Evaluation and Program Planning 42 (2014) 1–10

Contents lists available at ScienceDirect

Evaluation and Program Planning

journal homepage: www.elsevier.com/locate/evalprogplan

Assessing the feasibility and fidelity of an intervention for women with violent offenses

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ARTICLE INFO

Article history:
Received 9 April 2013
Received in revised form 30 July 2013
Accepted 11 August 2013
Available online 26 August 2013

Keywords:
Women
Criminal justice
Violence
Prison
Treatment

ABSTRACT

Women convicted of assaultive or violent offenses represent a small but important subpopulation of adults involved in the criminal justice system. The limited treatment and rehabilitation programs that are available for these women are usually developed for male offenders and do not consider factors that are especially relevant to women, such as higher rates of mental health and substance use disorders as well as their likely histories of interpersonal violence. Moreover, women's trajectories into violent behavior – as well as their trajectories out – may differ from their male counterparts. Due to the absence of programs available for this unique population, a new gender-specific and trauma informed intervention, Beyond Violence, was developed. This paper describes a pilot study with a mixed-methods approach that assesses the feasibility and fidelity of the intervention within a state prison for women. Overall, various components of feasibility (i.e. engaging the target population, gaining institutional support, and finding skilled treatment staff), were realized, as were fidelity elements such as adherence to the intervention material, and high attendance and satisfaction by participants. The positive results of this pilot study increase the likelihood of dissemination of the intervention and a randomized control trial is currently underway.

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1. Introduction

Violent offenses are defined as those that involve force, or threat of force, and include offense types such as homicide, robbery, assault and sex offenses. Females comprise a small fraction of those arrested (14%) and sentenced (5%) for a violent offense within the U.S. (West, Sabol, & Greenman, 2010). Within state prisons, women with a violent offense encompass the largest group of inmates (34%), compared to 30% with property offenses and 27% with drug offenses (Guerino, Harrison, & Sabol, 2011). Women with violent offenses also have a 49% rate of recidivism, mainly with drug-related crimes (Deschenes, Owen, & Crow, 2007). Although a very small proportion of women repeat violent offenses (Deschenes et al., 2007; Verona & Carbonell, 2000), violent and aggressive behaviors have higher risk factors, such as more serious injuries, for women than for men (Tjaden & Thoennes, 2000).

To date, most of the attention to violence perpetration by women has focused on partner violence, with little attention to a more expansive understanding of violence that may encompasses other targets of aggression. However, existing research about women and violence suggests that risk factors of mental health and substance use disorders are associated with women's experiences of both violence victimization and perpetration. Mental health disorders are associated with women's use of violence (Logan & Blackburn, 2009; Silver, Felson, & Vaneseltine, 2008) as well as their experiences of trauma and exposure to violence (Greenfield & Marks, 2010; Mechanic, Weaver, & Resick, 2008). Substance use disorders as assessed with criteria from the Diagnostic Statistical Manual of Mental Disorders (DSM; American Psychiatric Association, 1994) are linked to both women's experiences of traumatic victimization (Dowd, Leisring, & Rosenbaum, 2005; Widom & White, 1997) and to women's perpetration of violence (Dowd et al., 2005; Weizmann-Henelius, Putkonen, Naukkarinen, & Eronen, 2009).

These risk factors are more prevalent for women involved in the criminal justice system than for men. In a recent study, over a third of jailed women met criteria for serious mental illness compared to 15% of men (Kubiak, Beeble, & Bybee, 2010). Studies have also

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http://dx.doi.org/10.1016/j.evalprogplan.2013.08.001

found that between 75% and 90% of incarcerated women have a serious substance use disorder which are higher rates than those found for their male counterparts and the general population (Kubiak, Boyd, Young, & Slayden, 2005; Fazel, Bains, & Doll, 2006; Staton, Leukefeld, & Webster, 2003). Because females involved in the criminal justice system are more likely to have mental health and/or substance use disorders when compared to their male counter parts (Fazel et al., 2006; James & Glaze, 2006), multi-modal interventions that address the myriad of issues associated with violent behavior are suggested for reductions in and prevention of violence (McGuire, 2008). "Multi-modal" is a term used to describe interventions that focus on more than one issue or concern simultaneously, and while such interventions have been found to be generally effective, especially in gender-responsive formats (e.g. Messina, Grella, Cartier, & Torres, 2010), they offer more complexity in deciphering key components for treatment than single-issue interventions (Lipsey, 1995).

Models of treatment and rehabilitation for adults involved in the criminal justice system are often male focused or at best considered gender neutral. Existing research on treatment for adults with violent offenses primarily utilize samples of male offenders (i.e. Baro, 1999; Polaschek, Wilson, Townsend, & Daly, 2005; Serin & Preston, 2001; Ware, Cieplucha, & Matsuo, 2011) or do not identify the sex of the inmates (Lambert, Hogan, Barton, & Stevenson, 2007). Often recommendations are made for adaptation of the models to female offenders without guidance or evidence of such adaption (e.g. Bush & Bilodeau, 1993). Content of the aforementioned interventions are primarily cognitive–behavioral therapeutic (CBT) interventions with a focus on addressing and changing criminal thinking and often have been tested with male only samples (Landenberger & Lipsey, 2005).

In a recent systematic review of interventions specifically for women in correctional settings in the United States, none of the reviewed interventions were primarily intended for anger management or violence reduction and/or prevention (Tripodi, Bledsoe, Kim, & Bender, 2011). The majority focused on substance abuse treatment with the goal of preventing recidivism. The review excluded a study by Eamon, Munchua, and Reddon (2002) that focused on an anger management intervention for incarcerated Canadian women. In that study, the sample included females convicted of violent and/or nonviolent offenses and held in minimum or maximum security level cells within Canadian prisons. The treatment group had significant decreases in anger and aggression, as well as lower numbers of institutional charges than the control group (Eamon et al., 2002). In the literature to date, only one other anger management intervention for female inmates has been examined and it did not utilize pre- or post-test measures to test for efficacy (Wilfley, Rodon, & Anderson, 1986).

2. Beyond Violence

Beyond Violence: A Prevention Program for Women (Covington, 2013) is intended for women convicted of a violent offense. The intervention is considered trauma informed and gender-specific (Bloom, Owen, & Covington, 2003) as it incorporates attention to women's extant victimization history, the likelihood of substance use and/or mental health disorders and gender socialization. The intervention aims to simultaneously address these issues as they are strongly correlated and interconnected factors commonly present in the lives of women involved in the criminal justice system.

2.1. Intervention development

Development of this intervention was initiated by a Mid-western state's Department of Corrections (DOC) after identifying a need for a program that would address the core issues that resulted in an assaultive offense for women. To this end, Dr. Stephanie Covington was contacted to create the intervention. Once the need was defined, several steps were taken to craft the intervention (Fraser, Richman, Galinsky, & Day, 2009; Rothman & Thomas, 1994). First, focus groups were held within the prison with women convicted of a violent offense to elicit their perceptions of their offenses and what led to the crime. Second, a literature review was conducted of the current research on the treatment of women that engage in violence and the availability of evidence-based interventions. Finally, a survey was disseminated to nearly 600 randomly selected women within the state's prison system to assess similarities and differences between women with and without violent behavior and/or assaultive offenses (Kubiak, Kim, Fedock, & Bybee, 2013). Results from the survey showed that women who engaged in multiple acts of violence had significantly higher rates of mental health and substance use disorders, criminal justice involvement, personality indicators of anger, impulsivity and disinhibition, and overall criminogenic risk than women engaged in an isolated episode of violent behavior (Kubiak, et al., 2013).

2.2. Theoretical foundation

Trauma theory (Herman, 1997, 1992) provides a foundation for the intervention with the basic tenet that early trauma influences both perceptions of and reactions to life events (Kendall-Tackett, 2000), especially for women. Moreover, exposure, particularly early and/or ongoing, to traumatic events may result in repressed anger (Neumann, Houskamp, Pollock, & Briere, 1996; Newman & Peterson, 1996; Springer, Sheridan, Kuo, & Carnes, 2007) and the use of alcohol and other drugs (Hedtke et al., 2008; Najavitis, Weiss, & Shaw, 1997). For women, trauma is an antecedent to substance abuse whereas for men, trauma often occurs after the development of a substance use disorder (Sonne, Back, Zuniga, Randall, & Brady, 2003). Anger is confounded with emotional pain and often lacks healthy expressions, leading to the continual repression of anger and pain that may result in assaultive and violent behavior for women (Thomas, 2005).

Based on the existing literature about interventions that have been successful with female offenders, Beyond Violence utilizes a multi-modal approach and a variety of evidence-based therapeutic strategies (i.e. psycho-education, role playing, mindfulness activities, cognitive behavioral restructuring and grounding skills for trauma triggers) to address issues of mental health, substance abuse, trauma histories and anger regulation (Bradley & Follingstad, 2003; Eamon et al., 2002; Hall, Prendergast, Wellisch, Patten, & Cao, 2004; Messina et al., 2010; Sacks et al., 2008; Zlotnick, Najavits, Rohsenow, & Johnson, 2003). The materials are organized based on the social–ecological framework (Dahlberg & Krug, 2002) to assist women in understanding various forms of violence (see Box 1). The model recognizes the individual's responsibility in violence perpetration, as well as the context and influence of other factors such as the individuals' relationships, the communities they reside in, and the larger society which dictates social norms, as the foundation for guiding violence prevention efforts (Dahlberg & Krug, 2002).

2.3. Group goals

The overarching goal of Beyond Violence is to prevent subsequent aggressive and assaultive behaviors and interactions for women both in the community and within the institution, which includes preventing recidivism and institutional misconducts. To reach this goal, the program objectives are for participants to learn and understand the following: (1) the connections and relationships between their thoughts, feelings, and behaviors; (2) the influence of their families, relationships,

Box 1. Beyond violence manual components.

Opening session	
Module A: Self	Session 1: Thinking our thoughts Session 2: Feeling our feelings Session 3: Violence and trauma in our lives Session 4: The effects of trauma Session 5: Women and anger Session 6: Understanding ourselves
Module B: Relationships	Session 7: Our families Session 8: Communication Session 9: Power and control Session 10: Conflict resolution Session 11: Creating our relationships
Module C: Community	Session 12: Our communities Session 13: The importance of safety Session 14: Creating community Session 15: The power of community
Module D: Society	Session 16: Society and violence Session 17: Creating change Session 18: Transforming our lives Session 19: Honoring ourselves and our community

communities, and society on their lives and decisions; (3) the roles of anger and violence in their lives (e.g. how these aspects manifest and are expressed, and the results of these expressions); (4) the definitions of abuse and violence as they have experienced through victimization and/or perpetration; and (5) recognizing the connection between substance abuse and mental health symptoms with violent and aggressive behaviors. The materials in the BV curriculum focus on building skills in emotional management, communication, conflict resolution, decision making, making amends and restitution, and self-soothing/calming strategies.

2.4. Group process

Beyond Violence is delivered in a group format through 20 weekly or bi-weekly sessions. Each two hour session is structured with the following range of activities: an initial quiet time, an introduction to the session's main topic, debriefing from the previous session, a lecture on the current topic, related activities, an assignment of homework and a self-soothing activity at the closing of the session. It is recommended that the intervention be delivered by a trained mental health professional and that the number of group participants not exceed 15 members.

3. Current study

This pilot testing of Beyond Violence assessed the feasibility and fidelity of the intervention. Feasibility seeks to answer questions related to the ability to implement the intervention at the chosen site with the proposed targets of the intervention (Fraser et al., 2009), and the site for this study is a state prison with women convicted of a felony level assaultive offense. Fidelity is the degree to which the program is implemented with the same components, intensity and duration as specified by the program designer (Mowbray, Holter, Teague, & Bybee, 2003). In particular to this intervention, elements of adherence, dosage, quality and participant response are of interest for fidelity monitoring. This study seeks to answer the following research questions: (1) Can the intervention be delivered successfully within the institutional setting? (2) To what degree do participants receive the intervention dosage? (3) Do staff adhere to the intervention model as written and directed? and (4) Do participants perceive benefit and satisfaction from the intervention?

4. Method

4.1. Site of study

The pilot took place between September 2010 and June 2011 at the state's women's prison that houses approximately 1800 women. The pilot intervention was conducted within the Residential Substance Abuse Treatment (RSAT) unit in order to control confounding variables associated with differing units, officers and other interventions. The RSAT unit is a therapeutic community that utilizes trauma informed substance abuse interventions. While the attention to substance use and misuse and trauma are themes common to BV, none of the existing groups were explicitly focused on violence prevention or other issues outside of substance abuse.

4.2. Participants

4.2.1. Eligibility and selection

Beyond Violence has the goal of preventing violence perpetration – whether in the community or within the institution. Therefore, both women close to their release date and those facing longer-terms were selected to participate in the study. Eligibility criteria included: (1) current or previous conviction for an assaultive offense (i.e. homicide, robbery, assault); (2) substance abuse or dependency diagnosis as determined by prison staff through the Substance Abuse Subtle Screening Inventory (SASSI: Miller, 1999); and (3) the absence of any serious misconduct ticket within six months prior to program admission. A fourth criterion was an institutional policy that the participant was within 18 months of prison release to qualify for treatment services. This criterion was modified for the pilot in order to allow participation by women serving life sentences (see below).

Since other options exist for substance abuse treatment within the facility, women volunteer–or are strongly encouraged by parole board members–for admission to the Residential Substance Abuse Treatment (RSAT) unit. RSAT is a therapeutic unit dedicated to a 6-month substance abuse treatment program, and determined to be a stable and consistent environment for piloting a new intervention. A list of women, eligible for the prison's RSAT program with a conviction for an assaultive offense, was generated in alphabetical order by the institutional staff. Odd numbered names were randomly assigned, by the unit administrator and lead author, into treatment with Beyond Violence. Eight women with life sentences were purposefully selected for BV by correctional administrators based on their strong desire for treatment, leadership capacity, positive attitude and absence of any institutional misconduct tickets during the previous 18 months and for the possible role of peer facilitators in subsequent groups. This group of women was chosen to explore the influence of BV on preventing violence within the institution.

4.2.2. Group composition

Beyond Violence was piloted with three groups: Group 1 with 13 women (including 5 women with a life sentence); Group 2 with 10 women (including one woman with a life sentence); and Group 3 with 12 women (including two with life sentences) (see Table 1). Women in Group 3 were classified as 'dual diagnosis' – in other words, women with both a mental health and substance use disorder. Dual diagnosis was operationalized by DOC as women who were under the care of the Psychological Service Unit (PSU), currently prescribed psychotropic medication, and scoring in the

Table 1
Participants by group.

	N (%)			
	Total	Group 1	Group 2	Group 3
Number of participants completing pre-tests and proportion of total by group	35 (100%)	13 (100%)	10 (100%)	12 (100%)
Number and proportion of 'lifers' within group	8 (22.9%)	5 (38.5%)	1 (10.0%)	2 (16.7%)
Number and proportion of women with dual diagnosis within group	12 (34.3%)	0	0	12 (100%)
Number and proportion of women terminated during intervention	6 (17%)	2 (15%)	1 (10%)	3 (25%)
Number and proportion of women completing post-tests and proportion of totalby group	29 (82.9%)	11 (84.6%)	9 (90%)	9 (75%)
Dosage (% of sessions attended by those completing)	96.8%	95.2%	96.3%	99%

dependency range on the SASSI. All participants were subject to the same selection, consent, and testing process.

4.2.3. Participant characteristics

On average, participants entered the prison at 33 years of age (SD = 10.3) and were 39 years old (SD = 8.4) when participating in the program. The average length of incarceration was 6.5 years (SD = 7.7). Among the 35 participants, 8 women (23%) were serving life sentences and 12 women (34%) were assessed as having a mental health disorder and with their substance use disorder, considered dual diagnosis. The majority of women (57%) were identified as white and 40% were black. One woman (3%) was Native American. Most women, 60%, did not complete high school and 14% had a criminal record as a youth.

4.2.4. Facilitators

Each group utilized a different facilitator. Group 1 had two facilitators: the clinical director of the RSAT unit and a research team member. Group 2 experienced two facilitators (both clinical staff on the RSAT unit) due to a staff departure. Group 3 had one RSAT clinical therapist the entire group. All facilitators had many years of experience as substance abuse and/or mental health treatment counselors and attended 16 h of formal training provided by Dr. Covington on the curriculum, in addition to 'booster' sessions and discussions during the implementation process.

4.3. Procedures

Shortly after admission to the RSAT unit and prior to the start of BV, a member of the research team met with the women in a confidential setting. The informed consent forms that were approved by the university's Institutional Review Board were provided to all women and verbally reviewed with the group by the research team member. All women approached agreed to participate in the study. Following collection of the consent forms, all women completed the pre-test survey. At the culmination of treatment, women were approached to complete the post-test. (*Note*. Results of the short term outcomes associated with pre/post testing are reported elsewhere.)

4.4. Measures

Multiple measures were used to assess feasibility and fidelity throughout implementation including participant and facilitator surveys and focus groups. Participant and facilitator surveys were mailed after each group to research staff. Focus groups were conducted by research staff at midway and completion with each group.

4.4.1. Facilitator and participant surveys

Two measures assessed session content completion and helpfulness, fidelity, and satisfaction (see Box 2 for detail about each measure). Facilitator surveys were individualized to match

Box 2. Fidelity monitoring surveys for facilitators and participants.

Instrument	Sections	Indicators	Scale	When
Facilitator survey	Session content	Were intended activities completed? (outlined specifically to corresponding session content)	Yes/No	After each session
	Participation and group dynamics	Separate indicators for: overall level of cooperation, feedback, support, resistance, anger/defensiveness – within session	None (0) Low (1) Moderate (2) High (3)	
	Feedback	Recommended changes	Open-ended	
Participant survey	Session Content	Queries regarding the 'Helpfulness' of major session components: lecture, discussion, activities, homework	Not done (0) Not helpful (1) Somewhat (2) Very helpful (3)	After each session by each participant
	Participation and feelings	Self-rated level of cooperation, feedback to group members, support, resistance, anger/defensiveness	None (0) Low (1) Moderate (2) High (3)	
	Satisfaction	My needs were met My concerns were heard I felt respected I benefited from session	Yes/No	
	Feedback	Favorite thing Least favorite thing	Open-ended	

the specific session content to gather precise, detailed feedback about each session. A checklist required a yes/no response to whether the specific content was delivered and if not, an explanation as to why it was not delivered. Other sections queried group dynamics such as levels of cooperation, resistance, and anger and open-ended facilitator feedback on what worked and what did not and if there were recommended changes. Participant surveys were uniform for each session with the following aspects: participant ratings of the helpfulness of the session components (i.e. lecture, discussion, activities), participation and satisfaction with the session, and open-ended questions about the most and least favorite aspect of the session. Surveys were submitted for all 20 sessions for Group 1 and Group 3. Group 2 surveys were available for 16 of 20 sessions (missing Sessions 05–08) due to a staff departure.

4.4.2. Focus groups

To gain the perspectives of the women enrolled in the BV groups at two points in time, the first focus group was scheduled at the mid-way point in the curriculum (i.e. 10 weeks) and the second at completion. Due to scheduling issues within the unit (i.e. emergency mobilizations, staff out for illness, etc.), two of the focus groups did not occur at the midway point as scheduled. For this reason, we report only on the focus groups performed at group completion. Group 1 was split into two separate focus groups to assess unique contributions of women with life sentences: Group 1A was held with women with a life sentence ($n = 5$) and Group 1B was with the remaining women ($n = 8$). In Groups 2 and 3, there was no separation of the women with life sentences since each group only had one or two members with such an identity.

Two researchers were present for each focus group and used identical protocols and semi-structured interview guides. One research member led the group's discussion while the other transcribed the session since audio and video recording were not permitted by the institution's rules. The recorder and facilitator each wrote up notes from the focus groups and sent them to each other to check for accuracy and additional comments. The notes were combined and reviewed by the project coordinator. Themes were developed for each time period by team members after reading the transcripts. Coding was conducted by two different team members and assessed by the remaining team members to determine reliability. Simple counts were constructed to derive the primary (4 or more mentions of a theme within a group) and secondary (2–3 mentions) themes of each group. If an issue was mentioned a single time, it was noted as 'mentioned'.

5. Results

5.1. Intervention feasibility

Of the 35 women who provided consent, a total of 29 women (83%) completed the intervention. Of the six women who did not complete, one left the unit early because of a medical reason and five women were terminated for RSAT program (versus institutional) rule infractions such as limited group participation. On average, women who completed the intervention attended 97% of the scheduled sessions; average attendance in Groups 1, 2 and 3 was 95%, 96% and 99% respectively. Of the 29 participants who completed the intervention, 26 (90%) completed at least 19 (out of 20) sessions, and 14 (48%) completed all 20 sessions. Among the 6 non-completers, average attendance was 44% of scheduled sessions.

5.2. Intervention fidelity

5.2.1. Facilitator surveys

Fidelity was monitored by surveys after each session requesting information on the content completed within the session, as well as a rationale for incompletion. Facilitation with Group 1 was the first time the intervention had been implemented and both facilitators completed surveys for each session. Surveys revealed several barriers to content completion such as lack of time, room changes for the group, and prison events (i.e. mobilization and drug testing). After review of the two facilitator's surveys for the same group, it was determined that the unit administrator was more likely to endorse a component completed as compared to the research team member co-facilitating. After triangulating their surveys with the participant surveys, it was determined that there was more congruence between the participants and the research team member co-facilitating. Additional staff training was required to dispel the notion that we were evaluating the facilitators performance instead of trying to assess the whether the curriculum could be delivered as written within the setting. In all subsequent assessments of fidelity, we utilized the participants' surveys to triangulate content delivery.

In Group 1, 75% of the sessions were conducted with at least 75% adherence to the intended session components. By problem solving the institutional barriers and increasing the group length of time to 2 h, higher fidelity was found in the subsequent groups. Group 3 conducted 100% of the sessions with at least 75% adherence to the intended session content. The facilitator noted similar barriers of time, lack of supplies, and facility issues (i.e. lack of electricity). In Group 2, a staff departure necessitated a change of facilitator midway through the group and resulted in the absence of reports on several group sessions ($n = 7$ missing). Of the available data for Group 2, 92% of the sessions were held with at least 75% adherence to the intended session content.

5.3. Perceived helpfulness and satisfaction of intervention

5.3.1. Participant surveys

Participants rated the helpfulness of sessions and session components (i.e. lecture, discussion) on a four-point scale, ranging from 0 to 3. The overall mean associated with the helpfulness of the session content across all sessions was 2.81 (SD = 0.21), Women rated discussions highest among session components, with a mean score of 2.88 (SD = 0.1) (see Table 2). Group 3, consisting of dually

Table 2
Participants self-ratings of content, participation and satisfaction.

ITEMS			Mean (SD): out of a maximum of 3
Activities: Were the activities in today's session helpful for you?			
Total helpfulness mean			2.81 (0.21)
Discussion			2.88 (0.16)
Lecture			2.86 (0.19)
Homework assignment(s)			2.75 (0.26)
Activities			2.73 (0.26)
Participation: Rate your response to today's session			
Total participation mean			2.81 (0.18)
I cooperated and did what the counselors asked me to			2.89 (0.16)
I supported other group members			2.89 (0.38)
I accepted feedback from group members and counselors			2.77 (0.21)
I gave feedback to other group members and counselors			2.75 (0.22)
Feedback	Yes	No	Missing
My needs were met	92.0%	2.0%	6.0%
Overall, I benefited from the session	92.4%	1.1%	6.5%

Table 3
Open-ended responses by participants on favorite/least favorite aspects of session.

	Favorite	Least-Favorite
Context	"*To understand my anger, what kind of anger, is it anger, where it stems from. It really helps to have the visual aids and the stories to explain certain kinds of anger and anger management strategies to use.*"	"*When I had to close my eyes for meditation.*"
	"*Having the opportunity, through homework, to seriously reflect and take the responsibility for how my behaviors and crimes affected the community. I needed this.*"	"*The charts are too complex for my liking. It seems like it is to help us meet goals, but the working and set-up are almost intimidating.*"
	"*Learning grounding techniques has really been beneficial to my recovery. I am less likely to react. I pause and ground.*"	"*Letting what's going on in the unit affect our group.*"
Process	"*I've realized I was a dangerous type of angry-quiet-let it build. I thought I had it under control and there is so much deeper issues about anger I need to examine and I didn't know where to get help. But now we have this group and it has been very helpful in my recovery.*"	"*Reflecting back on my abuse and how I wasn't allowed or taught to communicate my feelings. The early dynamics of my childhood development are not memories that I'm comfortable going back to.*"
	"*Oh my God, I had an epiphany! The material and information made clear patterns noticeable. I got answers and role played communication. I uncovered answers to main anger problems in this session. This was an amazing session with connecting dots.*"	"*Seeing impulse control. Recognizing my ability to react impulsively. To just walk away from a situation when things are heated is very difficult at times in certain situations that you cannot escape.*"
	"*I had a realization hit me that I was unable to express any type of anger or uncomfortable feelings to my parents. I'm 35 years old and always assumed I wasn't angry or am over it. Today, for the first time, I realized I am very angry.*"	"*Trying to understand why I was such a coward. Trying to understand how I let drugs destroy my mind and how I accepted abusive relationships as a norm. Knowing my part in accepting my responsibility for how I ended up in prison.*"
		"*Remembering that I killed someone.*"

diagnosed women, scored 75% of sessions lower than their counterparts in Groups 1 and 2. For each session, participants were asked whether they felt their needs were met and whether they felt they had benefited from the session. Across participants, sessions and facilitators there was over 90% agreement that participant's needs were met and they attained some benefit from the material.

Open-ended questions asked participants to discuss their most and least favorite thing about each session. Their responses are organized in Table 3 by whether they were context or process related. Context is operationalized as comments that pertain to the curriculum, components of delivery such as lecture or activities and facility or unit issues. Process is operationalized as a personal response to the materials. In the context area, most of the feedback was related to the intervention's curriculum, including the workbook provided to participants. Participants had positive comments in regards to the visual aids (graphs, pictures, figures) and stories of other women in prison. Participants also expressed satisfaction with learning techniques for stress reduction and dealing with psychological triggers. Activities built into the curriculum, such as homework, also seemed to be liked. Least-favorite context issues included a variety of issues, from participant's desire for more depth on specific topics (e.g. self-inflicted abuse, childhood sexual abuse) to inferences about current life events in the correctional institution (e.g. a participant's conflict with an officer) infringing into group time. Several women did not like the meditation or quiet time exercises and a few specifically noted that they did not like to close their eyes for the meditation period. Some women complained about the complexity of the materials.

Related to group process, several of the women's comments focused on how their experience within the group was transformative. For example, many women wrote about how powerful it was to recognize and understand their repressed anger. Overall, many of the 'favorite' comments focused on how the group facilitated becoming a better person and realizing self worth. Interestingly, some of the 'least-favorite' process moments reflected similar themes. Reflection on past behavior was common; however, participants felt shameful when examining their former selves and judged themselves as acting with cowardice, weakness, and impulsivity. Some participants noted that this group was the first time they had ever spoken about their crime and reconciling the pain of what they had done was very difficult.

5.3.2. Focus groups

Coding of focus group content across the four different groups (1A, 1B, 2 and 3) found four major themes and two minor themes (see Table 4). Major themes were endorsed in all of the groups, whereas minor themes were mentioned extensively in at least one but not all of the groups. The four primary themes are explained below with an example for each.

5.3.3. Personal growth and positive change

Similar to the process category above, this theme is characterized by statements relating to women's transformation during or

Table 4
Thematic Coding of Completion Focus Groups.

Themes	BV		BV	
	Lifer Group 1A $n=5$	Non-lifer Group 1B $n=8$	Group 2 $n=9$[a]	Group 3 $n=9$[a]
Experiencing personal growth and positive change during treatment	P	P	P	P
Positive learning experiences from interacting with other group members, group cohesion	P	P	P	P
Relating childhood trauma to current condition	S	P	S	S
Realization of shame, guilt, anger, role of violence in life	P	P	S	S
Praise for staff	P	S	S	M
Need to make BV accessible for all women within the prison	M	S	S	NM

Key. P, primary; S, secondary; M, mentioned; NM, not mentioned; NA, not applicable.
[a] Both Group 2 and 3 had only one woman that was serving a life sentence.

as a result of the material in Beyond Violence. To illustrate this theme, one woman stated:

> I've been through a lot of treatment and when I came in I said to myself–"pay attention, you missed something that has messed up your life.' This is personal, I was supposed to be here. In all of the treatment I've had, I've never had gender specific stuff–this allowed me to know me. . .makes me realize that I deserve a second chance; I can ask for help–this is something woman of a certain age should know, but I didn't get it before. This is gentle learning; it's okay to be uncomfortable. You need to balance your life. This is a perfect ending to a horrible experience. I was supposed to be here.

5.3.4. Positive learning experiences from group cohesion

This second theme refers to participants feeling that they came to know and trust each other, which created a sense of safety and opportunities to learn from each other within the group. One woman expressed:

> Thought I'd 'fake it until I made it' – was just here to get my parole. Then one day I started crying in group when I was listening to other stories and I thought I wasn't alone; the rapes and abandonment I experienced I could share. It was this stuff that kept me using; now I'm hopeful that I can accomplish more; can help others with my story.

Comments regarding the group composition of women with and without life sentences were common, especially as within in the prison women with life sentences generally interact only with each other and not with 'short-termers'. As the next quote expresses, women with life sentences were involved in a crime where loss of life occurred and felt a special burden of guilt and shame only understandable by those in similar circumstances.

> I needed to be with others who took a life, needed to have those healing relationships – sometimes just to sit and know someone else understood (note: at this point, she and another woman squeeze each other's hands). I learned about healthy relationships.

The consensus was that the women in the group had a lot to learn from each other and that when women with life sentences shared, this honesty could prevent other women from ending up in similar circumstances.

5.3.5. Relating childhood trauma to current condition

The third theme focused on participants making connections between past abuse and their violent behavior. A participant described this dynamic as "trauma is what shapes us. It all ties in together – you become the abuser; the victimizer." Many of the participants were vocal about their prior perceptions about their families (e.g. isn't my family like all families?) and reported that completing the Adverse Childhood Experiences scale (Felitti et al., 1998) as part of the group activities and subsequent group discussion were pivotal in their recognition of what they endured. Two participants illustrate the power of this connection:

> Learned about core beliefs and to recognize childhood abuse. . .There were so many aspects of abuse and I found I was abusive too. I'm going to change my parenting. You get the entire package here. Glad I stayed the extra 6 months. I'm going to walk out someone different.
>
> Drugs weren't a big aspect of my life, so the drug treatment didn't get to what I needed. Taking me back to childhood; relating to what I did and why; relating to who I am, that pulls out the root and gets rid of it.

5.3.6. Realization of shame, guilt, anger, role of violence in life

Participants revealed that there was little discussion in general population about an individual's offense as well as a great deal of shame surrounding their offenses that made them reluctant to discuss it with anyone. The safety of the group allowed women to discuss what one of the participants described as their 'darkest secrets', which facilitated understanding patterns and connections in their life events.

> They told me that you dig deep and it would be up to me how far I go. I had to get to the shame, co-dependency, my always reading other people's minds. Had to address my taking a life – it was a heavy burden on my soul.
>
> It increased my understanding of myself by connecting all of the dots in my life. Taught me about triggers, resentment, anger, child abuse, and really helped me talk about those secrets I'd been hiding for so long.

6. Discussion

This study represents the initial feasibility pilot testing of the Beyond Violence intervention, utilizing a sample of women incarcerated in a state prison and convicted of assaultive offenses. Based on a mixed methods approach, we assessed the feasibility, fidelity, and participant perceived helpfulness and satisfaction of the intervention.

6.1. Feasibility

Overall, the feasibility (i.e. eligibility of the target population, institutional support, and capability of treatment staff) of conducting Beyond Violence within an institutional setting is high. There was little difficulty finding women that met eligibility criteria for inclusion in the intervention. An earlier study found that 60% of a randomly selected sample of 600 women within this state's prison system was convicted of an assaultive offense (Kubiak, Kim, Fedock, & Bybee, 2012). Although departmental policy restricted eligibility for RSAT treatment to those with fewer than 18 months before the possibility for parole, there was a sufficient sample of women meeting the offense criteria.

Support for implementation of the intervention was evident throughout the pilot period, ranging from prison staff assistance in the facilitation of the intervention development to the support of the parole board. Program supervisors provided interface between the research and treatment staff and facilitated day-to-day operation of the intervention. Treatment professionals delivering the intervention were trained in the intervention and participated in booster sessions and feedback sessions facilitated by the research team. While these promising feasibility results may not generalize to the broader prison population, future research of Beyond Violence will continue in a variety of settings, including general population and out-patient settings, to examine feasibility issues further and outcomes over time.

6.2. Fidelity

Although there were institutional constraints, the closed nature of the institution also facilitated high attendance rates, with 90% of the women completing 19 of the 20 sessions. The initial implementation in Group 1 began with a 1.5 h time period. This time period was inadequate to cover all of the material as written and was thus changed to two hours. Subsequent groups began with the full two hours. It is possible that Group 1 received less of the intervention dosage because of having the least amount of time for the intervention.

As the initial implementation of this curriculum, fidelity to the curriculum was assessed through a series of process notes written by the group facilitator on a form standardized across groups by the research team. As noted above, fidelity in the first group was lower, primarily due to institutional constraints and less group time, but rose in subsequent groups. In addition, some of the activities could not be conducted due to institutional policies. For example, one session uses red food coloring in a glass of water to illustrate the effects of drugs. The food coloring was not allowed in the prison. However, overall, discussions with group facilitators indicated their appreciation of the material and their ease of use and perceived usefulness for the participants with the intervention's curriculum.

Conversely, there were times when content was refined for the intervention based on feedback from the participants' survey. For example, participants asked for a clearer definition of a certain term or more information about a particular topic. Likewise, the facilitators of the intervention provided feedback and suggestions for changes to the curriculum based upon the facilitator's knowledge of other group models and were mainly to address questions from the participants about more in-depth topic material related to trauma. As part of the feedback provided to the intervention's author, these components may be added in future iterations of the intervention's curriculum.

6.3. Perceived helpfulness and satisfaction of the intervention

Women responded well to the curriculum by highly rating the material, their participation and satisfaction with the intervention. Group 3, the dual diagnosis group, was more likely to rate the individual sessions lower than the women in the other groups. This may be attributable to the higher level of mental health distress experienced by these women, or it may be due to their greater familiarity with the culture of mental health treatment as they had higher rates of access to individual treatment as part of the Psych Services Unit.

Focus group with each of the treatment groups at completion found widespread endorsement of the material. Four key themes were revealed in the focus groups, and women in general shared how insight gleaned from the group could help prevent violence in the future. Many of the participants commented within the focus groups and on their surveys that they appreciated the small and intimate nature of the group. The size of the group seemed to be extremely important to them as it gave them all time to express their feelings and work through the material. Group cohesion was noted in all of the focus groups as the women supported each other and provided space for each to share. Women also endorsed an idea that talking about their offenses carried a myriad of intense emotions, including guilt and shame, and future research may explore the dynamics of this sharing in groups conducted in non-therapeutic units such as general population or outpatient settings.

The women with life sentences seemed to appreciate the group, and the opportunity to be involved in any treatment, more so than the other women. Since many of these women had been incarcerated for more than 20 years, there was much to process about life prior to as well as during incarceration. Many discussed how helpful it would have been to have this type of intervention earlier in their prison term – for them personally, as well as the possibility of a different institutional climate.

6.4. Lessons learned

The context of the prison is a key element influencing evaluation efforts. Providing programming within a prison setting has advantages and disadvantages. Although participants are referred to as a 'captive audience' because they do not have the freedom to come and go at will, there are also inherent conflicts and competing demands in the dual goals of institutional safety and rehabilitation within the prison. Some of the issues related to feasibility were attributable to these competing demands and corresponding institutional policies and procedures. For example, standard times when women were required to be in their cells for institutional counts meant that Group 1 had a very strict time boundary for group sessions. Other institutional practices included limited group space, emergency mobilizations and mandatory drug testing during group time. Likewise, institutional policies created obstacles to some structured group activities, such as the restriction of the use of food coloring. Also, importantly, therapist fidelity was measured by self-reports with comparison and validation with the participants' reports of the sessions. Ideally, sessions would be videotaped and evaluated for therapist adherence and competence. Given the setting and institutional rules, videotaping was prohibited within the prison and thus, this research team relied on various self-report methods. Evaluation efforts within prisons thus have to consider the specific prison's institutional climate, policies, and procedures in order to operate successful within this setting.

Lastly, the psychological work demanded of the participants by the intervention is intense. Often women were sharing the details of their offense for the first time since they came to prison. These painful revelations were possible because of the safety they felt in the group, thanks to the skill of the therapists, but may also have been influenced by the prison setting. Although attendance was voluntary, residing within a therapeutic unit may have encouraged women to adhere. In a less secure setting (e.g., parole or probation), or in a general population versus therapeutic unit, it may have been easier to drop out when the work was too emotionally painful. Moreover, an intervention focused on prevention of violence can only be successful when an individual does not fear for his/her own safety. In settings where participants do not perceive safety outside the group, it may be difficult to internalize the skills embedded within the intervention as useful. Future research will continue to examine the feasibility and fidelity of the intervention in a range of contexts, as well as short and long term outcomes of the intervention.

7. Conclusion

Women with violent offense histories lack treatment or rehabilitation programs that meet their unique needs. The pilot of this gender-specific and trauma-informed intervention, Beyond Violence, demonstrated the feasibility of delivery within an institutional setting. Furthermore, trained professionals were able to adhere to the manual without difficulty and participants across three different groups received a high dosage. Participants seemed to benefit from treatment and analysis of short term outcomes is underway.

Future studies will determine if long term outcomes support decreases in violent or aggressive behavior within the institution as well as the community. Since violent recidivism is rare for women (Deschenes et al., 2007), outcomes should include any return to prison, parole violations as well as any new offenses. In general, women at highest risk for recidivism are those with multiple needs such as substance abuse and/or mental health related issues (Holtfreter & Morash, 2003). Therefore the factors addressed in Beyond Violence, such as trauma histories, mental health concerns, and substance abuse, are related to not just violence perpetration prevention, but also to preventing recidivism. Monitoring of long-term outcomes will reveal how Beyond Violence influences recidivism rates for this population of women. In addition, a randomized control trial will also determine if differences in outcomes are attributable to the model or other

individual or treatment characteristics. As comprehensive evidence is gleaned in regards to this new intervention, Beyond Violence may be a welcome addition to women's prisons that struggle with the lack of specialized, evidence-based treatment for women with violent offenses. Overall, research on this innovative treatment intervention draws attention to a marginalized population within the criminal justice system, advancing knowledge about the needs of women involved in violence and encouraging other researchers to test interventions in atypical settings.

References

American Psychiatric Association. (1994). *Diagnostic and statistical manual of mental disorders* (4th ed.). Washington, DC: Author.

Baro, A. (1999). Effects of a cognitive restructuring program on inmate institutional behavior. *Criminal Justice and Behavior, 26*, 466–484.

Bloom, B., Owen, B., & Covington, S. (2003). *Gender-responsive strategies: Research, practice, and guiding principles for women offenders*. Washington, DC: National, Institute of Corrections (NIC Publication No. 018017).

Bradley, R. G., & Follingstad, D. R. (2003). Group therapy for incarcerated women who experienced interpersonal violence: A pilot study. *Journal of Traumatic Stress, 16*(4), 337–340.

Bush, J., & Bilodeau, B. (1993). *Options: A cognitive change program*. Washington, DC: National Institute of Corrections.

Covington, S. (2013). *Beyond Violence: A Prevention Program for Criminal Justice-Involved Women*. Hoboken, NJ: Wiley and Sons.

Dahlberg, L. L., & Krug, E. G. (2002). Violence: A global public health problem. In E. Krug, L. L. Dahlberg, J. A. Mercy, A. B. Zwi, & R. Lozano (Eds.), *World report on violence and health* (pp. 1–56). Geneva, Switzerland: World Health Organization.

Deschenes, E. P., Owen, B., & Crow, J. (2007). *Recidivism among female prisoners: Secondary analysis of the 1994 BJS recidivism data set (NIJ Document No.: 216950)*. Washington, DC: National, Institute of Justice.

Dowd, L. S., Leisring, P. A., & Rosenbaum, A. (2005). Partner aggressive women: Characteristics and treatment attrition. *Violence and Victims, 20*(2), 219–233.

Eamon, K. C., Munchua, M. M., & Reddon, J. R. (2002). Effectiveness of an anger management program for women inmates. *Journal of Offender Rehabilitation, 34*(1), 45–60.

Fazel, S., Bains, P., & Doll, H. (2006). Substance abuse and dependence in prisoners: A systematic review. *Addiction, 101*(2), 181–191.

Felitti, V. J., Anda, R. F., Nordenberg, D., Williamson, D. F., Spitz, A. M., Edwards, V., et al. (1998). Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults: The Adverse Childhood Experiences (ACE) Study. *American Journal of Preventative Medicine, 14*(4), 245–258.

Fraser, M. W., Richman, J. M., Galinsky, M. J., & Day, S. H. (2009). *Intervention research: Developing social programs*. New York: Oxford University Press.

Greenfield, E. A., & Marks, N. F. (2010). Identifying experiences of physical and psychological violence in childhood that jeopardize mental health in adulthood. *Child Abuse and Neglect, 34*(3), 161–171.

Guerino, P., Harrison, P. M., & Sabol, W. J. (2011). *Prisoners in 2010 (NCJ 236096)*. Washington, DC: Bureau of Justice Statistics Bureau of Justice Statistics Bulletin.

Hall, E. A., Prendergast, M. L., Wellisch, J., Patten, M., & Cao, Y. (2004). Treating drug-abusing women prisoners: An outcomes evaluation of the forever free program. *The Prison Journal, 84*(1), 81–105.

Hedtke, K. A., Ruggiero, K. J., Fitzgerald, M. M., Zinzow, H. M., Saunders, B. E., Resnick, H. S., et al. (2008). A longitudinal investigation of interpersonal violence in relation to mental health and substance use. *Journal of Consulting and Clinical Psychology, 76*(4), 633–647.

Herman, J. L. (1997). *Trauma and recovery*. New York: Basic Books.

Herman, J. L. (1992). Complex PTSD: A syndrome in survivors of prolonger and repeated trauma. *Journal of Traumatic Stress, 5*(3), 377–391.

Holtfreter, K., & Morash, M. (2003). The needs of women offenders: Implications for correctional programming. *Women and Criminal Justice, 14*, 137–160.

James, D. J., & Glaze, L. E. (2006). *Mental health problems of prison and jail inmates*. Washington, DC: U.S. Department of Justice, Bureau of Justice Statistics (NCJ Publication No. 213600).

Kendall-Tackett, K. A. (2000). Physiological correlates of childhood abuse: Chronic hyperarousal in ptsd, depression, and irritable bowel syndrome. *Child Abuse and Neglect, 24*(6), 799–810.

Kubiak, S. P., Kim, W. J., Fedock, G., & Bybee, D. (2013). Assessing differences among incarcerated women with assaultive offenses: Isolated versus patterned use of violence. *Journal of Interpersonal Violence, 28*, 2462–2490 http://dx.doi.org/10.1177/0886260513479034.

Kubiak, S., Kim, W. J., Fedock, G., & Bybee, D. (2012). Assessing short-term outcomes of an intervention for women convicted of violent offenses. *Journal of the Society for Social Work and Research, 3*(3), 197–212.

Kubiak, S. P., Beeble, M., & Bybee, D. (2010). Testing the validity of the K6 in detecting major depression and PTSD among jailed women. *Criminal Justice and Behavior, 37*, 64–80.

Kubiak, S. P., Boyd, C., Young, A., & Slayden, J. (2005). Assessment of the substance abuse treatment needs of prisoners: Implementation of an integrated statewide approach. *Journal of Offender Rehabilitation, 41*(2), 1–19.

Lambert, E. G., Hogan, N. L., Barton, S., & Stevenson, M. T. (2007). An evaluation of CHANGE, a pilot prison cognitive treatment program. *Journal of Articles in Support of the Null Hypothesis, 5*(1), 1–17.

Landenberger, N., & Lipsey, M. (2005). The positive effects of cognitive–behavioral programs for offenders: A meta-analysis of factors associated with effective treatment. *Journal of Experimental Criminology, 1*(4), 451–476.

Lipsey, M. W. (1995). What do we learn from 400 studies on the effectiveness of treatment with juvenile delinquents? In J. McGuire (Ed.), *What works: Reducing re-offending: guidelines from research and practice* (pp. 63–78). Chichester, UK: Wiley.

Logan, C., & Blackburn, R. (2009). Mental disorder in violent women in secure settings: Potential relevance to risk for future violence. *International, Journal of Law and Psychiatry, 32*, 31–38.

McGuire, J. (2008). A review of effective interventions for reducing aggression and violence. *Philosophical Transactions of the Royal Society B: Biological Sciences, 363*(1503), 2577–2597.

Mechanic, M. B., Weaver, T. L., & Resick, P. A. (2008). Mental health consequences of intimate partner abuse: A multidimensional assessment of four different forms of abuse. *Violence Against Women, 14*, 634–654.

Messina, N., Grella, C. E., Cartier, J., & Torres, S. (2010). A randomized experimental study of gender-responsive substance abuse treatment for women in prison. *Journal of Substance Abuse Treatment, 38*(2), 97–107.

Miller, G. A. (1999). *The SASSI manual: Substance abuse measures* (2nd ed.). Springville, IN: SASSI Institute.

Mowbray, C. T., Holter, M., Teague, G., & Bybee, D. (2003). Evaluation methods to establish best practices: Fidelity criteria. *American Journal of Evaluation, 24*(3), 315–340.

Najavitis, L. M., Weiss, R. D., & Shaw, S. R. (1997). The link between substance abuse and posttraumatic stress disorder in women: A research review. *American Journal on Addictions, 6*(4), 273–283.

Neumann, D. A., Houskamp, B. M., Pollock, V. E., & Briere, J. (1996). The long-term sequelae of childhood sexual abuse in women: A meta-analytic review. *Child Maltreatment, 1*(1), 6–16.

Newman, A. L., & Peterson, C. (1996). Anger of women incest survivors. *Sex Roles, 34*(7), 463–474.

Polaschek, D. L. L., Wilson, N. J., Townsend, M. R., & Daly, L. R. (2005). Cognitive–behavioural rehabilitation for violent offenders: An outcome evaluation of the violence prevention unit. *Journal of Interpersonal Violence, 20*, 1611–1627.

Rothman, J., & Thomas, E. J. (Eds.). (1994). *Intervention research: Design and development for human service*. New York: Haworth.

Sacks, J. Y., Sacks, S., McKendrick, K., Banks, S., Schoeneberger, M., Hamilton, Z., et al. (2008). Prison therapeutic community treatment for female offenders: Profiles and preliminary findings for mental health and other variables (crime, substance use and HIV risk). *Journal of Offender Rehabilitation, 46*(3–4), 233–261.

Serin, R. C., & Preston, D. L. (2001). Violent offender programming. *Compendium 2000 on effective correctional programming* (pp. 146–157). Ottawa, Canada: Correctional Service Canada.

Silver, F. E., Felson, R. B., & Vaneseltine, M. (2008). The relationship between mental health problems and violence among criminal offenders. *Criminal Justice and Behavior, 35*(4), 405–426.

Sonne, S. C., Back, S. E., Zuniga, D. C., Randall, C. L., & Brady, K. T. (2003). Gender differences in individuals with comorbid alcohol dependence and post-traumatic stress disorder. *American Journal on Addictions, 12*, 412–423.

Springer, K. W., Sheridan, J., Kuo, D., & Carnes, M. (2007). Long-term physical and mental health consequences of childhood physical abuse: Results from a large population-based sample of men and women. *Child Abuse and Neglect, 31*(5), 517–530.

Staton, M., Leukefeld, C., & Webster, J. M. (2003). Substance use, health, and mental health: Problems and service utilization among incarcerated women. *International, Journal of Offender Therapy and Comparative Criminology, 47*(2), 224–239.

Thomas, S. P. (2005). Women's anger, aggression, and violence. *Health Care for Women International, 26*(6), 504–522.

Tjaden, P., & Thoennes, N. (2000). *Extent, nature and consequences of intimate partner violence*. Washington, DC: US Dept of Justice Publication NCJ 181867.

Tripodi, S. J., Bledsoe, S. E., Kim, J. S., & Bender, K. (2011). Effects of correctional-based programs for female inmates: A systematic review. *Research on Social Work Practice, 21*(1), 15–31.

Verona, E., & Carbonell, J. L. (2000). Female violence and personality: Evidence for a pattern of overcontrolled hostility among one-time violent female offenders. *Criminal Justice and Behavior, 27*(2), 176–195.

Ware, J., Cieplucha, C., & Matsuo, D. (2011). The Violent Offenders Therapeutic Programme (VOTP)—Rationale and effectiveness. *Australasian Journal of Correctional Staff Development, 31*, 1–12.

Weizmann-Henelius, G., Putkonen, H., Naukkarinen, H., & Eronen, M. (2009). Intoxication and violent women. *Archives of Women's Mental Health, 12*(1), 15–25.

West, H. C., Sabol, W. J., & Greenman, S. J. (2010). *Prisoners in 2009 (NCJ 231675)*. Washington, DC: Bureau of Justice Statistics Bureau of Justice Statistics Bulletin.

Widom, C. S., & White, H. R. (1997). Problem behaviours in abused and neglected children grown up: Prevalence and co-occurrence of substance abuse, crime and violence. *Criminal Behaviour and Mental Health, 7*(4), 287–310.

Wilfley, D., Rodon, O., & Anderson, W. (1986). Angry women offenders: Case study of a group. *International Journal of Offender Therapy and Comparative Criminology, 30*, 41.

Zlotnick, C., Najavits, L. M., Rohsenow, D. J., & Johnson, D. M. (2003). A cognitive–behavioral treatment for incarcerated women with substance abuse disorder and posttraumatic stress disorder: Findings from a pilot study. *Journal of Substance Abuse Treatment, 25*(2), 99–105.

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