The CARE programme: an accredited offending behaviour programme specifically for female offenders at risk of violence

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Abstract

Purpose – *The purpose of this paper is to outline the development, structure and implementation of the Choices, Actions, Relationships and Emotions (CARE) programme.*

Design/methodology/approach – *This paper will present some of the background to the programme, its aims, structure and delivery methods and the nature of the treatment population to date. It will also reflect on some of the lessons learnt through the development and implementation of the programme and the challenges faced in evaluating its impact. Plans for its future evaluation and development are discussed.*

Findings – *Female offenders represent a distinct group with particular treatment and responsivity needs. These have traditionally been accommodated in programmes developed for male offenders, adapted slightly to meet their needs. CARE represents a distinct approach, designed specifically for the needs of female offenders with a history of violence and complex presentations.*

Originality/value – *CARE is a relatively new programme and this is the first paper to outline its structure and content.*

Keywords *Mindfulness, CARE programme, Female offenders, Narrative therapy, Offending behaviour programmes, Violent offenders*

Paper type *General review*

Introduction

Over the last five years in England and Wales, women have accounted for 15 per cent of offenders under supervision in the community, as a result of community and suspended sentence orders, and 5 per cent of the prison population (Ministry of Justice, 2013). While they may make up the minority of offenders, the number of women convicted of violent offences is on the increase with over 907 women serving sentences in England and Wales involving violence against the person in June 2013 (Ministry of Justice, 2013). Studies exploring the nature of women's use of violence have found it to be less visible than that of men's, with more offences being committed against known victims such as partners and children. It has also been found to be less serious in terms of physical injury and more reactive in expression, rather than sexual and instrumental; being typically driven more by emotional and relational jealousy (Fusco *et al.*, 2011).

In addition, women's behaviour within forensic settings such as prisons can also be problematic. Incarcerated women are ten times more likely to self-harm compared to male prisoners

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(National Offender Management Service, 2012). Women are also more likely to experience mental health difficulties whist in custody and have problems with substance misuse (Sacks, 2004). Logan and Blackburn (2009), further estimated that half the female forensic population meet the criteria for anti-social personality disorder and 40 per cent for borderline personality disorder. It is noted that this is higher than some other studies. Fazel and Danesh (2006) found that 20 per cent of female detainees from 62 studies across 12 countries met the criteria for anti-social personality disorder and in Canada, Laishes (2002) found that just under 37 per cent of women offenders met this criteria.

It is argued that many of these complex presentations stem from traumatic early experiences. For example, it has been found that half of women in prison have endured physical or sexual abuse at some time in their lives, and this rate appears to be higher for those involved in violent offences (Pollock *et al.*, 2006). It is therefore vital that, when working with women and encouraging them to learn skills to help facilitate change, their needs are carefully considered and responded to using a trauma informed and gender-specific approach.

This paper outlines the Choices, Actions, Relationships and Emotions (CARE) programme; a therapeutic offending behaviour programme that aims to specifically meet the needs of female offenders with histories of violence and complex presentations. This paper will outline the background to the creation of CARE, its aims, structure and delivery methods, the nature of the treatment population and plans for programme evaluation. It will also reflect on some of the lessons learnt over this period.

Why the CARE programme was developed?

In 2007, Baroness Corston's report "A review of Women with Particular Vulnerabilities in the Criminal Justice System" called for a new approach to working with female offenders (Home Office, 2007). Baroness Corston highlighted the complex needs of women offenders and recommended a multi-agency, woman-centred and holistic approach to reduce reoffending. The evidence suggested that men and women share criminogenic factors (Andrews and Bonta, 2003; Greiner *et al.*, 2015; Nicholls *et al.*, 2009), but how these come together and operate is distinctly different for the two groups (Kruttschnitt, 2002; Pollack and Davis, 2005; Hollin and Palmer, 2006; Van der Knapp *et al.*, 2012). There has also been discussion in the literature regarding the direct applicability of the Risk, Need and Responsivity principles (Andrews and Bonta, 2003), to female offenders, as they are considered for male offenders (Blanchette and Brown, 2006; Hannah-Moffat, 2006).

For example, it was found that women are much more likely than men to experience mental health problems that relate to their use of violence (Henning *et al.*, 2003; Logan and Blackburn, 2009) as well as experiencing ongoing or repeated trauma and exposure to violence (Battle *et al.*, 2002; Greenfield and Marks, 2010; Mechanic *et al.*, 2008). Studies had also reported that many women who have committed violent offences have a serious substance use disorder that links to their perpetration of violence (Dowd *et al.*, 2005; Weizmann-Henelius *et al.*, 2009) and that these rates were higher than for men and the general public (Fazel *et al.*, 2006; Staton *et al.*, 2003). Such factors can therefore form important risk and responsivity areas (Andrews and Bonta, 2003) for treatment, as they can contribute to women's offending and difficulties sustaining engagement with services.

Women offenders with histories of violence were therefore argued to represent a distinct population, in need of treatment that was responsive to their difficulties with mental health, substance misuse, self-harm/suicide, engagement, and personality disorder. As a result, it was agreed that a gender-responsive, trauma informed, multi-model treatment was required (Bloom *et al.*, 2005; de Vogel *et al.*, 2012; McGuire, 2008) that focuses on the identified gender-specific responsivity and treatment needs (Blanchette and Brown, 2006; Bottos, 2007).

The National Offender Management Service (NOMS) have been designing, delivering and evaluating offending behaviour programmes for many years. However, offending behaviour programmes have been criticised for being largely designed for male offenders, with only minor tweaking for female participants in an acknowledgement of the potential differences between

men and women, especially around mental health and substance misuse (Gerstein and Johnson, 2000; Hollin and Palmer, 2006; Worrall and Gelsthorpe, 2009). Although, it is acknowledged that more attention has been paid to this issue in more recent programmes. For example, the Thinking Skills Programme (TSP) had been developed with a gender neutral approach, informed by literature on both male and female offenders.

Following the recommendations of Baroness Corston and a review of the literature available at the time, the Women and Young People's Group developed a programme for this population which Intervention Services within NOMS further developed to form the CARE programme. This aimed to fill the gap of interventions specifically tailored for female offenders.

The CARE programme

CARE is the only accredited offending behaviour programme designed by NOMS Intervention Services specifically for delivery with women. It is aimed at medium/high risk female offenders with a history of violence and complex presentations. The content of the programme, the sequencing of learning, treatment methods, level of exposure and personal demands on group members have been carefully planned to be trauma informed and gender sensitive.

CARE was accredited by the Correctional Services Accreditation and Advice Panel (CSAAP; Lipton *et al.*, 2000; Maguire *et al.*, 2010) in 2010, following a successful pilot process. CSAAP is an Advisory Non-Departmental Public Body, which was established to advise the Home Secretary on programmes aimed at reducing offending. The CSAAP's rigorous accreditation criteria are based on the "what works" literature (McGuire, 1995). Following its accreditation CARE was commissioned by NOMS for delivery at HMP Foston Hall in 2011 and more recently has been co-commissioned by NOMS and NHS England at HMP New Hall as part of the Women Offender Personality Disorder Pathway (Ministry of Justice and Department of Health, 2011).

Treatment aims

Ultimately CARE aims to help women to better understand their risk and needs and to help them lead a more meaningful and pro-social life. Whilst reducing levels of violence is an important outcome for CARE it is recognised that other outcomes are as important, for example, improved engagement with services and improved psychological health. This is with the aim of maximising the benefits that can be gained from CARE and future services as part of the women's wider rehabilitation. The treatment targets come from a review of the literature related to risk and protective factors for violence and aggression for female offenders. These are; motivation and engagement, insight and awareness, attitudes and beliefs, emotion management, interpersonal skills, social inclusion and resettlement (Blanchette and Brown, 2006; Bloom *et al.*, 2005; Kendler *et al.*, 2005; National Offender Management Service, 2008). Other relevant factors highlighted in the literature on female offenders have been taken on as responsivity needs.

CARE aims to develop each participant's insight into the various factors which contribute to their difficulties, including their violent and aggressive behaviour. Participants learn and practice skills related to cognitive flexibility, emotional management and interpersonal skills. These help them to self-monitor the presence of problem factors and develop strategies to manage these. They develop an awareness of their existing skills and develop protective factors to strengthen a personally meaningful and pro-social way of living. They are also supported in applying and further developing their skills in their everyday lives through regular assignments.

Therapeutic techniques and methods

For CARE to be successful it was acknowledged that it was as important to consider how things needed to be achieved in treatment as it was to establish what needed to be achieved. CARE makes use of a range of integrated therapeutic techniques including; Narrative therapy, Mindfulness, Cognitive Behavioural therapy, emotion approach coaching, mentoring/advocacy, pro-social modelling and psycho-education. Narrative therapy is one of the key techniques underpinning the programme (White and Epston, 1990). This aims to support rehabilitation by

helping the individual move away from self-narratives such as "addict" or "failure" and to recognise positive events in their life without them being overcome by negative discourse. Through practices such as decentring, externalising, scaffolding and narrative maps (White, 2007) it aims to help women safely discuss problems without thinking they are part of the problem. In this way it is particularly helpful with female prisoners who tend to incorporate their problems into their identity (Mahoney and Daniel, 2006). As well as exploring problem narratives and their effects, a strong focus is placed on helping the women to discover unique outcomes; times she was able to have control over the problem story, and identify the knowledge and skills she used in order to achieve this outcome. Preferred story narratives are then strengthened using a number of narrative methods.

Throughout the programme, 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 can use in order to enhance this. The portfolio is a valuable source of evidence, for both the women as well as others, to help motivate them and strengthen their preferred way of living. Towards the end of CARE, participants take part in a preferred story skills practice where they have the opportunity to practice their response to a potentially destabilising/risky situation. CARE also makes use of definitional ceremonies (Myerhoff, 1986) to mark the end of the treatment and celebrate the women's work towards her preferred way of living. This also helps to prepare for the post programme review, where the participant is invited to share her preferred story with other people and receive feedback about this.

Narrative therapy has been found to positively impact on a range of self-reported symptoms-related trauma, anxiety and stress and to shift personal narratives in a positive direction (Muntigl, 2004; Ungar and Teram, 2000). As well as finding narrative therapy effective, recipients have also reported to experience it as inclusive and respectful (O'Connor *et al.*, 1997). It is acknowledged that the evidence for the effectiveness of narrative therapy is currently limited due to a current lack of methodologically rigorous research. The use of narrative therapy with a female forensic population is therefore an innovative approach. While based on sound theoretical arguments, the effectiveness of this approach with this population will form part of the evaluation strategy of CARE.

In addition to Narrative Therapy, CARE also incorporates Mindfulness (Kabat-Zinn, 1994). This helps individuals to develop a level of awareness that is in the present moment, non-judgemental, and in a particular way. Mindfulness originates from Buddhist practices of meditation and came to the western world when Thich Nhat Hanh delivered a retreat in the USA. The practice was then taken on board by Jon Kabat-Zinn in 1979 where he founded a Mindfulness-Based Stress Reduction (MBSR) programme (Kabat-Zinn, 1982, 1990; Gazella, 2005). A systematic review found that MBSR improved mental health and reduced the risk of depression relapse in individuals (Fjorback *et al.*, 2011). Mindfulness-based cognitive therapy (MBCT; Segal *et al.*, 2013) combines elements of cognitive behavioural techniques and MBSR. Randomised controlled trials suggest MBCT is a beneficial intervention for patients with depression to prevent a relapse and has received positive support for the treatment of active depression (Sipe and Eisendrath, 2012). A study exploring the effects of MBCT on anxiety disorders found significant improvements in patients in anxiety, rumination, worry and sleep quality post MBCT (Yook *et al.*, 2008).

Mindfulness programmes are being delivered and accepted on a large scale in the USA (Samuelson *et al.*, 2007). Mindfulness forms part of the Buddhist chaplaincy in prisons in England and Wales (Angulimala, 2010) and is now being incorporated into a number of offending behaviour programmes. Within CARE, Mindfulness is used in both group sessions and personal exercises. Facilitators lead a mindfulness exercise as part of each group session to aid emotion management and reduce impulsivity, rumination and suppression. Participants are then encouraged to practice various mindfulness exercises outside of the group setting. There is also scope to practice mindfulness exercises within individual sessions.

The delivery of CARE

CARE is delivered by a multidisciplinary team of facilitators from health, psychology and probation backgrounds, who all have experience of working with women either in a criminal justice or mental health setting. All staff involved in CARE receive specific training from NOMS in delivering

the programme as well as external training in Narrative therapy and Mindfulness. The facilitators are in turn supported by a Treatment Manager who is a Registered Forensic Psychologist as well as a Programme Manager, Healthcare Manager and Resettlement Manager.

CARE consists of 30 group sessions, nine individual sessions and an initial narrative assessment interview. It is recommended that the programme is delivered at a pace of three sessions per week. Each session is two-and-a-half hours long with a 15 minute break in the middle. The individual sessions, which are spread across the programme, each last about an hour. While regular attendance is required for group sessions, if for some reason a woman misses a session, the facilitators will deliver this on a one-to-one basis, ensuring no session material is missed.

Working with trauma

For the CARE population, it is acknowledged that due to prior histories of trauma, engaging in and benefiting from treatment can be very difficult and threatening. Several safety features have been included in the programme in order to work pro-actively with these responsivity needs.

First it is recognised that if the woman does not feel safe (either psychologically or physically) she will not be able to engage in learning. To help create a safe atmosphere the layout and design of the group room is designed to be light, airy and welcoming. Soft furnishings are used and participant's art work is displayed on the walls. A time-out space to the side of the room and a time out room are also available for participants should they feel the need for some personal space during the group work sessions. Sessions follow a predictable format and right from the first group session attention is given to the end of CARE via the use of a count up and count down panel, which the participants update at the beginning of each group. This can help to foster a sense of achievement and acknowledges the ending at the outset, which helps to manage participant's attachment to the group.

The level of exposure to personally challenging material is also carefully controlled. The pacing and level of exposure is gentle and gradual, to ensure that the 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 themselves.

Exposure to traumatic material is avoided in the CARE groups. A non-disclosure policy is maintained during group sessions, to protect the women from sharing or hearing details of past traumatic abuse. Participants can and do speak outside of these sessions, on an individual basis, about past experiences of abuse and their own offending. Whilst there is the opportunity to engage in these conversations, and facilitators will be supportive when they do happen, participants are not obliged to do this. It is accepted that participants can make progress towards the treatment aims without this.

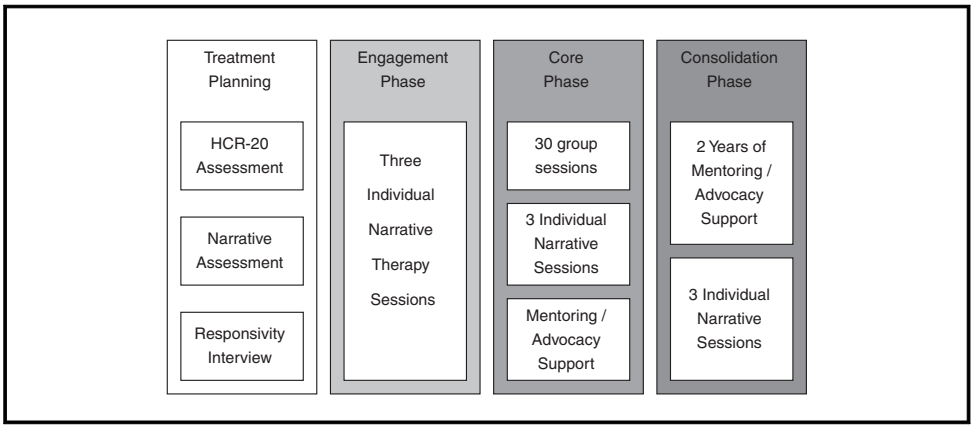
CARE places as much emphasis on recognising and building on strengths as it does addressing problems. During sessions, CARE acknowledges and builds on moments of success and skill, it identifies and records strengths, abilities and past achievements and asks the women to reflect on how these can inform their new preferred way of living. Participants are encouraged to identify a new preferred life, and each week they consider how the knowledge and skills they are recognising and developing may help them to reach this goal.

To help participants work alongside each other and achieve their goals participants are asked to sign up to three conditions for success: keep an open channel of communication, be respectful at all times and participate constructively. In outlining the conditions for success, facilitators also outline the consequences of choosing to follow or not to follow them. Facilitators make it clear that they will respect a participant's choice, but that they will enforce the consequences of that choice (Harris *et al.*, 2005).

The programme structure

CARE allows for an individualised approach to treatment within a structured and evidenced based approach. As shown in Figure 1 the programme consists of four phases; an assessment phase, engagement phase, core treatment phase and a final consolidation phase. The final consolidation phase can be delivered in custody or in the community.

Figure 1 The structure of CARE



During the treatment planning stage a Historical Clinical Risk (HCR-20) assessment (Webster *et al.*, 1997), or the new version three of the HCR-20 (HCR-20v3; Douglas *et al.*, 2013), is carried out to identify salient risk and protective factors for the individual. This assessment makes use of the Female Additional Manual for the HCR-20 (de Vogel *et al.*, 2012). An individual Narrative assessment interview is also completed. This assessment interview, based on Narrative therapy techniques (White and Epston, 1990), aims to assess the participant's readiness to engage in treatment, their ability to identify and discuss problems in their life and how they would prefer their life to be.

The engagement phase consists of three individual Narrative therapy sessions that are designed to build on the discussions in the initial Narrative assessment interview. The sessions aim to help the participant name their problem and preferred stories and to start to consider the impact of these stories on their life. Unique outcomes are identified, namely, times in the women's life she has been able to resist the problem story, allowing her to start to acknowledge her existing skills and strengths. Importantly the woman is seen as being the expert in her life, allowing for a collaborative relationship to be developed. These sessions give the facilitator the opportunity to gain insight into the participant's life and plan how to effectively support them in group sessions. They also begin the process of setting and holding clear boundaries, pro-social modelling and the development of pro-social support networks.

The core phase is comprised of 30 group sessions with a maximum of eight participants, three further individual narrative sessions and input from a mentor/advocate. During the core phase participants will further develop their insight into their problems and will work to strengthen their preferred way of living by learning and practicing various skills. This core phase makes use of emotion approach coaching, tools to reduce emotional arousal, mindfulness exercises, daily acts of care and social skill coaching. Narrative individual sessions continue to develop the rich understanding of the participant that started in the engagement phase, focusing in particular on the participant's relationships and social support networks. Throughout CARE, participants are encouraged to practice using the skills from the programme in their daily lives and to share their experiences with the group as part of the "recap and personal assignment review" element of each session.

The consolidation phase consists of three final individual Narrative therapy sessions, tailored to meet the individual needs of the woman. The content of sessions is led by the responsivity needs of the participant, with some emphasis on the ongoing development, application, evaluation and revision of their preferred stories. This phase is designed to help the woman make an effective transition from being a group participant to working more independently on their process of self-change. It aims to maximise the progress participants make during the core phase, encourage them to generalise the skills acquired and see a personal value and relevance in doing so. As part of this process, specific further objectives are identified with the treatment delivery team. During this phase participants also have access to up to two years of mentoring/advocacy support.

Mentoring and advocacy

As part of being responsive to the individual needs of the women, each CARE participant has a personal mentor/advocate, through an independent organisation, who supports them throughout the core and consolidation phases of the programme. This provides ongoing support in the approach of CARE and follows the participant as they progress through their sentence, possibly on into the community. The mentoring and advocacy service aims to help the women build social and professional support networks, as well as reduce and compensate for potentially negative influences which may destabilise them and reduce motivation for change. They help with the application of skills learnt in treatment to everyday life and provides the individual with a strong pro-social model of effective problem solving and conflict resolution.

Women are introduced to the mentoring and advocacy service near the start of the core phase, after which they are offered regular sessions in order to build up their relationship with the service and access help. Within the consolidation phase the mentoring and advocacy service continues for up to two years providing advice and support, enabling the woman to resolve their own problems and conflicts and to take up new opportunities and services. As part of this the mentoring and advocacy service can advocate for the woman with other agencies around issues related to progress and resettlement including training, accommodation, employment, finance, substance misuse, health and family issues. The mentor/advocate works closely with Offender Management arrangements to offer the additional emotional and practical support in helping participants with the transitions they face as they progress.

The CARE population

To be eligible for CARE women need to have a history of violence/aggression in their offending history or institutional behaviour, be medium or high risk of violent reoffending and have at least two of the five responsivity need areas. These needs are; a history of substance misuse problems, a history of self-harming or suicidal behaviour, mental health difficulties, personality disorder and past difficulties in accessing or benefiting from interventions.

At the time of writing 65 women have started CARE at HMP Foston Hall and 62 of these have completed the programme. Of those women originally referred to CARE, 55 women did not start the programme. These women did not start due to their risk level, their treatment needs, or both elements not meeting the suitability criteria for the programme. The issue of the suitability of referrals is being further explored in the upcoming process study. Only three individuals have started a programme but not completed it, and one of these went on to complete a later CARE programme. Considering those who start CARE, the group have a mean age of 38 (SD = 9.73) ranging between 22 and 64 years of age. Considering ethnic group, 57 (87.7 per cent) classed themselves as white, 6 (9.2 per cent) as mixed race, 1 (1.5 per cent) as black, and 1 (1.5 per cent) as Asian. In terms of sentence, the majority of participants were serving an indeterminate sentence with 69.2 per cent (45) of women serving either an indeterminate sentence for public protection or a life sentence and 30.7 per cent ($n = 20$) serving a determinate sentence. Considering index offence type, 49 (75.4 per cent) were serving their sentence for a violent offence including robbery, one (1.5 per cent) for a sexual offence, two (3.1 per cent) for burglary and 11 (16.9 per cent) were for other offences (e.g. arson, attempting to pervert the course of justice and cruelty or neglect of children). In addition to this, 50.8 per cent ($n = 33$) of women were known to have carried out some form of institutional violence. This included incidents such as assaults, verbal aggression and robbery.

In terms of the risk and responsivity profiles for CARE participants, these portray the complexities of the population that were anticipated from the literature. All participants met the risk criteria for CARE. The most common responsivity need area was self-harming behaviour with 89.2 per cent ($n = 58$) having a history of this. Substance misuse (81.5 per cent, $n = 53$) and mental health problems (73.9 per cent, $n = 48$) were also common in this group. Just under half of those who started CARE had a history of previous problems in treatment (49.2 per cent, $n = 32$) and 36.9 per cent ($n = 24$) had been highlighted as meeting the requirements of the personality disorder pathway in terms of problematic personality disorder traits. Looking at the responsivity

profiles of individuals, 100 per cent ($n = 65$) of those women who started CARE displayed an issue in more than one area. With 10.8 per cent ($n = 7$) of women having an issue in two areas, 36.9 per cent ($n = 24$) of women having an issue in three areas, 33.8 per cent ($n = 22$) of women having an issue in four areas and 18.5 per cent ($n = 12$) having an issue in all five areas.

Developments and lessons learnt

CARE has now been running in HMP Foston Hall for around three years. As a result of this, and its recent implementation into HMP New Hall, a great deal has been learnt regarding the programme and working with this population, which is outlined here. This learning has come through close liaison with key stake holders including; commissioners, facilitators, mentors/advocates and participants. Throughout this process, close links have been maintained between the programme developers and CARE delivery sites, including both staff and participants. This has been invaluable in continually reviewing and developing programme materials and addressing operational issues. For example, towards the end of the core phase of CARE, participants take part in a preferred story skills practice where they have the opportunity to practice their response to a potentially destabilising/risky situation. In light of feedback from facilitation teams, this element of CARE has been further enhanced through the inclusion of psychodrama techniques (Kipper and Ritchie, 2003).

It was known at the outset that the CARE population would bring a range of complex dynamics and responsivity needs that would have to be managed. Despite being prepared for this, one of the biggest challenges for facilitators at both sites has been supporting women in sessions. During the roll out of CARE at HMP Foston Hall, it was common place to experience women arriving late or wishing to leave early from sessions, especially during the early stages of the programme. In this regard, facilitators reported finding it difficult to maintain treatment integrity whilst respecting the women's choice. The conditions of success were therefore introduced to provide participants with a clear message about what was acceptable in terms of their behaviour and the consequences of this. This has provided facilitators with a helpful framework with which to manage engagement issues.

Many women also required considerable additional support outside of sessions in order to maintain their engagement with the programme, often taking up valuable resources. Improved case formulation at the treatment planning stage has enabled facilitators to respond more strategically to such occurrences, recognising that sometimes offering additional support could be counterproductive to encouraging the women to take more responsibility for their own choices and decisions.

When CARE was first implemented there was a view to only recruit female facilitators. This was with the knowledge that many participants would have histories that included traumatic experiences with men, histories that the programme needed to be responsive to. A collection of events prompted a review of this and a decision to recruit male facilitators. This has proved to be a particularly positive development. Consideration is given to individual histories and needs, in identifying a suitable personal facilitator for participants, and male facilitators do not provide individual sessions to participants who report having particular anxieties in working with men. However, having male facilitators has provided positive relational figures within the group environment and seems to have helped to challenge some participant's attitudes and beliefs.

CARE incorporates a number of treatment techniques, such as Narrative therapy, that may not be familiar to some key stake holders. As such, CARE staff have found they have a particularly important role to play in communicating the work of CARE to other interested parties. Participants' progress in treatment, which is often expressed in Narrative therapy terms on the programme, has to be communicated in a language that is compatible with risk reduction and sentence management processes. This has involved being clear in relating individuals preferred stories to changes in their risk and ongoing treatment needs.

Since CARE was first implemented there have been significant developments in relation to working with individuals with personality disorder traits within the NOMS. The Women's Offender Personality Disorder Pathway (Ministry of Justice and Department of Health, 2011) is based on the principle that the personality disordered offender population is a shared responsibility of

NOMS and the NHS. This pathway places a heavy emphasis on the early identification of problematic personality traits, and multidisciplinary formulation and treatment planning. It also works with individuals through the different stages of their sentence and incorporates a mentoring/advocacy service. Given the clear overlaps and compatibility with CARE, the programme has been incorporated as one of the treatment approaches within the National Personality Disorder Pathway for Female Offenders. This is a particularly positive development for CARE for a number of reasons, not least that it offers support to the benefits of engaging mentor/advocacy services for offenders, an element of CARE that has attracted some resistance in the past due to the resources involved.

Future plans

CARE is based on sound evidence in terms of the needs of female offenders and good practice in addressing offending behaviour, as has been evidenced by the CSAAP. There is a need to evaluate effectiveness and an evaluation plan was developed for CARE from the outset, as part of the accreditation process. This plan acknowledges the time it will take to develop a sample size suitable for a reconviction study. It makes use of the information available at different stages in order to build up an evidence base for this approach and guide ongoing delivery of the programme. It is now possible to start to review the findings from the initial stages of this evaluation plan.

Specifically, a qualitative study is underway that aims to understand participant's experiences of taking part in CARE. This will help us to establish how the techniques used within the programme are received by participants, and how successful it is in its aim of engaging and motivating individuals and supporting them to self-manage their feelings and behaviours. There is also a process study being completed that will review data from a range of sources, including interviews with participants, facilitators and mentors, to establish how CARE is being implemented. This is happening alongside a review of some initial indicators of success for CARE. This includes consideration of changes in relevant psychometric measures, engagement, custodial behaviour and risk assessments. It is anticipated that the findings from these studies will be available within the next year. As sample sizes develop, further studies are planned that will investigate various outcomes. For example, a clinical change study is planned to review change in treatment targets over the course of treatment by comparing pre and post psychometrics. Participant feedback forms will also be reviewed and findings will be collated. Due to the responsive nature of the programme, and the small sample sizes, methods such as multiple case study design will be employed to look in detail at relevant changes over time. Currently there is a gap in the literature looking at the benefits of Mindfulness practice and Narrative therapy within interventions with UK forensic populations. As such, these areas would also benefit from specific further research.

The two prison sites where CARE is currently commissioned have dedicated personality disorder services, set within a wider "enabling environment" context. This will provide opportunities for a much closer working relationship between the CARE facilitation team, criminal justice and mental health agencies for both clinical practice and evaluation opportunities. This treatment pathway, in addition to the "Transforming Rehabilitation" (Ministry of Justice, 2013) and "Women's Custodial Review" (National Offender Management Service, 2013) agenda within NOMS, will also see an increased provision of mentoring/advocacy for female offenders. Future work will involve incorporating these changes into the structure and process of CARE, so that the intervention continues to provide a high quality, integrated and sustainable service.

There continues to be national and international developments in the research regarding the treatment of violent offenders, and female offenders in particular. As such, it will be important for the developers of CARE to continue to keep abreast of the literature to make sure that the programme maintains its position as an evidence based intervention. There is always an ongoing effort to ensure that there is a match between developing theory and current practice.

Summary and conclusions

CARE is an innovative programme, designed specifically to meet the needs of women offenders with a history of violence and complex needs. The programme was developed in response to a clear gap in provision within NOMS and makes use of up to date research and treatment

techniques available at the time. As anticipated, CARE participants represent some of the most difficult and challenging client groups within the Criminal Justice System. The development and implementation of the programme has been a challenging process that has led to some helpful learning regarding working with this population. There is anecdotal information from staff and participants that this is an effective approach that people buy into. It is also clear that individuals are able to complete treatment, a significant achievement for many participants. However, the formal evaluation of the success of CARE is in the very early stages. The ongoing evaluation of CARE will help to inform any developments with the programme and delivery at current, and any new, treatment sites.

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