a range of cognitive behavioural techniques to support participants in developing awareness and insight into their thinking, feelings and behaviour and in developing skills for managing emotions and coping which are practised and reinforced throughout the programme.

4.4.2 The following are examples of CBT work covered by CARE. More information is available within the Programme Manual and Theory Manual.

- Interpersonal skills training – including skills for asking for help, dealing with criticism, responding to differences of opinion
- Assertiveness training – including assertive body language and communication
- Grounding skills and emotion first aid skills including muscle relaxation, breathing, distraction techniques, self-soothing and time out.
- Self-talk including calming statements
- Behavioural experiments
- Self-monitoring including diary work on thoughts, feelings and situations

4.4.3 CBT is a well tested approach within offending behaviour work and the treatment of a range of mental health issues. Facilitators have the scope to ensure that the scenarios practised are relevant to the cultural context of individual women, and this is particularly important for women from black and minority ethnic backgrounds. Course materials ensure that examples are used of women from a range of ethnic backgrounds.

4.5 Emotion approach coaching

4.5.1 CARE uses emotion approach coaching to teach individuals to approach, observe, identify and describe their emotions. This involves the ability to tolerate and sit with emotions and understand what they are telling you about what is important to you and what is going on around you. The aim is to help women who have developed an avoidant coping style, and who may

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experience panic attacks and emotional crises, to understand, tolerate and manage their emotions more effectively. This approach helps participants acknowledge and take stock of their emotions and circumstances and avoid reacting impulsively with aggressive, violent or harmful action.

4.5.2 Emotion approach coaching occurs during every group session of CARE and uses gradual exposure to emotional experience. This starts with simple statements of being ok/not ok, then on to rating the intensity of emotions, and exploring physiological emotional responses. Women are encouraged to identify and differentiate between different emotions, and notice when several emotions are present, in particular when they are experiencing anger masking shame. Exercises which use emotion approach coaching also support participants in considering the function of emotions, enabling them to make better choices around how they think and react.

4.5.3 As with other treatment approaches, facilitators ensure that the examples used is sessions are relevant to the individual women and take into account any learning difficulties, cultural differences or mental health challenges

4.6 Psycho-education

4.6.1 Care employs a strong psycho-education element to support women in developing insight into their risk, thinking and behaviour. This is delivered using a range of mediums including discussions, inter-active exercises, handouts, stickers, DVDs, books and CDs. The range of approaches ensures compatibility with different learning styles and cultural backgrounds. Some of the actors in the DVDs are from minority ethnic backgrounds.

4.6.2 The areas covered build understanding about the role of emotions in keeping us safe and informing our behaviour, specifically:

- The nature and experience of different emotions, particularly the thoughts, feelings, sensations and physical experiences which accompany anger and fear
- The links between physical arousal and fight and flight responses, and the consequences of these
- Personal and mutual boundaries, their importance, nature and implications
- Self-responsibilities, particularly within the context of relationships.

4.7 Pro-social Modelling

4.7.1 An important element of CARE is the way in which facilitators, managers and the mentor and advocate service model coping with emotions, setting goals and dealing with others in a pro-social way.

4.7.2 CARE is a highly collaborative programme and facilitators often participate in skills exercises and share experiences. This promotes opportunities for pro-social modelling and reinforces that the knowledge and skills taught on the programme are genuinely useful in everyday life. Facilitators, mentors and advocates are responsive to the cultural backgrounds of participants in order to ensure that they work with scenarios that are relevant to the women, both in individual and group sessions. Women are provided with contemporary examples of the skills in practice and are given the opportunity to observe skills as well as learn about them and practise them.

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4.7.3 The mentoring and advocacy service provides long term pro-social models for the women. The mentors actively demonstrate a range of skills for coping with setbacks, communicating, dealing with difficulties and conflicts, solving problems, avoiding impulsive responses and managing emotions.

4.8 Mentoring and advocacy

4.8.1 CARE participants are offered up to two years individualised mentoring and advocacy support which can span their time in prison and community. This service focuses on addressing the range of social inclusion and resettlement needs targeted by CARE but also provides support, monitoring and feedback on the generalisation of skills, motivational enhancement and empowerment. There is strong evidence supporting the use of mentor and advocates in the rehabilitation of offenders and in tackling social exclusion. This is described in more detail in the Theory Manual.

4.8.2 The service is responsive to women's individual needs, recognising that women from black and minority ethnic backgrounds may be particularly distrusting of mainstream services. The service provides exclusively female mentors and advocates and will refer specifically to culturally sensitive services where required.

4.8.3 The mentoring and advocacy service is introduced to the women at session three of group work. The frequency, nature and duration of contact and support will depend on the needs and circumstances of each woman, but contact at the end of the group work phase begins weekly. They are involved in the course review and work alongside the Offender Manager.

4.8.4 The service provides further assessment and monitoring of the woman's needs around education, training, employment, housing, finance, debt, family matters or any other issues which are likely to destabilise the woman or are related to her attaining her preferred life. Mentors will then act on behalf or with the woman to resolve issues, maintain and open opportunities and empower her to solve her own difficulties and create a stable and successful life for herself.

4.8.5 Examples of support provided to CARE participants during the pilots include:

- Completing referrals and negotiating accommodation with hostels and local authorities
- Providing advice on CVs, encouraging engagement in education courses and helping women identify possible career paths
- Researching courses and training opportunities and setting these up for women on release
- Providing women with self-motivation books
- Attending MAPPA meetings and parole hearings and advocating for the woman
- Advocating for women with social services and adoption workers
- Securing clothing grants
- Escorting women on town visits, meetings women at the prison gate on release and accompanying her on her journey home on public transport.
- Providing telephone support to the woman when in crisis and talking through issues
- Accompanying a disabled relative on a visit, which would not otherwise have happened

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(5) Skills Orientated

5.1 CARE aims to develop a range of skills which map on to the treatment targets. Some skills (such as mindfulness) have multiple functions. The methods used to develop these skills are explained in Section 4 and the sequencing of the skills is described within section 6 of this submission. More information is also provided within the Theory Manual and introductory chapters of the Programme Manual.

5.2 The development of skills during CARE is complemented by the psycho-educational components which support the development of knowledge and understanding. For example, this work includes developing awareness and understanding of emotions and increasing understanding of dynamics within relationships.

5.3 In addition to the skills addressed in the individual therapy and group work sessions the mentoring and advocacy service seeks to identify any additional needs and will enhance a range of skills. This will be based on the circumstance and progress of each individual woman and may involve the engagement and support of other services and agencies. Examples of skills enhanced during the pilots were financial management, writing CVs, vocational skills and parenting skills.

5.4 The skills are described in the table below, alongside the main treatment targets they address.

<table>
<tr><th>Factor</th><th>Skills covered by CARE</th></tr>
<tr><td>Limited insight into areas of risk, thinking and behaviour</td><td rowspan="2">Mindfulness skills for enhancing focus and concentration, tolerance of internal experiences and reduction of rumination. This aids self-monitoring and disclosure of internal experiences.

Self-narrative skills for identifying problems and describing a preferred life and identity.

Skills for fully participating in activities including speaking in front of others, joining in group activities and leading exercises.</td></tr>
<tr><td>Low belief in the possibility of change</td></tr>
<tr><td>Difficulties in regulating self-esteem</td><td>Skills for proactively managing day to day wellbeing including enhancing pleasure and relaxation (DODACs).</td></tr>
<tr><td>Low awareness, understanding and acceptance of emotions</td><td>Skills for emotion approach, including the ability to identify and describe emotions, disclose feelings and thinking to others and identify links to situations and cognitions.

Emotion tolerance skills.

Skills for using emotions to inform thinking (i.e. considering what messages emotions are giving you about the world around you, your goals and other people).</td></tr>
<tr><td>High emotional reactivity/ sensitivity</td><td>Emotional regulation skills including calming self-statements and calming breathing exercises, muscle relaxation and the use of safe space imagery. Distraction techniques and strategies for giving yourself time out.</td></tr>
</table>

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<table>
<tr><td>Frequent, intense and prolonged feelings of anger and shame</td><td>Emotion first aid skills as described above

Skills for recognising when shame is present and when it is masked by anger.</td></tr>
<tr><td>Hostile rumination, suspicious, angry, resentful thinking about others</td><td>Mindfulness, and objective, non-judgemental thinking skills

Cognitive steps for understanding the perspective and motives of others

Skills for understanding boundaries and expectations within relationships</td></tr>
<tr><td>Over reliance on a limited range of coping strategies (including emotional and cognitive avoidance, rumination, suppression, dissociation, substance misuse and self harm)</td><td rowspan="3">Emotion regulation skills

Assertive communication skills including
▪ assertive body language
▪ assertive language
▪ responding to criticism
▪ describing and dealing with conflicting views

Skills for disclosing information

Skills for asking for help

Setting personal and mutual boundaries

Mindfulness and objective self-monitoring

Impulse control skills including 2nd take thinking and 3 minute breathing space</td></tr>
<tr><td>Difficulties resolving interpersonal conflict (making personal disclosures, asking for help, assertive communication)</td></tr>
<tr><td>Poor impulse control when under stress</td></tr>
<tr><td>Disengagement with long term goals when under stress</td><td rowspan="6">Asking for help

Setting realistic and relevant goals

Planning skills and monitoring of outcomes

Assertive communication

Impulse control skills

Through mentoring and advocacy the development of a range of vocational and resettlement skills depending on the individual's needs and circumstances (e.g. job attainment skills, literacy and numeracy skills, parenting skills, financial management skills).</td></tr>
<tr><td>Lack of feasible risk management plans</td></tr>
<tr><td>Low identification with pro-social models</td></tr>
<tr><td>Barriers to accessing financial support, employment and accommodation</td></tr>
<tr><td>Low access to pro-social support</td></tr>
<tr><td>Likelihood of exposure to destabilisers (including violence)</td></tr>
</table>

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(6) Sequencing, Intensity and Duration

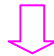
6.1 CARE is a moderate-high dose intervention which includes 30 group work sessions, 10 individual narrative therapy sessions and up to 2 years mentoring and advocacy support. Length and intensity of support in the mentoring phase is carefully managed so that it is responsive to the individual needs and progress of each woman.

6.2 Throughout CARE there is an active emphasis on building pro-social support and links to other services and activities. Since a core goal of the programme is to enhance belief that change is possible and thus to provide the motivation to realise that change, CARE also acts as a foundation programme which opens opportunity and new choices to the women.

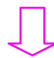
6.3 Attendance on CARE is therefore likely to be a springboard to a broad range of treatment, support and professional services. This applies to custodial and community settings. Post course mentoring, advocacy and narrative work directly supports and monitors this engagement in further work.

6.4 **The CARE programme consists of:**

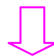
- Discussion with the woman, leading to referral.
- Discussion to gain informed consent to participate in assessment and treatment.
- Pre course interview for HCR-20 and psychometric testing.
- One to one narrative interview with a facilitator to confirm readiness for treatment.



- Six one to one narrative sessions, sequenced at the beginning and middle of the group work phase of CARE. These are around one hour.
- Thirty group work sessions which are around two hours long with a 15 minute break. These are usually delivered three times a week, no more than four times a week and no less than one.
- Around five individual mentoring and advocacy support sessions (45 minutes each)
- Course work and assignments after each session.



- Post course assessment. Post course risk report.
- Feedback and discussion of post programme facilitators report.
- Post course review, objective setting and follow up by the treatment team.
- Three further individual narrative sessions sequenced to meet the women's needs and delivered within 6 months of completion of the group work phase.



- Up to two years mentoring and advocacy support through an independent provider. Frequency of contact will depend on the individual, but will begin at once a week and then reduce in response to the woman's progress and needs.

6.5 During the referral and selection phase a decision may be made that the woman needs some **preparatory work** prior to CARE to enable her to engage and gain from the programme, or to enhance her wellbeing. For example, this might include support to stabilise a current mental health difficulty, manage self harming behaviour, reduce difficulties from current substance misuse

or improve literacy skills and use of English. This work should be time bound and monitored to ensure the woman accesses CARE as soon as she is ready to benefit from the programme.

6.6 As discussed earlier CARE acts as a catalyst to social inclusion and connects participants with other services and opportunities. **Following the group work phase** of the programme the individual facilitator maintains contact through narrative sessions and the mentoring and advocacy service maintains regular contact and works proactively with the woman for up to two years. The post course review will have identified objectives. These will be supported by the CARE team which in addition to facilitators, mentors and the treatment manager will include representatives from healthcare, offender management and where appropriate individuals linked to CARATs, ACCT, MAPPA and other agencies. This multi-disciplinary approach and long term contact with the women is designed to identify any outstanding needs post treatment and to monitor and action any further work and support needed. The format, sequencing, intensity and duration of this work should be tailored to meet the range and combination of needs the woman has.

6.7 The **treatment targets and methods** used by CARE have been chosen carefully, with reference to the existing evidence base and good practice. The **sequencing and structuring** of these is also carefully designed to take account of the complex needs and engagement difficulties the women are likely to have. This is part of CARE's trauma informed approach, ensuring a safe therapeutic environment is created and that women are able to participate and learn in a productive and positive way.

The building up of knowledge and skills provides women with the opportunity to try out skills safely, within scenarios and examples first, before moving on to applying them to their lives. During this process they are able to test out skills within sessions, receive feedback, have further practice and then try out skills out of session and in different contexts. The generalisation of skills is supported by both the multi-disciplinary CARE team and the independent Mentoring and Advocacy service. Feedback from behavioural monitoring further supports the development and monitoring of pro-social skills.

Given the complex and inter-related needs of the women CARE targets the programme takes an integrative approach. Each individual woman will have her own unique blend of risks and needs which will naturally fluctuate over time. In order to take the individual needs of each woman into account, each participant has a personal facilitator, who works with her on her narrative therapy sessions and her Preferred Story Portfolio from the pre-group phase until up to six months after the group has finished. She also has an independent, personal mentor and advocate who works with her throughout the 2 year period.

6.7.1 **Awareness**

Work on enhancing insight into areas of risk, thinking and behaviour is threaded throughout the intervention. The pacing and level of exposure to personally challenging material is gentle and gradual to ensure women remain engaged and are not re-traumatised. Early work uses scenarios and third parties, building up to exercises which require greater personal disclosure and application to self. The use of the personal portfolio, a range of diaries, course work, feedback on work and skills practices all support the development of self-awareness. Mindfulness training helps the women notice their thinking and experiences and maintain focus and concentration. Self-

awareness is also directly targeted in the ten narrative therapy sessions which enable the women to understand and map out problems in their lives and also their preferred ways of being, personal goals, hopes and the steps they can take towards a new life.

6.7.2 **Motivation and engagement** (discussed in more detail in chapter 7)
Motivation enhancement is embedded throughout the group sessions, individual therapy and mentoring and advocacy of CARE. The aim is to empower individuals, enabling them to create a personal vision of a new successful and pro-social life, and the confidence and belief that they can change if they choose to. This includes work to stabilise self-esteem and their sense of self-efficacy. During sessions CARE acknowledges and builds on moments of success and skill, it identifies and records strengths, abilities and past achievements and asks the women to reflect on how these can inform their new preferred way of being. Participants are encouraged to identify a new preferred life and each week consider how the knowledge and skills they are developing and recognising in themselves may help them reach this goal.

Throughout, the women work on their Preferred Story Portfolio which builds up a picture of their preferred way of living and documents the skills and pro-social contacts they have developed in order to enhance this. This piece of work forms a valuable document of evidence to show others and to keep for themselves and their own encouragement.

From the start CARE aims to build strong therapeutic relationships between the women and the delivery team. The facilitation style is transparent, respectful, collaborative and participant focused. The women are seen as the expert in their lives. They are introduced to CARE through individual narrative therapy sessions during which the facilitator explores the woman's experiences, views and how she would like her life to be. This allows the opportunity to show genuine interest in the woman, gain insight into her life and plan how to work effectively with her in group sessions. These sessions also begin the process of setting and holding clear boundaries, pro-social modelling and development of support networks. Narrative sessions in the middle and end of the programme continue to develop this rich understanding of the women and support their individual progress. Assignment work is acknowledged and discussed as part of every session and used to individualise the treatment process.

From the beginning of the programme facilitators are trained to be mindful of the difficulties some women will have sustaining engagement, so the skill of taking 'time out' when feeling stressed/angry/distressed is introduced from session one.

Throughout treatment sessions, the mentoring and advocacy service builds social and professional support networks with the woman which continue to enhance her motivation and focus on change. These also aim to reduce and compensate for negative influences which may destabilise the woman and which may diminish her hopes and efforts for change.

6.7(iii) Emotion management
CARE aims to enable participants to approach, understand and manage their emotions and thinking. The first seven group sessions focus strongly on teaching and practising a range of emergency first aid skills (using predominately cognitive-behavioural techniques) and acts of self-care referred to as DoDACs. These skills include calming breathing, self-calming statements,

knowing a safe space, muscle relaxation, distraction and Time-out. These help the women tolerate the treatment environment, disclose and address issues and maintain their engagement in treatment as it becomes more personally challenging. They also target areas of need related to offending including high emotional and physical reactivity, intense emotions of anger and shame, hostile thinking, avoidance, rumination and suppression. The skills are practised repeatedly to ensure the women can use them when in more difficult and emotionally aroused circumstances.

There is also an important psycho-educational element to CARE which is threaded throughout but has greatest focus in the first half of the programme. This helps the women recognise, describe and understand physiological and emotional experiences and their causes and consequences.

Emotion approach coaching is introduced early in the programme and uses gradual expose to enable the women to identify, describe and approach their emotions. The skills are practised regularly and encourage the women to reach a point where they can disclose their feelings to others, understand them and recognise the thinking and behaviour that is associated with them. This includes work on self-monitoring and the ability to objectively evaluate and describe the facts of a situation. These are likely to be particularly difficult skills for women who are emotionally avoidant and have experienced trauma and is carefully facilitated using a range of exercises and materials including mood boards, cards, scenarios and handouts. The skills are also modelled by facilitators.

Mindfulness training is introduced from session 8 and is used to enhance work on maintaining concentration and focus, coping with stress, tolerating emotions and avoiding impulsive responses, hostile rumination and angry and resentful thinking. The complexity of the skill is increased throughout sessions with regular practice within groups and through assignments. This supports the women in planning for and maintaining goals, and increases their awareness and understanding of their emotions and physiological reactivity. Mindfulness is a non-judgemental approach which supports self-monitoring skills and objectivity. A range of materials including books, CDs and DVDs are available to help with this work.

Emotional awareness and tolerance is further enhanced within sessions focusing of understanding anger, shame, and the relationships between these emotions. Links are made with behaviour and relationships with others. Skills for recognising and understanding these emotions are introduced including steps for allowing more time, control and choice over how you react (again using CBT approaches).

Facilitators are trained to remain mindful of the high levels of physiological arousal that will be experienced in the room and to not underestimate how powerful feelings of anxiety and shame may be for women. They are given materials which are carefully sequenced and constructed but are asked to make judgements within exercises about how far to encourage each woman to disclose and approach her emotions.

6.7 (iv) **Coping skills**

Following on from the emergency first aid skills which reduce immediate emotional reactivity and early work on understanding and approaching emotions CARE moves on to develop a range of coping skills for participants.

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DoDACs practice continues encouraging participants to identify, plan and evaluate activities which increase their coping strategies and includes skills for, amongst other things, self-soothing, distraction, healthy living and goal setting.

The middle group and narrative sessions look at relationships and conflicts which can arise between the need to be independent and need to belong. The work acknowledges that the women are likely to have an avoidant attachment and relational style due to past experiences. Sessions look at people's needs and expectations within relationships, building perspective taking skills and more objective and considered thinking around other's behaviour and motives. Later sessions encourage the women to identify principles for how they want to be treated within relationships, and consequently their own responsibilities around how they should behave with others. The work builds insight and skills for communication and disclosure, which feed into later work on assertiveness and asking for help. A number of sessions focus on developing and practicing assertiveness culminating in the final sessions which include role play practice with significant people from the women's lives. Assertive communication is taught in a structured, gradual and experiential way which increases intensity and exposure according to the woman's needs and progress.

Throughout sessions focus on managing autopilot- the automatic emotional, physiological and cognitive responses women experience as a result of circumstances or trauma. The emphasis is on providing participants with skills to utilize a range of options around how to respond, building up a repertoire of coping skills and networks of support.

These final sessions pull together all the skills taught in a challenging but supportive environment. In these sessions the women practise what they have learnt in role plays which reflect real life situations and possibilities.

6.7 (v) **Social inclusion and resettlement**

The initial assessment, referral to CARE and the first narrative therapy sessions begin to explore and understand the range of social inclusion and resettlement needs the women may have. This work includes identifying problems and goals, the presence and availability of support networks and the influence of peers. Group work, course work and individual narrative sessions continue this process throughout. Participants are introduced to the Mentoring and Advocacy Service in session 3, after which they are offered sessions during group work to build up their relationship with the service and access their help. The mentoring and advocacy service continues for up to 2 years providing advice and support, enabling the women to resolve her own problems and conflicts and to take up opportunities and services. The service also acts on behalf of the woman, advocating for her with other agencies and services around issues related to her successful resettlement or progress including training, accommodation, employment, finance, substance misuse, health and family issues. This provides the woman with strong pro-social models of effective problem solving and conflict resolution.

Post course the woman is also supported with a further three narrative sessions which facilitate a positive ending from the group work element of the programme. She identifies further objectives with the multi-disciplinary delivery team and is supported within a post course review.

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Chapter 4 of this Submission Document describes the treatment methods mentioned above in greater detail.

6.9 Participants are able to miss up to four session of treatment before a review needs to take place to consider whether they are able to continue meaningfully with the programme. If a women misses a session she is offered one-to-one catch up time to cover the key skills and material.

6.10 Facilitators use the debriefs, the treatment needs analysis and supervision to monitor and discuss each woman's progress. If a woman is not progressing or is experiencing difficulties with the programme this is discussed with her in an individual session, in supervision and collaboratively with the treatment team. The aim is to enable her to remain in treatment as long as it is not causing her or others harm. The treatment team may decide on additional support, a refocusing of her treatment targets and plan for helping her engage.

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(7) Engagement and Motivation

7.1 The women referred to CARE are likely to have had difficulties engaging in or completing interventions previously and may be viewed by the system as difficult to treat or even as 'untreatable'. They are likely to feel hopeless about aspects of their futures, have little belief that change is possible or faith that others will support them through change. CARE does not require women to be highly motivated to participate. Instead it focuses on developing motivation for change. The requirement pre treatment is that a participant is able to identify some problems in her life and some alternative, preferred ways of living. She must be willing to attend treatment and is asked to sign up to a set of group rules for ensuring her time on the programme is productive and not disruptive of others' engagement.

7.2 Enhancing Motivation

7.2.1 CARE aims to enhance motivation through the treatment methods used, the content of the programme, the use of coursework, the support of a multi-disciplinary team and the skills and approach taken by staff. It focuses on developing self-efficacy and stable self-esteem, on helping women set meaningful goals in their lives and on maintaining their motivation to work towards these and sustain change.

7.2.2 During the programme participants are asked to identify and enhance existing strengths and capitalise on their experiences of skill and success. This **focus on strengths and abilities** is supported with the development of a personal portfolio which records the progress and achievements of the women, which can be shared with others and used as a motivational tool by the woman.

7.2.3 Treatment is **individualised** in a number of ways including the individual narrative therapy sessions, bespoke mentoring and advocacy service and by means of personal coursework. This increases the responsiveness of the programme and helps staff match the type, level and intensity of support to the woman's needs, self-confidence and beliefs about how relevant and useful CARE is for her.

7.2.4 **Individual narrative therapy** is used during CARE to help the woman identify problems in her life but also create a **vision of how she would like her life to be**. This identification of a preferred life forms the foundation for motivational work around goal setting, empowerment and building confidence and self-efficacy. Narrative therapy is particularly helpful for women with complex needs as it separates out the woman's problems from the woman herself, and helps her view her problems in a more objective, focused and less avoidant manner.

7.2.5 CARE supports women in sustaining change through the development of **pro-social networks**, fostering an atmosphere of support between group members and with the delivery team and mentor and advocate. Further support is enlisted from key individuals within the woman's life, and the woman's progress and vision for a new life is shared with them in the definitional ceremony and course review.

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7.3 Enhancing Engagement

7.3.1 CARE is designed to accommodate and respond to complex needs. Pre-course **assessment** and the first four narrative therapy sessions are designed to help CARE staff identify the range of strengths and needs the women have and the implications for their engagement. Information from these is fed into the treatment needs analysis (which remains a live document) and used to plan the woman's treatment pathway and the approaches staff take when working with her.

7.3.2 CARE brings together staff from the Probation, Prison and Health Services within both the management and facilitator team. This increases the level of **specialist knowledge** within the team and helps with the early identification of individual needs and appropriate responses within treatment and through other services and support.

7.3.3 The readiness assessment also identifies where **preparatory work or additional support** would aid the women. At this stage guidance is also given on thinking through potential needs, strengths and opportunities which are associated with the woman's cultural, ethnic and religious background.

7.3.4 From the beginning there is a strong focus on the development of positive **therapeutic relationships**. This is achieved initially through four individual narrative therapy sessions when the participant is introduced to her personal facilitator and time is taken to understand what she really cares about and what her life is like. This is part of the process of showing genuine interest in the woman and recognising that she is the expert in her life. The **facilitation style** in individual and group sessions is respectful, collaborative, transparent, and participant focused, styles which have been more successful with personality disordered offenders and individuals who may find it difficult to engage in treatment.

7.3.5 Throughout CARE there is an emphasis on clear boundaries and ensuring a **safe therapeutic space**. This is important for women with trauma-based complex needs and for those who work with them. These boundaries include a non-disclosure group rule around past abuse and victimisation. The group room should be comfortably furnished and private, and the women are encouraged to build relationships with each other. These approaches act as an incentive to being part of the group.

7.3.6 The use of an **independent mentoring and advocacy service** which specialises in women offenders provides support from outside the formal criminal justice service. This can be helpful for women who are mistrustful of authorities and find it hard to engage with prison and probation staff.

7.3.7 The theory underpinning CARE has been tested with the available data on lesbian and for **black, Asian and minority ethnic women** (BME) and for people experiencing mental ill health. Separate literature reviews, focus groups and consultations were conducted as part of the development process. A race impact assessment was completed for CARE and has identified areas for continual monitoring.

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7.4 Trauma

7.4.1 As discussed, many of the women on CARE will have experienced trauma. In building relationships with staff and attending treatment they will therefore be vulnerable to triggers that activate their traumatic coping responses.

7.4.2 In response to this CARE is **trauma informed** and was developed in consultation with two agencies working with adults who have experienced abuse as children and three agencies working with women who have experienced domestic abuse. The holistic nature of CARE and attention to trauma is also consistent with the Department of Health's implementation guidance on women's mental health and good practice in relation to dual diagnosis.

7.4.3 CARE aims to find the balance between i) treatment being insufficiently demanding so that it fails to provide adequate exposure to emotions and opportunities for cognitive processing with ii) making it so demanding that the methods and materials overwhelm participants and trigger their traumatic coping responses including self harm, dissociation and aggression. This is achieved through a gradual increase in exposure to and intensity of materials across sessions and across the programme as a whole. This is carefully controlled and adapted to the progress and needs of each woman. Exercises use scenarios and examples of third parties before moving on to personal application and more personally challenging work. Emotional approach coaching slowly builds up the requirement to notice, explore and describe emotions and the thoughts and circumstances that go with them. Facilitators frequently model exercises which can provide useful guidance and reassurance.

7.4.4 Across CARE the sequencing of exercises encourages development of skills to enable change but also engagement within treatment. For example, the first seven group sessions of CARE focus on developing emotional first aid and emotion approach skills which support the women remaining in the group setting and help her tolerate the difficulties of engaging in treatment. This is followed by mindfulness training which helps the women focus and concentrate in session and builds skills for avoiding dissociation and rumination during treatment. This sequencing is describe more fully in Chapter 6 of the Submission Document.

7.4.5 CARE also employs a stable, familiar and **predictable structure** within sessions and across the programme. This aims to have safety and familiarity of the therapeutic environment which is helpful to women who have experienced trauma and also supports those who may find learning more challenging. As part of this the programme uses frequent signposting. At the beginning of the programme there is a session which describes the content and sequencing of the whole programme. Each session begins with an explanation of what is going to be covered and exercises are introduced with an explanation of what to expect.

7.4.6 The CARE pilots identified that for many participants the ending of the programme created some distress and triggered issues around rejection, loss and broken relationships. Because of this the ending of the group sessions is now carefully managed with three additional narrative therapy sessions within 6 months of completing the groups work phase. These sessions are designed to help the women deal with moving on, building new relationships and **coping with endings**.

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Supporting Learning:

7.5 (i) Many women on CARE are likely to have had negative experiences of formal learning and may have a range of needs such as **dyslexia or lower intellectual functioning** that impact on their capacity to learn and retain skills and information.

7.5 (ii) CARE does not requirement high level of **literacy**. It provides a brad range of materials and modes of learning which can matched to the needs and abilities of participants. The written materials follow guidance from the National Dyslexia Association and guidance has been taken from the Learning and Skills Council. This includes the choice of font type and back and foreground colours. Plain English is used in handouts and materials are uncluttered and use photos pictures, symbols and bullet points. Many of the concepts and tasks that are expressed in words are also accompanied by or can be replaced with symbols. Coursework is also tailored to participants' preferred learning styles. Materials have been developed to support visual, auditory and kinaesthetic learning styles and include handouts, CDs, DVDs, 3 dimensional models and cue cards.

7.5 (iii) To reinforce memory and support recall mnemonics are used to support learning as they associate new or hard to recall information with easy-to-remember constructs.

7.6 Future safety:

7.6 (i) CARE acknowledges that participants may continue to be exposed to violence within their relationships and life. Safety issues are identified at the assessment stage and the mentor and advocacy service provides support with accessing a range of services related to experiencing violence. Within treatment skills such as assertiveness and self-disclosure as taught as options rather than replacement for coping, this allows the women to hold on to more protective coping approaches for times when they are in great personal threat and likely to be harmed.

7.7 Support within the wider treatment environment

7.7 (i) The attitude, awareness and support from staff within the institution is influenced in a number of ways to increase the effectiveness of CARE

- The make-up of the CARE management team and facilitator includes representatives from Probation, Prison and Health integrating the programme into the wider running of the prison and offender management process.
- Staff awareness sessions and local training is a requirement for delivering CARE
- From session three the Mentor and Advocate services begins its bespoke service for each participant. Depending on the individual's needs and circumstances this may include advocating for them within the prison, probation service or other 3rd sector agencies and services. This work increases awareness of the aims of CARE and fosters support.
- CARE's focus on social inclusion and links with effective resettlement will draw in a range of staff from different sections of the prison including education and vocational training. This may be related to course work, in reviews and objective setting or through the personal facilitator or mentor and advocate.
- The behavioural monitoring process includes staff training and feedback and engages a broader range of staff in the support and evaluation of CARE.

7.8 Experience from the pilots

7.8 (i) During the pilot 20 out of the 23 women who commenced CARE completed treatment. Of the three who did not complete one was transferred from the prison and one left the pilot due to ill health. The third individual chose to leave CARE to engage in individual therapy, this followed her adult children coming back into her life after having been adopted and her feeling the need for more individual and 'on call' support.

7.8 (ii) The session attendance rate for the first two pilots of CARE was 93% which rose to 95% for the third pilot.

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(8) Continuity of Programmes and Services

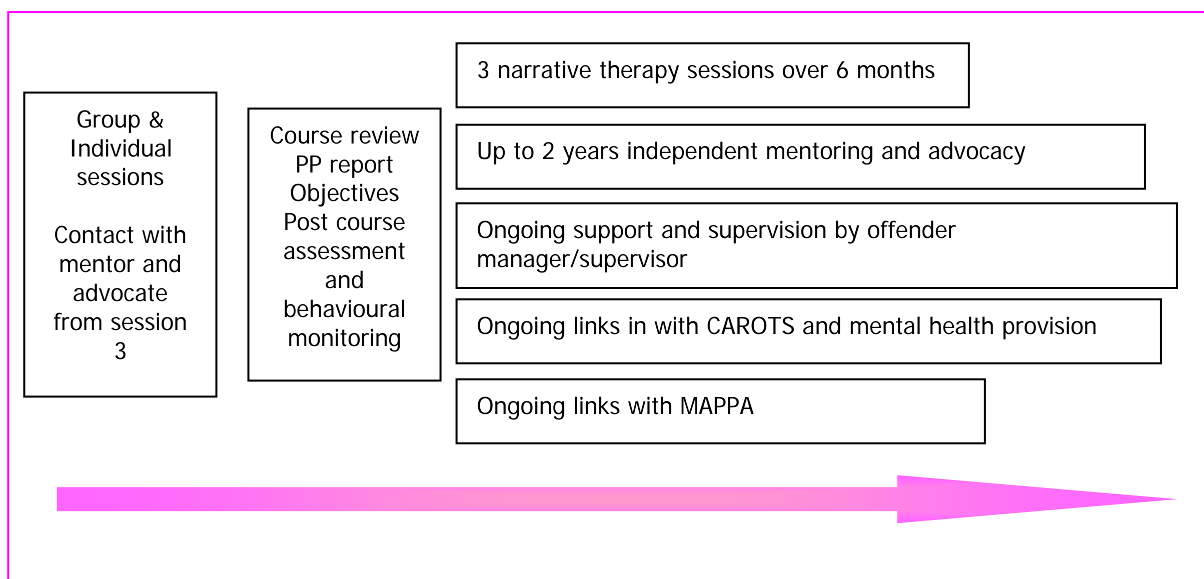
8.1 A core feature of CARE is an emphasis on social inclusion, effective resettlement and the development of prosocial support networks. Earlier chapters of this document have described how the individual therapy and group work sessions focus on developing awareness, skills and the motivation to live a successful and pro-social life. This leads the women to identifying preferred ways of being, with plans for how this can be achieved.

8.2 This work includes the development of a personal portfolio which describes how the woman would like her life to be, the skills and strengths she has and needs to continue to develop to achieve this, and the support networks which will be important to her success. As part of this and other work covered in CARE each woman is encourage to develop and document feasible long term progression and resettlement plans which reflect her needs and changing circumstances.

8.3 CARE's multi-disciplinary approach means that the programme's managers and facilitators represent a range of specialisms and services. The team are equipped to identify and understand a range of needs and will be involved with the provision of mental and physical health care, substance misuse work, psychological therapies and safer custody within the prison. The roles and responsibility of the CARE managers (a team of 4 including a Treatment Manager, Programme Manager, Healthcare Manager and Resettlement Manager) are described within the Manager's Manual.

8.4 The Offender Supervisor and Offender Manager form part of the CARE team (they are likely to take the role of Resettlement Manager) and will at the very least be involved in identifying needs, chairing the post course review, setting and following up objectives and enhancing progression pathways. The offender management process then works hand in hand with the mentor and advocacy service, both spanning custody and community.

8.5 CARE therefore supports women in maintaining and generalising their treatment gains in a number of ways. These are described in the diagramme below.



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8.6 The mentoring and advocacy support begins at session three of CARE when the women are introduced to their mentor and advocate. They will receive up to five individual support sessions sequenced within the group work and narrative therapy sessions. The frequency, duration and number of these sessions will depend on their needs, circumstances and readiness to engage with their mentor. Mentoring and advocacy support then continues for up to two years, initially this is likely to be one contact session a week, but again the nature and frequency of mentor contact will depend on the woman's progress and needs.

8.7 During the pilots the mentoring and advocacy provision was commissioned from an independent service specialising in women offenders. This allowed one or two part time mentors to be allocated to each group of women. The independent status of the service was particularly useful and valued by the women.

8.8 The mentor and advocacy service provides individually tailored support from specialist staff. This support is tailored to meet the needs of the women but can include:

- Information, advice and individual casework/advocacy support across all nine reducing re-offending pathways
- Building self-confidence/self-esteem and learning new life skills
- Empowering women to sustain employment/education and other positive life changes
- Help with accessing various education opportunities both whilst in prison and release, in some instances this includes help with funding, materials and grant applications
- Information, advice and guidance about employment
- Help with accommodation including how to keep a tenancy and making sure tenancies are given up in a way that means the woman is more likely to be housed on release.

8.9 CARE recommends that only female mentors are used. ISMG has been involved in the recruitment and briefing on mentor and advocates to date and will provide guidance and information on the role of the mentor within CARE.

8.10 A range of materials are available to delivery sites which explain the goals, content and approach taken by CARE. These can be used to inform staff, offender managers/supervisors about CARE and the women it targets. Local sites will be encouraged to adapt materials to suite local circumstances, for general use and to meet their requirement to deliver local awareness training. Once CARE becomes accredited it will form an important element of the suite of programme available to women, and will be described within broader compendiums, presentations and guidance documents which are disseminated through the DOMS offices by ISMG and to other groups including the Parole Board.

8.11 If a women drops out of CARE a report is completed on her needs, progress and reasons for not continuing. A format for this report is provided within the Manager's Manual. The treatment manager is required to make recommendations for next steps for the woman and communicate

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these to the offender manager. These will reflect the reasons why she was unsuccessful in completing the programme and may include additional support and help around complex needs, referral to alternative interventions or treatment and consideration of whether another opportunity to complete CARE may be appropriate in the future.

8.12 The Manager's Manual includes information on the assessment and reporting procedures for CARE. This includes the treatment needs analysis, post programme report and risk assessment.

8.13 In order to gain informed consent CARE provides a booklet on a) consenting for CARE – which includes details of the assessment and treatment approaches and programme aims, b) a more general booklet on consenting to interventions and c) a consent form which the women are asked to sign before the assessment process begins. The CARE booklet and consent form are included in the Manager's Manual. At this stage confidentiality is discussed including the boundaries to confidentiality and how information on the women's participation and progress will be shared with others involved in her progression and management.

8.14 If during CARE concerns arise regarding the safety and protection of children or other vulnerable individuals this is first discussed with the woman, and then appropriate action is taken to inform the relevant services and individuals.

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(9) Maintaining Integrity

9.1 The integrity and quality standards for CARE are outlined in the Management Manual which highlights in bold areas which will be formally audited. Quality assurance will be provided through annual support visits from ISMG, annual clinical reviews of session videos, referral and assessments, post course reports and supervision notes and biannual audit (in line with the revised accredited programme audit). Quality assurance is also the responsibility of the local Management team, and related tasks are built into their job roles and supported by ISMG through audit, advice and training. Job descriptions are included in the Management Manual.

9.2 The Management Manual explicitly sets out the minimum requirements that need to be in place to enable the programme to function effectively. It describes the practical arrangements and resources required. It refers explicitly to accommodation requirements, recommended staffing levels and continuity, the importance of retaining skilled and experienced staff and the importance of ensuring that sessions and activities are delivered in accordance with planned schedules and that cancellation is avoided wherever possible.

9.3 CARE's management team consists of a Programme Manager, Treatment Manager, Resettlement Manager (who is either an SPO or Offender Manager) and the Healthcare Manager. This multi-disciplinary approach reflects the complex needs of participants, enhances communication between departments and ensures that the profile of CARE is maintained within the establishment. The team liaises closely with the mentoring and advocacy service as well as other departments and agencies who are involved in the progression and broad resettlement need of the women.

9.4 CARE's Training and the Management Manuals describe the recruitment and selection procedures for facilitators and include a comprehensive description of the competencies that those delivering CARE. Facilitators must pass a local selection event before progressing through the training programme. This involves the five day core CARE training which is pass/fail and two further courses on mindfulness and narrative therapy which are provided by expert external trainers. Facilitators and Treatment Managers are also offered the opportunity to attend CORE skills training as a foundation course and with the introduction of the Knowledge and Understanding Framework, being developed as part of the Criminal Justice and Health response to Bradley, are likely to have access to Personality Disorder Awareness Training and PD related qualifications up to degree level.

9.5 A key component of the CARE competencies involves an ability to demonstrate awareness of issues relating to diversity, a theme that continues throughout the training process (described in detail in the Training Manual).

9.6 Embedded in CARE is a range of strategies designed to maintain the wellbeing of facilitators and limit the risk of burnout, exhaustion and secondary trauma. These strategies start at the facilitator selection and recruitment stage, are introduced and explored on training and are actively implemented throughout delivery of CARE. The Management Manual sets out a series of measures including structured supervision and support sessions, debrief and facilitator "health checks" that are designed to mitigate against the challenges that delivering CARE might present. The evaluation strategy includes staff feedback on the impact of the programme, a process evaluation and a number of studies which include questions around the wellbeing of staff. The results of these evaluations will inform the ongoing revision of programme materials, training ad support provision, management strategies and advice from NOMS ISMG.

9.7 The Management Manual also provides guidance on the ongoing assessment of facilitator competence and how feedback from monitoring should be used to develop and improve performance. In CARE feedback on performance is given within a framework that is structured and supportive. The Management Manual specifies the use of both individual and group supervision sessions and also provides guidance on the frequency and content of those sessions to ensure that opportunities to develop as individuals and as a team are maximised.

9.8 The Management Manual contains a detailed description of the measures that need to be in place to facilitate effective delivery. This includes an overview of the referral and
selection criteria for women which are more comprehensively described in the Assessment and Evaluation Manual.

9.9 The future direction and development of CARE will be influenced by the experiences of those who participate in it. The Assessment and Evaluation manual describes a series of research studies which will look at the delivery and effectiveness of CARE. Included in these are a number of projects which seek feedback from participants. Within the first two years a qualitative exploration of women's experiences of CARE will be completed, which will look how well they think CARE met their needs, how they felt about the way the programme is delivered and how the programme could be more responsive. Multiple case studies will also be completed and a process evaluation will seek further feedback from participants. Feedback from the women will be used to inform future revision to the materials, staff training and management of CARE. We will also monitor the characteristics of participants to ensure that it is accessible to those who will benefit from participation in the programme and that the inclusion criteria and targeting guidance is being adhered to. This will be included in an annual review of the programme.

(10) Ongoing evaluation

10.1 The long-term evaluation of CARE will involve collecting and analysing reconviction data. This is likely to take a minimum of two years or more to allow for credible reconviction data providing a sufficient amount of offenders have participated in the programme. In the short and medium-term, other measures that make use of the CARE triangulated approach to assessment will be used for the evaluation of impact:

- Structured Assessment Measures - structured rating scales such as the HCR-20 which usually involve a review of collateral information, interviews and observation
- Self Report Psychometric tests - standardised self-report measures which provide information on offenders' self-report attitudes and behaviour before and immediately after participation in a programme in relation to the targets of the programme.
- Observations - Behavioural Monitoring feedback from third parties

10.2 The CARE research strategy includes a number of evaluation approaches, which are summarised below:

Short-Term Projects: 1 to 2 years:

10.3 Annual Review of CARE Participants

Each year an overview of CARE delivery will be written, which will form a process of ongoing monitoring of programme implementation. This will include a summary of programme delivery, including feedback on quality of delivery from the clinical support and audit processes. It will include a summary of descriptive information about participants, covering demographic and pre-treatment risk and need information to enable monitoring of effective targeting. In addition, completion rates, take-up rates of mentoring schemes, length of mentor support, early leaving and reasons for leaving will be included to monitor for any trends in relation to responsivity or implementation issues. Summaries of pre and post treatment psychometrics will also provide some indication about the extent and direction of psychometric change in the short-term.

10.4 Qualitative Exploration of Women's Experiences of CARE

This study will explore the experiences of women engaging in CARE, with a particular focus on how responsive the programme is to their perceived needs. The study will explore women's views on how well CARE meets their needs, how they feel about the way in which the programme is delivered, and how the programme could become more responsive and effective.

10.5 Since this study is exploratory in nature, a qualitative approach will be used. Participants will be recruited using a purposive sampling strategy in which all the offenders who participate in the CARE programme within the first 12 months will be approached to take part. The women who agree to be interviewed will be seen individually by the researcher a week after the programme has finished. The women will be interviewed using a semi-structured interview schedule, and a content analytic approach will be used to identify themes that emerged from participants' accounts of their experience of the programme. Participants will also be invited to take part in a focus group to explore ways in which the programme could become more responsive to their needs. This information will also be analysed using a content analysis procedure.

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10.6 Multiple Case Studies

Given the small numbers likely to go through the programme in the short-term, it is proposed that a series of in-depth case studies will be completed to provide an indication of effectiveness pending the completion of larger scale evaluation projects. These case studies will help to build a picture of the extent to which CARE contributes to positive changes for offenders and will not only consider psychometric information, but also indicators of behavioural change for participants following completion of CARE. This approach will allow triangulation of information from different sources: the offender's self-report, third party observations and more objective behavioural indicators (for example, prison adjudication records). Potential research questions will include:

- What evidence is there for a positive impact of the programme on the key skills targeted by the programme?
- Is there evidence from outside the groups that learning has generalised to current behaviour?
- Can we evidence the impact of the CARE programme on behavioural outcomes: e.g. self harm, substance misuse, engagement in services and activities, mental health and experience of distress, adjudications in custody, and relationships with peers/staff/family/?
- Is the programme appropriately targeted to participants on dimensions of risk, need and responsivity?
- Is there any indication that issues of diversity have been properly addressed during programme delivery?
- Does the programme provide a flexible and joined up approach across community and custody?
- To what extent are facilitators described by participants as collaborative, warm, non-judgemental, curious, encouraging, positive, directive but not confrontational?
- Is the assessment and evaluation process seen as relevant and useful by participants and facilitators?
- Do offenders report they have had sufficient time/opportunity to practice the skills they are acquiring?
- Do participants experience a productive and purposeful working environment where they feel that they can work in a supported and focused way on issues which are important to them?
- Is there any evidence that the programme impacts negatively on the safety and wellbeing of participants?

Medium-Term Projects: 2 to 3 years

10.7 Evaluation of Behavioural and Clinical change

In order to evaluate the short-term impact of the CARE programme on participants, two research projects are planned. These studies are described below and will aim to determine the extent to which CARE reduces aggression and violent behaviour and encourages positive changes in the areas of need targeted by the programme.

10.8 Behavioural Change Study

The purpose of this study will be to evaluate whether CARE participants demonstrate any positive change in behaviour whilst in prison following completion of the programme. A range of behavioural indicators will be used as outcome variables, which will be drawn from a variety of

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sources, including staff behavioural monitoring sheets, ACCT documentation, wing history sheets, and adjudication records. This will enable researchers to determine the extent to which CARE reduces aggressive and violent behaviour in prison and other non-reconviction benefits of the programme; for example, reduced frequency and seriousness of self-harm, improved mental health, and improved management of emotions. Potential research questions will be:

- Do we have relevant, engaging, reliable and valid behavioural measures for each programme target?
- What evidence is there for a positive impact of the programme on the key skills targeted by the programme?
- Are there any differences according to age, ethnicity, and learning ability on short-term change?
- Is there evidence from outside the groups that learning has generalised to current behaviour?
- Can we evidence the impact of the CARE programme on behavioural outcomes: e.g. self harm, substance misuse, engagement in services and activities, mental health and experience of distress, adjudications in custody, and relationships with peers/staff/family/?

10.9 A quasi-experimental design will be used with CARE participants being compared to a matched group of women who meet the suitability (risk & need) criteria for CARE but who are located in prisons where CARE is not available and/or a waiting list control group.

10.10 Psychometric Change Study

This study will employ a similar methodology to the above behavioural change study; however, data from psychometric measures will be used as outcome variables. The purpose of the study will be to investigate whether the CARE programme is associated with positive change on the pre and post-programme psychometric measures. In addition, changes on the dynamic items from pre and post programme HCR-20 assessments will also be included as a further measure. Potential research questions will be:

- Do we have relevant, engaging, reliable and valid measures for each programme target and principle and valid for the offender population?
- What evidence is there for a positive impact of the programme on the key skills targeted by the programme?
- Are there any differences according age, ethnicity, and learning ability on short-term change?
- What are the characteristics and under what conditions do participants seem to benefit most from this intervention in terms of short-term impact?

10.11 A quasi-experimental design will again be used with CARE participants being compared to a matched group of women who meet the suitability (risk & need) criteria for CARE but who are located in prisons where CARE is not available and/or a waiting list control group.

10.12 Process evaluation

In order to ensure that an evaluation of CARE is carried out at the appropriate time a process study will be conducted to ensure that CARE has been implemented properly before, or whilst

planning takes place, for an outcome study. The process study will be conducted before any analysis of reconviction or post-release outcome.

10.13 The process evaluation will draw on data from interviews with staff delivering the programmes and CARE participants, in addition to reviewing a wide variety of programme documents. Potential research questions will be:

- Is the programme appropriately targeted to participants on dimensions of risk, need and responsivity?
- How long does a woman wait to start a programme once referred?
- Do the characteristics of those referred, selected and those who complete indicate that issues of diversity have been properly addressed in programme implementation?
- Does the programme provide a flexible and joined up approach across community and custody?
- What is the rate of non-completion, what are the reasons for non-completion and what are the characteristics of those who fail to complete compared to those that do?
- To what extent are facilitators described by participants as collaborative, warm, non-judgemental, curious, encouraging, positive, directive but not confrontational?
- Is the assessment and evaluation process seen as relevant and useful by participants and facilitators?
- Do offenders report they have had sufficient time/opportunity to practice the skills they are acquiring?
- Do participants experience a productive and purposeful working environment where they feel that they can work in a supported and focused way on issues which are important to them?
- Do facilitators report that training and supervision are sufficient?
- Are all staff assessed before attending programme training?
- Have all staff attended the appropriate training before delivering the programme?
- What are the characteristics of staff that deliver CARE and what is the rate of staff turnover?
- Are the right number of sessions delivered at the specified rate?
- What does the audit tell us about the implementation of the programme at different sites?
- What are the views of staff and participants of the programme?
- Are the data collection protocols followed?
- How much does it cost to deliver the programme?
- What are the levels of missing data and what is the impact for conducting short and long term evaluation studies?
- What are the views of staff and participants on how effective the programme is in the short-term?
- Is there any evidence that the programme impacts negatively on the safety and wellbeing of participants?
- How can we ensure the wellbeing of staff delivering CARE?

Long-Term Projects: 3 years plus

10.14 Analysis of reconviction and post release outcome

The long-term objective of the research strategy is to undertake an analysis of reconviction for CARE participants following release from prison. The purpose of this study will be to determine

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whether completion of the CARE programme is associated with a reduction in reconviction, in particular reconviction for violent offences. This will include a review of severity of reoffending, time to reoffending and frequency of reoffending.

10.15 Reconviction data will be obtained from the Ministry of Justice Police National Computer extract. This will enable one and two-year reconviction rates for CARE participants to be compared to a matched group of women who met the suitability (risk & need) criteria for CARE but who were located in prisons where CARE was not available.

10.16 In addition to reconviction, other post-release outcome measures may be used to demonstrate the effectiveness of the programme in improving social inclusion and resettlement; for example: attendance and completion of training, time to getting a job, time within employment, type of employment, ability to pay bills and stay out of debt, amount of time in housing, standard of housing). We will also receive an annual report from participants' mentor and advocacy service describing take-up and outcomes from their work.

10.17 Potential research questions would be:

- What evidence is there for a positive impact of the programme on: Employment or vocational training, learning skills, links with supportive pro-social peers and family members, self-harm and suicidality, substance misuse, mental health difficulties, managing personal finances, stable accommodation, and take up of other interventions/services to assist in pro-social living?
- What evidence is there for a positive impact of the programme on re-offending e.g. reconviction; time to reconviction and seriousness of reconviction?
- How do outcomes compare with those in an appropriate comparison group?
- How do short term outcomes relate to longer term outcomes?
- Are there any differences according to age, ethnicity and learning ability in relation to long-term impact?

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30 March 2010

Dear Gill and Deborah

CARE (Choices, Actions, Relationships, Emotions)
– application for accreditation

1. At its meeting of 23rd March 2010, the Correctional Services Accreditation Panel (CSAP) considered your application for accreditation of the CARE programme.

2. The Panel marks applications against each of the accreditation criteria, awarding scores of 2 (fully met), 1 (partially met) or 0 (not met) to each. The maximum possible score is 20 for the ten criteria. To be fully accredited an application must score at least 18 points.

3. **The Panel awarded the programme a score of 18** and I am pleased to inform you that the CARE Programme has been awarded **full accreditation.** The Panel was impressed with the work that had been done on the documentation for the programme, and found the materials now to be attractively presented, much simplified and generally clearer.

General Comments

4. The Panel are aware that this programme is likely to be rolled out to more prisons. Although the Panel was assured that the rollout will be limited, it felt nevertheless that the manuals need to contain sufficient information to allow new staff to run and manage the programme. The comments below about changes to the manuals are made with this in mind.

5. It would be helpful to have a brief overview at the beginning of the appropriate manuals, both of how this programme is intended to fit with other interventions (ideally, as a 'foundation' programme to help 'stabilise' women so they will get more out of subsequent programmes or other treatment – although it is recognised that it can also be used as a stand-alone programme for those with shorter sentences) and of

the logistics of its delivery, especially in respect of the mentoring arrangements. This was well explained verbally in the meeting. It would also help to have a list of all the documents used on the programme.

Criterion 1 - A Clear Model of Change Score 2

6. This criterion was fully met.

7. The Panel felt, in discussion with the programme developers, that this programme aims to stabilise offenders and develop in them the skills and motivation to engage in further treatment or engage with relevant services. As such, this should ideally be viewed as a foundation programme. This would particularly be the case where there is a serious history of violence.

8. Whilst greater engagement with further treatment and services could plausibly be linked to reductions in violent offending, the link is not straightforward and there is no evidence as yet that the programme *per se* could achieve a reduction. Consequently, the Panel suggests that paragraph 1.1 of the Submission document, which describes the aim of the Programme as promoting understanding, reducing risk and living a more satisfying and pro-social life is more accurate than paragraph 1.3 which covers reducing violence and aggression.

9. The aim of promoting engagement could lead to follow-up studies which assess the impact of the programme by investigating participants' subsequent engagement with treatment and services.

10. The Panel found the diagram on the Care Model of Change (Theory Manual p.12) confusing. It is more a model of the origins of offending behaviour and other problems. A model of change should show how the interventions provided by the programme will impact on the identified areas of need in participants and how this will lead to reductions in problematic behaviour. This may be achievable through reorganisation of the existing diagram. A possible alternative approach might be to include two diagrams – one showing the developers' understanding of the genesis of problem behaviour, and the other a model of how the programme will bring about change in relation to key risk factors.

Criterion 2 - Selection of Offenders Score 1

11. This criterion was partially met.

12. This programme is designed for difficult and dangerous women. Whilst the characteristics of participants are well-described in the manuals, it is not clear how the programme ensures that women with appropriate levels of risk are selected. The selection 'rules' are reasonably clear (apart from on personality disorder – see below), but if used in a mechanical fashion they could result in the selection either of women whose level of personality disorder and psychopathy are too high to fully engage, or of women whose level of risk is too low to warrant their having a place on the programme. The manuals refer to 'caveats' which allow staff involved in selection to use their judgement to override the rules, but more guidance needs to be provided on how to make such decisions.

13. Most importantly, there is no information on how the selection process would deal with high PCL-R scorers, or how these would be integrated into a programme which may contain vulnerable women with borderline personality disorder and other kinds of mental health problems. Further guidance might also be provided on how information of patterns of personality disorder should be used in selection decisions.

14. During the meeting, in response to Panel members' concerns about the risks of mixing vulnerable women wth highly aggressive personality disordered women, the programme developers explained how they have facilitated programmes which contain a such mixes. This should be noted in the manuals and any appropriate advice given, since it is likely to be an issue on all programmes.

Criterion 3 – Targeting a Range of Dynamic Risk Factors Score 1

16. This criterion was partially met.

17. The table (p 14-18 of the Submission Document and elsewhere) which describes the mediating risk factors and which clusters them under the five main treatment headings is a useful analysis of programme activity However, several of the risk factors described in the table are not known to be associated with offending, while conversely no mention is made of, for example, beliefs and attitudes, or other widely recognised risk factors for offending which are listed in the CSAP Accreditation Criteria document, and are often addressed via cognitive skills training. As the Care Programme makes some use of such methods, the Panel suggests that one or more of these risk factors would be appropriately identified as targets for this programme and included in the appropriate tables and lists. (In saying this, the Panel recognises that this programme focuses less on addressing 'deficits' than most cognitive skills programmes. However, it considers some mention of them to be advisable). In addition, **if risk factors to be addressed are not on the list provided in the CSAP Accreditation Criteria document, their link with offending needs to be more explicitly explained.**

18. Where risk factors are not addressed by the programme (eg: substance abuse) the manuals should indicate how this programme is to be sequenced with other interventions which do address them.

Criterion 4 - Effective Methods Score 2

19. This criterion was fully met.

20. The Panel felt the manuals were much clearer and that some sessions had been simplified.

21. There are some small errors (eg: Passive Paula in the assertiveness section becomes Passive Patsy) and a number of typographical errors.

22. Session 30 no longer contains psychometric tests and reference to this should be removed from the Management Manual.

23. The Panel felt that Session 4 – A Bad Day – would be too crowded and over-complicated.

Criterion 5 - Skills Orientated **Score 2**

24. This criterion was fully met.

25. The Panel was impressed with the inclusion of the final skills practices in the last few sessions of the programme.

Criterion 6 – Sequencing, Intensity and Duration **Score 2**

26. This criterion was fully met.

27. The Panel felt that ideally this programme should be the first that the women attend, and that attention should be given in the manuals to how this programme would link to other subsequent interventions (see previous comments on this).

Criterion 7 – Engagement and Motivation **Score 2**

28. This criterion was fully met

Criterion 8 – Continuity of Programme and Services **Score 2**

29. This criterion was fully met.

30. The Panel was impressed by the work of the Mentors and Advocates from the Third Sector Organisation (Women in Prison). This is clearly a very important part of the work with the women, especially for leaving prison and settling back into the community in a positive way.

31. At present mentors continue to meet with the women they met on the programme, either by travelling to the woman's local area or by the woman travelling to their offices. The Panel was concerned that whilst this arrangement is practicable for current operating levels, when the programme is rolled out on a larger scale it may be more difficult to manage, and that local mentors may need to be appointed. As noted in the previous letter, the Panel felt that the national reach of the Third Sector organisation currently working in partnership with the programme was advantageous, and suggested there may sometimes be advantages for this organisation in networking with others which have a local reach to support the Mentoring and Advocacy work.

Criterion 9 – Maintaining Integrity **Score 2**

32. This criterion was fully met.

33. Some of the topics covered in the CARE Training Manual repeat topics now in the new Core Skills package. As facilitators will have received Core Skills training

before embarking on the CARE training, these would be redundant and the time could be better used.

34. The work of the Treatment Manager will be crucial in maintaining the integrity and quality of the programme, and the appointment of adequately skilled and experienced personnel for these posts is essential. The Panel asks that the documentation clearly specifies the competencies and qualifications required for this post.

Criterion 10 - Ongoing Evaluation **Score 2**

35. This criterion was fully met.

36. The Panel was pleased to see the three-part plan for evaluation and looks forward to seeing how this has progressed and the available results when the programme is reviewed in three years time.

37. If you would find further clarification of the Panel's discussion helpful, you are welcome to contact the Chair of the Sub-Panel, Barbara Rawlings on barbara.rawlings@talk21.com

Thank you once again for bringing this application to the Panel. I trust that you will find this advice helpful.

Yours sincerely,

David Griffiths
CSAP Chair

Members of the sub-panel who considered this application are listed below:

Barbara Rawlings (Chair)
Mike Maguire
Linda Blud