



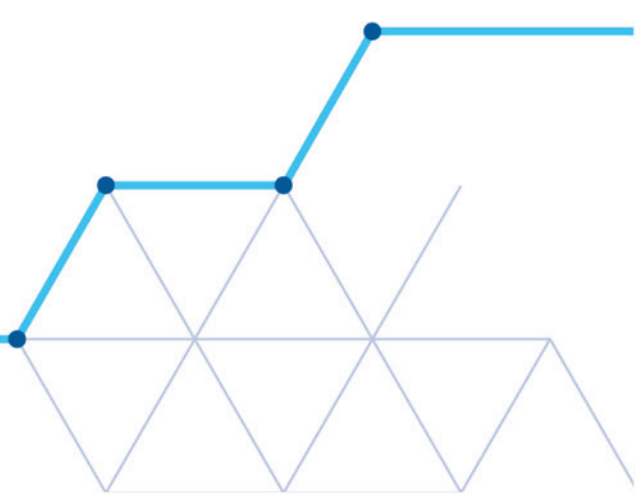
Ministry
of Justice

Intervening with Women Offenders; a process and interim outcome study of the Choices, Actions, Relationships and Emotions (CARE) programme

Keely Wilkinson, Sinéad Bloomfield and Sarah Ashcroft

Ministry of Justice Analytical Series
2019

Protecting and advancing the principles of justice



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First published 2019



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ISBN 978-1-84099-867-2

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1. Summary

The Choices, Actions, Relationships and Emotions (CARE) programme is an accredited custodial intervention for adult women who have a history of violence and complex needs, and a medium to high risk of reconviction. CARE was designed to reduce reoffending, and the risk of harm women pose to themselves and others by helping them to gain insight into their thoughts, feelings and behaviours, equip them with skills to manage their emotions, problem-solve and help them to develop a pro-social identity. This study, conducted in 2015, uses both quantitative and qualitative methods to evaluate the short term effectiveness of the programme, and to gauge perceptions from both programme participants and facilitation staff to help to understand delivery and to highlight any areas for improvement.

There were 99 participants who completed the CARE programme between April 2011 and March 2015 at two sites; HMP New Hall and HMP Foston Hall. Pre and post programme psychometric scores of participants were analysed and, 92 women had at least one psychometric measure completed both pre and post programme. Records of prison adjudications, misconduct and self-harm were obtained and assessed for 91 of the programme completers. Participant feedback was gained through thematic analysis of 40 completed post programme questionnaires (38% response rate). Understanding of the staff perceptions of the programme was gained through four focus groups and two interviews with thirteen staff members, comprising programme facilitators, treatment managers and mentor advocates.

The study findings should be interpreted in light of the limitations, including the lack of a matched control group, a relatively small number of programme completers over a four year period and a low response rate to the post programme participant questionnaire. The study also does not measure the impact of the programme on longer term outcomes such as reconviction.

1.1 Key findings

- The overall results of the evaluation suggest positive short term outcomes for the CARE programme, as well as positive perceptions from both participants and staff.
- Statistically significant differences between pre and post programme scores were found in the majority of programme targets (emotional management, coping styles and anger management), which were measured by two psychometric tests. The differences were in the desired direction and had small to large effect sizes.
- Significant reductions were also found in the mean number of proven adjudications in the 12 months following programme completion, compared to the 12 months pre-programme. Reductions were also observed for incidents of misconduct, and incidents of self-harm but these were not statistically significant. All results had small effect sizes.
- Programme participants gave positive feedback on their post programme questionnaires, with the vast majority (90%) of participants reporting they enjoyed CARE. Sessions on assertiveness, safe space and mindfulness were seen as most valuable. Three quarters of programme participants reported already using the skills learnt on CARE and all were confident of using the skills in the future. Most participants had set future goals following the completion of CARE including being more assertive, building confidence and getting out of prison.
- Feedback from staff interviews and focus groups was very positive. Staff felt there was clear value to providing a programme designed specifically for women and their needs. The complex needs of the participants on CARE does make it a particularly challenging programme to run, however staff felt that the programme content and the multidisciplinary nature of CARE allowed participants to make progress and work towards their goals.
- Some suggestions for improvement were made by some staff including additional guidance for mindfulness and the individual sessions, and additional training for personality disorders, beginning the mentor advocacy support earlier in the programme and extending this to other establishments, covering some areas of the programme in greater depth, and having a 'top-up' of CARE for those serving life sentences.

2. Introduction

Women account for approximately 5% of the prison population in England and Wales (MoJ, 2018), and violence against the person offences make up the highest group of convictions for this cohort (MoJ, 2018). While it is accepted in the literature that male and female service users can share common criminogenic needs such as substance misuse, education, employment, accommodation etc., there is also recognition that some needs can be more influential for women e.g. lack of closeness with family, poor temper control and binge drinking (Travers & Mann, 2018). A government commissioned review of women with particular vulnerabilities in the criminal justice system recommended that a woman-centred, holistic and multidisciplinary approach in the justice system would be more responsive to specific needs experienced by female prisoners (Corston, 2007). Furthermore, the Ministry of Justice Female Offender Strategy (MoJ, 2018) sets out the policy framework for working with female service users, including tailoring interventions appropriately to the needs of women which has been shown to be more effective than applying a generic approach to males and females alike (Gobeil, Blanchette & Stewart, 2016)

When looking at the profile of the female prison estate, there are frequent reports of poor mental health, with high levels of depression, anxiety, psychosis and suicide attempts (MoJ, 2013). Female prisoners are also highly likely to self-harm (MOJ, 2018), a behaviour which is frequently associated with aggression and other violent behaviour (Motz, 2008, Yakeley, 2010). Moreover, female prisoners are often likely to have been taken into care, experienced abuse and witnessed violence as a child (MoJ, 2013), contributing to highly complex profiles. Previous rehabilitative programmes for violent offending have been developed with males in mind and therefore a gap in provision was identified for females who have committed violence against the person offences, leading to the development of the Choices, Actions, Relationships and Emotions (CARE) programme.

The CARE programme has been designed to reduce reoffending, and the risk of harm women pose to themselves and others by helping them to gain insight into their thoughts, feelings and behaviours, equip them with skills to manage emotions, stress, and solve problems, and help them to develop a pro-social identity. The programme uses an integrated model of change to incorporate the bio-psycho-social model¹ (Mann & Carter, 2012) Risk,

¹ A multidimensional perspective that recognises the importance of biological, psychological, and sociological influences on criminal behaviour.

Need and Responsivity² principles (Andrews & Bonta, 2013) and desistance from crime literature (Maruna, 1999).

CARE has been specifically designed for delivery to medium to high risk of reoffending women prisoners, who have a history of violence and present with challenging rehabilitation needs. Women on the programme may have found engaging in rehabilitative interventions to be difficult previously due to their complex needs which can include substance misuse, trauma, poor mental health and self-harm/suicide attempts.

Whilst on the programme, the women work on the following targets; awareness, motivation and engagement, emotion management, coping skills, and social inclusion and resettlement. Work on these targets is achieved through a range of holistic, multidisciplinary and integrative techniques including cognitive behavioural therapy, narrative therapy, mindfulness, emotion approach coaching and pro-social modelling. Alongside the programme, a mentoring and advocacy service supports the women with resettlement plans in areas such as employment, accommodation, finance, and family services.

2.1 Participant Characteristics

CARE has been run in HMP Foston Hall since 2011 and in HMP New Hall since 2014. 104 women started the programme between April 2011 and March 2015 and during this period the majority of women (99, 95%) completed the programme. Of those who didn't complete the programme, three participants voluntarily withdrew, one participant was transferred and one was removed for misconduct.

Women can be referred to CARE if they have a history of violence or aggression, assessed as medium-high to high risk, and have two of the following areas of need; history of substance misuse problems, history of self-harming or suicidal behaviour, mental health difficulties, personality disorder, and past difficulties in accessing or benefitting from help or interventions. All (104, 100%) of CARE starters met the risk and need targeting criteria for the programme and all had a history of violent/aggressive behaviour. The main offence committed by participants was offences against the person (73%), followed by robbery (15%), criminal damage (8%), theft and handling (4%) and drug offences (1%).

² Effective interventions have been shown to adhere to the Risk, Need and Responsivity principles set out by Andrews and Bonta (2013). Risk states that the level of risk of re-offending the individual poses should be matched to the intensity of the intervention being delivered. Need refers to the intervention targeting specific criminogenic needs. Responsivity states that interventions are matched generally to individual's learning styles and specifically to an individual's abilities, strengths and circumstance.

The participants ranged in age from 19 to 62, with a mean age of 35. The majority of participants identified as White (84%).

3. Approach

The evaluation used both quantitative and qualitative methods to gauge the short-term effectiveness of the CARE programme, as well as to gain insight to both the staff and participants perceptions of the programme. This research was carried out on the 99 completers of the CARE programme between April 2011 and March 2015.

Data from psychometric³ tests administered pre and post programme were compared to see if there was any evidence of change across a number of programme factors (e.g. emotional management, coping skills, and control of anger), which CARE aimed to address. 92 of the 99 programme completers had data for at least one of the psychometric tests pre and post programme.⁴

Records of institutional behaviour were obtained for 91 of the 99 CARE completers.⁵ These were also compared pre and post programme to determine any changes in the number of recorded adjudications, incidents⁶ and self-harm.

Feedback from participants on CARE was obtained through analysis of 40 (38%) completed post programme questionnaires. Finally four focus groups and two interviews were conducted with thirteen staff members including facilitators, treatment managers and mentor advocates to gain insight into their perception of the programme.

3.1 Psychometrics

Two psychometric tests; the STAXI-2 and the CSQ-3 were administered to the 99 participants at the pre and post phase of completing CARE. Data was obtained on at least one of the psychometric subscales for 92 of the 99 participants. The STAXI-2 is a 57 item self-report measure which contains twelve subscales to assess an individual's experience, expression and control of anger (Spielberger, 1999). This psychometric measures the programme targets of awareness and emotion management. The CSQ-3 is a 41 item self-report measure which contains three subscales which measures the way in which an

³ Psychometric assessments provide an intermediate measure of the impact of programmes, reporting on changes in attitudes and behaviour during and immediately after attending a programme.

⁴ Missing psychometric data occurs either where participants have not completed the tests, which are not a mandatory requirement for the programme, or where specific items in the tests have not been completed and therefore the subscale cannot be calculated.

⁵ Matching CARE completions to adjudications, incidents and self-harm records resulted in available data for 91 of the 99 participants.

⁶ Incidents include; Assaults; Damage; Absconds/attempted escapes; Concerted indiscipline; Disorder; Arson; Firearms; Hostage taking; Miscellaneous; Mobile phones; Drugs; Tools/implement loss.

individual copes with stress (Roger, Jarvis & Narjarian, 1993). The CSQ-3 measures the programme targets of coping skills and emotion management. Pre and post programme changes in the mean scores of these psychometric tests were compared using paired sample t-tests. Due to the number of measures being explored pre and post programme, Bonferroni correction was applied to the t-tests performed to reduce the chance of a type I error occurring, which is the increased probability of observing at least one statistically significant result due to chance when multiple tests are performed. Bonferroni correction adjusts the p values to account for this possibility. See Appendix 1 for further details on the psychometric measures.

3.2 Institutional behaviour

The Prison National Offender Management Information System (P-NOMIS) allows recording of prisoner adjudications and incidents including misconduct and self-harm. Recorded adjudications and incident data was matched to CARE programme completers between July 2011 and March 2015. Matching this data resulted in adjudications, incidents and self-harm data being obtained for 91 of the 99 programme completers. The average number of adjudications and incidents recorded on P-NOMIS up to one year before commencing CARE and one year following completion of CARE were compared using paired sample t-tests. Bonferroni correction was applied to reduce the chance of type I error occurring.

3.3 Participant and staff feedback

Participants are routinely asked to complete an evaluative questionnaire following completion of the CARE programme. There were forty questionnaires voluntarily completed by participants who completed CARE between 2011 and 2015 (38% response rate). These were collated and subjected to thematic analysis, using the approach advocated by Braun and Clarke (2006).

Four focus groups and two interviews were carried out in 2015 with the treatment managers, facilitators and mentor advocates of CARE at HMP Foston Hall and HMP New Hall. Four focus groups were conducted with facilitators and mentor advocates, participants were selected through random opportunistic sampling. Two interviews were conducted with the Treatment Manager for CARE at each of the sites. The focus groups and interviews were transcribed and subject to thematic analysis (Braun and Clarke, 2006), allowing for both inductive and deductive development of the key themes.

3.4 Limitations

Due to the lack of a matched control group in the study, it cannot be fully concluded that any changes seen in both the psychometric scores, and the number of recorded adjudications, incidents and self-harm is attributed to the impact of the programme alone. It also cannot be concluded that the changes seen are not ones that naturally occur due to habituation to the prison environment over time.

The sample size of the study is small, which may explain some of the smaller effect sizes observed. Over the study period of almost four years, only 99 women completed the programme; this small number of throughput gives rise to difficulties for evaluation such as limited generalizability and low statistical power.

There is a variation in the number of psychometrics that were completed by participants; pre and post psychometric data was available for at least one of the psychometric subscales for only 92 of the 99 participants. This is likely to be due to either participants not wishing to/being unable to complete psychometric measures, or due to specific items on the psychometric being missing, preventing the subscale from being calculated. Additionally the matching process for finding the adjudications, incidents and self-harm data meant data was only available for 91 of the 99 completers.

There was also a low response rate (38%) for the post programme questionnaire completed by the group participants, which limits the generalizability of these findings and therefore these findings should be regarded with caution.

The aim of the study was to evaluate the short-term effectiveness of the programme and gauge staff and participant perceptions, and whilst the findings here are promising, they are not an indication of long-term successful outcomes. Further evaluation work is needed to determine the success of the programme in affecting longer term changes in behaviour such as reconviction. This can be conducted when a sufficient number of participants have completed the programme and been released.

4. Results

4.1 Psychometrics

Table 1: Pre to Post Programme Psychometric Mean Scores

Psychometric Scale		Pre-Prog. Mean	Standard deviation (SD)	Post-Prog. Mean	Standard deviation (SD)	Significant	Effect Size	Number (N)
STAXI 2:	State anger – Feelings	7.20	2.59	4.99	2.21	.001*	.91	92
	State anger – Verbal	6.66	9.10	5.95	2.25	.041	N/A [‡]	91
	State anger – Physical	5.28	1.32	5.51	1.65	.228	N/A [‡]	92
	State anger Total	19.12	6.10	16.41	5.27	.001*	.47	91
	Trait anger – Temper	7.82	3.14	5.64	1.71	.001*	.86	92
	Trait anger – Reaction	8.03	2.99	6.57	2.21	.001*	.55	92
	Trait anger Total	19.72	6.68	15.28	4.32	.001*	.79	92
	Anger Expression Out Scale	15.68	5.02	13.73	3.39	.001*	.45	90
	Anger Expression In Scale	18.14	4.69	14.15	4.05	.001*	.91	92
	Anger Control Out	21.88	6.03	24.30	5.18	.001*	-.43	91
	Anger Control In	21.65	6.13	25.58	5.50	.001*	-.67	91
	Anger Index	38.82	17.19	26.29	14.23	.001*	.79	89
Coping Styles Questionnaire	Emotional/ Detached	31.20	7.78	35.26	6.36	.001*	-.57	85
	Rational	13.60	5.08	13.53	4.73	.912	N/A [‡]	88
	Avoidance	14.21	5.85	12.82	6.14	.031	N/A [‡]	89

* Significant to $p < .003$ after Bonferroni corrections. Bonferroni correction adjusts the p value significance cut off to account for the increased probability of type I errors due to multiple tests being performed

[‡] Effect size (Cohen's d) cannot be calculated due to confidence intervals crossing 0.

Table 1 shows the pre and post mean scores on the two psychometric tests. There were significant statistical differences⁷ on 10 of the 12 subscales of the STAXI-2. These were in the desired direction and had moderate to large effect sizes.⁸ On the CSQ-3, one of the three subscales had a significant change in the desired direction, with a moderate effect size.

⁷ A result can be viewed as statistically significant if the probability of achieving the result by chance alone is less than 0.05 (5%).

⁸ Effect size is an objective and standardised statistical measure of the magnitude or size of the observed effect. Cohen's d (as used in this study) is defined as the difference between two means divided by a standard deviation for the data (Cohen, 1988).

4.2 Institutional Behaviour

Table 2: Recorded institutional behaviour for one year pre and post CARE

Institutional behaviour	Pre CARE mean	Standard deviation (SD)	Post Care mean	Standard deviation (SD)	Significant	% Difference	Effect Size	Number (N)
Adjudications	5.02	7.35	3.04	5.70	0.01*	39.4%	.30	91
Incidents of misconduct	1.01	1.71	0.62	1.18	0.03	38.6%	N/A*	91
Self-Harm incidents	6.86	20.12	2.96	8.99	0.04	56.9%	N/A*	91

*Significant to $p < .02$ after Bonferroni corrections. Bonferroni correction adjusts the p value significance cut off to account for the increased probability of type I errors due to multiple tests being performed

‡ Effect size (Cohen's d) cannot be calculated due to confidence intervals crossing 0.

Table 2 shows the pre and post mean of recorded adjudications, incidents of misconduct and self-harm incidents for CARE. The findings show a statistically significant percentage decrease in adjudications, in the 12 months after completion of CARE compared to the 12 months prior to CARE. Decreases were also observed for incidents of misconduct and self-harm incidents but these were not statistically significant after Bonferonni correction.

4.3 Participant feedback

Three themes were identified from the 40 participant questionnaires; overall experience, concerns before the programme and future expectations. Overall participants reported they were very positive about CARE, with 90% reporting that they enjoyed the programme, and felt it was relevant and helpful. Participants also described their excellent relationships with the facilitation staff, and felt the sessions on assertiveness, safe space and mindfulness were the most beneficial.

Participants described their concerns prior to going on the programme; citing anxiety and nerves associated with participating in a group, having a lack of self-esteem and confidence, and fear of not being able to cope. Following completion of the programme, many of the participants felt that they had been well supported in the group and had been heard, some for what felt like the first time.

Regarding future expectations, three quarters of participants said they were already using the skills they had learnt on CARE, and all were confident of using them in the future. Participants described their goals which included being more assertive, building their confidence, getting out of prison and getting a job, and remaining drug free. Over half the participants expressed an interest in doing another programme, and many had already accessed external support agencies.

4.4 Staff feedback

Feedback from the staff who participated in the four focus groups and two interviews across the two sites was very positive. The value of running a programme that had been specifically designed to help women and considered the complexity of their needs was something that was apparent across the interviews. The content of the programme as well as the methods used were also highly praised by the staff who felt that these were valuable in achieving the programme aims. Specifically the use of narrative therapy, emotion approach coaching, mindfulness and the mentoring and advocacy service were all seen as highly beneficial.

Staff did, however, make some suggestions for improvement, including covering some areas of the programme in more depth, particularly relationships, and many felt they would benefit from more guidance for the mindfulness and individual sessions. Additionally it was felt that support from the mentor advocacy service should come earlier on in the programme, and that this should be offered in other establishments to provide support to women after transfer.

Feedback about the quality of training and support for the programme was also encouraging, with staff saying they felt confident in delivering CARE. Some problems were also discussed; these included issues with establishing a new programme in a prison, and also challenges of working with a group with highly complex needs, particularly with regard to some of the more challenging exercises like mindfulness. Having flexibility with some of the programme content was suggested as an improvement which would help in working with a challenging cohort and being able to be responsive to the women's needs. Some staff also suggested that more training in personality disorders would be helpful.

Despite working with a challenging cohort, staff felt they had learnt a lot from delivering the programme, and have since been able to work through some of the issues they have faced. Additionally, many of the staff stated that whilst working with the women had been challenging, it was also very rewarding when they could see the CARE participants making progress.

5. Conclusions

The findings of the study suggests some positive short term effectiveness for the CARE programme. There were statistically significant changes in the majority of programme factors assessed (positive changes in mean scores of 10 of the 12 subscales of the STAXI-2), indicating an improvement in the participant programme targets of emotion management and awareness following the completion of CARE. Significant change in the emotional/detached coping subscale (on the CSQ-3) also suggests there is improvement in these types of coping for the participants following CARE completion. Change in this particular style of coping is a positive outcome as emotional management is a key target of the programme. Whilst there was no statistically significant changes in the other two subscales, change in the avoidance subscale was in the desired direction which is encouraging. Any change could be seen as a positive step, and it can be hoped that this might extend into longer term outcomes. The lack of statistical significance may be due to a smaller sample size, or perhaps due to the complex nature of the participants.

There was also a statistically significant decrease in recorded adjudications in the 12 months following completion of CARE, which suggests a positive effect on institutional behaviour and that the programme is potentially reducing institutional violence. CARE also aims to reduce the risk individuals pose to themselves as well as others, so the reduction in levels of self-harm incidents is also encouraging even though this wasn't found to be statistically significant after Bonferroni correction.

The majority of both the participants and the staff, who participated in this study, expressed positive perceptions of the programme, suggesting that CARE is well received, relevant and potentially having a positive impact on the participants.

All findings should be considered in light of the limitations as outlined earlier in this report.

5.1 Areas for Improvement

Although the response to the programme was largely positive, staff did also make some suggestions for improvement, and therefore there are a number of recommendations which were made from the staff interviews;

- Many of the programme staff, involved in the study, felt that additional guidance would be useful for mindfulness exercises and one-to-one sessions. They also felt that more flexibility with some of the programme content might help with working

with a challenging cohort. Finally, they suggested additional training for personality disorders would be helpful.

- The Mentor Advocacy Service could be improved by mentor advocates having contact with the women from the outset of the programme, not just from the 3rd session. Additionally transfers following completion of the programme impair the amount of support provided to the women, therefore it would be beneficial if the Mentor Advocacy Service was provided in more establishments. Finally it was felt that support should coincide with release dates when the women are likely to need it most.
- Some programme staff felt that there were areas on the programme which could be covered in more depth, particularly relationships.
- A CARE 'top-up' for those serving life sentences may be beneficial.
- Promotion of CARE would increase referrals to the programme, as well as help overcome some operational issues such as allowing prisoner movements for programme sessions.

Since this study was completed, the findings have been shared with the programme developers who have made a number of adjustments to CARE based on the recommendations set out above. CARE has since been reaccredited in 2016 by the Correctional Services Accreditation and Advice Panel⁹ (CSAAP), with this research providing support for its reaccreditation.

As with all accredited programmes, the Ministry of Justice will continue to evaluate the effectiveness of CARE in improving outcomes for service users. A longer term impact study exploring CARE's effect on reconviction rates will be conducted. However it will not be possible to conduct such a study until a sufficiently large sample has completed the programme, been released, and spent 3-5 years in the community to examine any impact of CARE on reconviction rates.

⁹ Accreditation is the process of reviewing, validating and approving offender interventions which have been designed to reduce reoffending. CSAAP consists of specialist sub-panels comprising three to five experts, who review each programme according to published evidence-based criteria. See the following website for further information about accredited programmes and CSAAP: <https://www.gov.uk/guidance/offending-behaviour-programmes-and-interventions>

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Appendix 1

Psychometric Scales

The State –Trait Anger Expression Inventory (STAXI-2) comprises six scales and five subscales;

- 1) State Anger – assesses the intensity of the anger as an emotional state at a particular time. Consists of three subscales; Feelings – feeling angry at a particular time, Verbal – feeling like expressing anger verbally, Physical – feeling like expressing anger physically Trait Anger – measures how often angry feelings are experienced over time. Consists of two subscales; Temper, and Reaction
- 2) Anger Expression Out – measures the expression of anger towards other persons or objects
- 3) Anger Expression In – measures holding in or expressing angry feelings
- 4) Anger Control Out – measures controlling angry feelings by preventing the expression of anger towards other persons or objects
- 5) Anger Control In – measures controlling angry feelings by preventing the expression of anger towards other persons or objects
- 6) Anger Control In – measures controlling suppressed angry feelings by calming down or cooling off
- 7) Anger Index – overall total to measure angry expression

All items are rated on a four point scale: Not at all, Somewhat, Moderately, Very Much.

The Coping Styles Questionnaire (revised version CSQ-3) comprises of three subscales measuring how a person typically responds to stress.

- 1) Avoidant: measures the maladaptive coping mechanism of avoidance coping, characterised by the effort to avoid dealing with a stressor.
- 2) Rational: measures the adaptive coping mechanism of rational coping, characterised by facing the stressor and working to overcome it
- 3) Detached/Emotional: a confirmatory factor analysis merged detached and emotional coping into a bipolar scale in the revised CSQ-3. High scores indicate a detached coping style, characterised by the ability to maintain perspective during stressful situations. Low scores indicate an emotion-focused coping style, characterised by an attempt to reduce negative emotional responses to stressors such as fear, anxiety and aggression.

All items are rated on a four point scale: Never, Sometimes, Often, Always.