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Identifying Women's Pathways to Offending and the Primary Prevention and Early Intervention Opportunities for Women at Risk of Offending in Wales

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We promote the sharing of ideas and learning, and to challenge and change ways of working, so together we can break the cycle of ACEs.

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Abbreviations

ADHD	Attention Deficit Hyperactivity Disorder
ACE	Adverse Childhood Experience
CBT	Cognitive Behavioural Therapy
CAPRICORN	Collaborative Approaches to Preventing Offending and Re-Offending by Children
CMHT	Community Mental Health Team
CPIC	Community Partners in Care
CJS	Criminal Justice System
GP	General Practitioner
GRT	Gypsy, Romany or Traveller
HMPPS	HM Prison and Probation Service
MDT	Multidisciplinary Team
PCC	Police and Crime Commissioner
PICT	Practice Integrated Care Team
SCIE	Social Care Institute for Excellence
TBI	Traumatic Brain Injury
UK	United Kingdom
USA	United States of America

1. Background

1.1 The Costs of Women's Imprisonment

The United Kingdom (UK) has one of the highest rates of imprisoned women amongst Western European countries, which carries significant direct and indirect costs to public expenditure (Bereford, 2018). There are no prisons for women in Wales, forcing women from Wales who are sentenced to prison time to be sent to a prison in England, an average of 101 miles away from their home (Prison Reform Trust, 2019a). In 2017, 74% of women in prison from Wales were held in either HMP Eastwood Park in South Gloucestershire or HMP Styal in Cheshire, and a prison place at HMP Styal cost a yearly average of £40,635 (Prison Reform Trust, 2019a). There are also significant economic and social costs to women's imprisonment through the breakdown and impact on women's wider family and household, particularly impacting children whose mothers are involved in the criminal justice system (CJS). The New Economic Foundation has estimated that over a 10-year period the imprisonment of mothers for non-violent crimes costs their children and the state over £17 million, which is strongly associated with the increased risks that imprisoned mothers' children will have poorer educational attainment and employment outcomes (Bereford, 2018).

An imprisoned household member during childhood is classed as an adverse childhood experience (ACE), which are associated with increased risks of negative life-course outcomes such as physical and mental illness, drug and alcohol addiction, poor educational attainment, and CJS contact (Evans *et al.,* 2020; Ford et al., 2019; Hughes et al., 2017; Ministry of Justice, 2007). Children with an imprisoned mother rather than an imprisoned father are also more likely to experience associated negative impacts (UK Parliament 2019a). Women are often the primary care giver (a fifth of women imprisoned in the UK are lone parents before entering prison), therefore when a child's mother is imprisoned, they are significantly affected in all aspects of life, as well as experiencing a range of distressing emotions such as grief and shame (Vince and Evison, 2021). Other significant disruptions often occur in the child's life when their mother is imprisoned, such as moving school, leaving the family home and becoming separated from their siblings (Bereford, 2018; Minson, 2017; Vince and Evison, 2021).

Women are often the primary care giver (a fifth of women imprisoned in the UK are lone parents before entering prison), therefore when a child's mother is imprisoned, they are significantly affected in all aspects of life, as well as experiencing a range of distressing emotions such as grief and shame (Vince and Evison, 2021)

A study in England reported that a grandparent cared for 40% of the 95% of children who had to leave the family home following maternal imprisonment (Kincaid, Roberts and Kane, 2019: 14). When this is considered with the evidence that 25% are cared for by their grandmother seen in table 1, it suggests that women (grandmothers) remain more likely to take on the care giving responsibilities of the child compared to men (fathers and grandfathers) (Kincaid, Roberts and Kane, 2019: 14; Vince and Evison, 2021; Williams, Papadopoulou and Booth, 2012). Additionally, when both grandparents are caring for a child whose mother is in prison, the grandmother often takes on the majority of the care responsibilities (Raikes, 2016). However, there is a lack of routine data collection around the outcomes for children when a mother or father is imprisoned, as well as in research studies; the last comprehensive study investigating care outcomes for children following maternal imprisonment was published in 2007 (data seen in table 1) (Home Office, 2007; UK Parliament, 2019a).

Table 1. The percentage of children in different care settings when their mother is in prison in England (Home Office, 2007).

Outcomes	Percentage of children
Not in the family home	95%
Cared for by their father	9%
Cared for by their grandmother	25%
Cared for by other family members or friends	29%
In care, with foster parents or are adopted	12%

1.2 Approaches to Women who offend in Wales

The UK Government's 2018 Female Offending Strategy has aimed to reduce the number of women coming into contact with the CJS by intervening earlier, diverting women from the CJS where appropriate to address the root causes of the offending behaviour and prevent re-offending. The strategy has acknowledged the significant influence of social factors in women's risk of offending by also aiming to fund community provision and domestic abuse services for women (Ministry of Justice, 2018a).

In Wales, the Women's Justice Blueprint (formerly named the Female Offending Blueprint) began in 2019 to improve outcomes for women at each stage of the CJS through a whole system focus, including to address gaps in provision for Welsh women at risk of offending before contact has been made with the CJS. The Women's Justice Blueprint Programme has a work stream that is specifically focussed on enhancing early intervention and primary prevention opportunities for women, which is delivered through partnership working between HM Prison and Probation Service (HMPPS) Wales, the Ministry of Justice, and the Welsh Government, and in collaboration with wider partners including Police and Crime Commissioners (PCCs), Police and third sector partners. This workstream includes diverting women away from the CJS at the earliest opportunity to reduce the levels of complexity amongst women coming into contact with the CJS (Welsh Government, 2019a).

There is growing evidence that a whole-systems approach through multi-agency working bringing together criminal justice, statutory and third sector organisations improves the outcomes of offenders with complex needs (Ministry of Justice, 2018b). Additionally, a gender and trauma-informed approach to women who offend that addresses the root causes of offending behaviours such as experiences of abuse or trauma has also been evidenced to provide better outcomes for women (Gobeil, Blanchette and Stewart 2016; McCoy et al., 2020). Therefore, women's centres can be best placed to implement this approach to address a range of circumstances such as housing, substance use and domestic violence, in a women-only and holistic environment with individual support packages.

A Ministry of Justice Data Lab Analysis evaluated 32 women's centres working with the CJS across England, which found that they had reduced a single centre taking a whole-systems approach was estimated to save £6 for every £1 spent (Ministry of Justice, 2018b). Women's centres' approaches can vary, as well as the interventions they offer, for example, one-to-one advice and support in a range of areas such as housing, substance use, domestic violence; groups and courses; or "working with the CJS to provide a community resolution, conditional caution or Rehabilitation Activity Requirement as part of a court order" (Ministry of Justice, 2018b: 5). For example, Trevi House in Plymouth has a Women's Centre offering a range of courses, groups and services in one place, as described in figure 1 (though no published evaluation of the service was available) (Trevi, 2022). Additionally, Brighton Women's Centre lead a multi-agency partnership

A Ministry of Justice Data Lab Analysis evaluated 32 women's centres working with the CJS across England, which found that they had reduced a single centre taking a whole-systems approach was estimated to save £6 for every £1 spent (Ministry of Justice, 2018b)

programme called Inspire, to support women with multiple vulnerabilities after receiving a community sentence and across all stages of involvement in the CJS. Brighton's Women's Centre reports that 90% of service users state the Inspire programme was 'hugely significant' in enabling them to build a positive future, and a programme evaluation found statistically significant evidence that the intervention reduced women's re-offending rates (see figure 2) (Ministry of Justice, 2017; Brighton Women's Centre, 2022).

Figure 1. Trevi House's Sunflower Women's Centre in Plymouth (Trevi, 2022).

Trevi House in Plymouth has established their Sunflower Women's Centre with co-located partners including probation services, Department of Work and Pensions, sexual health and other third sector organisations. The centre offers various courses, groups and services, including:

Courses and groups

- **Nourish:** nutrition and respecting your body through healthy food
- **Freedom programme:** education about domestic violence and abuse, as well as a helpline and helpdesk
- **Maths and English**
- **Making connections:** therapeutic arts and crafts
- **Survive:** recovery support
- **Warrior women:** building resilience and strength
- **Power parenting:** caring and respecting yourself to build a healthy relationship with your child
- **Stress and stress management**
- **Fitness**
- **Mental health and wellbeing**

Services

- **Employment support**
- **Pause Plymouth:** working with women at risk or with repeated experiences of removal of children from their care to develop new skills and behaviours
- Assistance with **finances** and **debt support**
- **Counselling**
- **Criminal Justice Specialist Outreach Service**
- Assistance with **rehousing** and **accommodation**
- Support with **parenting and access to childcare**
- **Support to build community connections**

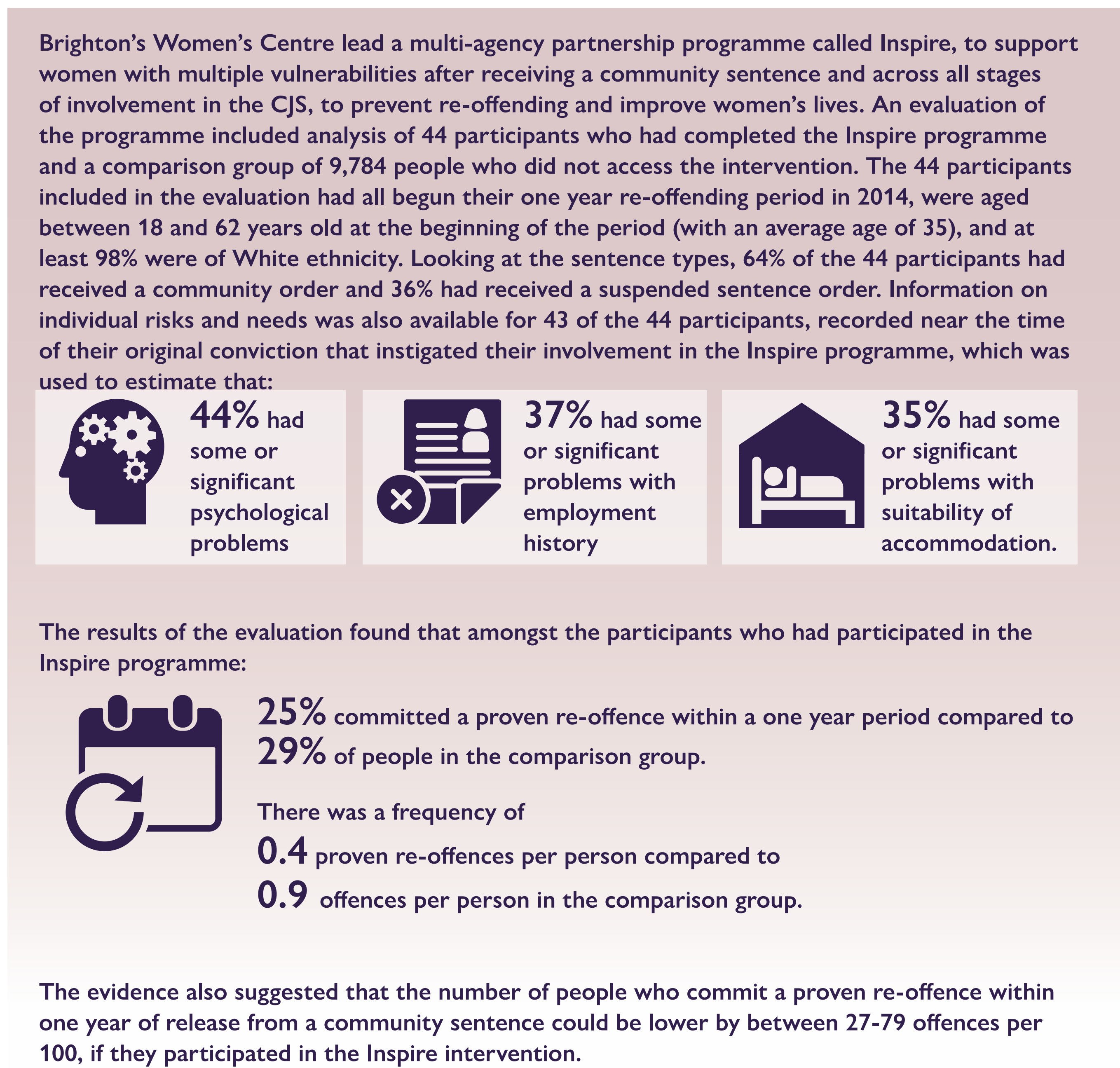
x500

The service states that they have supported over 500 local women to address their complex needs such as addictions, mental illness, offending behaviours and domestic abuse victimisation. No formal evaluation has been published, however, the service states that:

82% of women report feeling able to move forward in life following support from the centre between 2020 and 2022

90% of women said that the support received from Sunflower had been a lifeline.

Figure 2. Evaluation of the Involve programme led by Brighton Women's Centre (Ministry of Justice, 2017; Brighton Women's Centre, 2022).



The Women's Pathfinder initiative established in 2013 piloted (between 2014 and 2019) a whole systems approach to supporting women in Wales who offend through a multi-agency response, including a diversion scheme to divert women away from the CJS to support services. The initiative was led by the four PCCs and police forces in Wales, in collaboration with Welsh Government and various third sector partners (IOM Cymru, 2021). Commissioners in Wales have since invested in whole systems approach services to deliver support across the four police forces in Wales, such as those seen in table 2. In 2019, a commissioning partnership formed between South Wales PCC, Gwent PCC, HMPPS and the Welsh Government commissioned the Women's Pathfinder Whole System Approach service delivery model alongside the 18-25 Early Intervention Service in Gwent and South Wales police force areas, which incorporates a diversion service. This approach was developed using the good practice and learning from the Women's Pathfinder initiative pilots (Centre for Justice Innovation, 2022; Cordis Bright, 2021). Between January 2020 and June 2021, 1,287 women had been referred to the Women's Pathfinder Whole System Approach, who were an average age of 35 and largely White women (96%), 40% also reported having a disability (though type of disability was not specified) (Cordis Bright, 2022).

Table 2. Examples of some of the key services currently commissioned to deliver support to women across each of the four police forces in Wales.

Police force region(s)	Service provider(s)	Services offered via local commissioned women's pathfinder initiatives
Dyfed-Powys	Pobl	Pobl offers support to women who offend through the diversion scheme commissioned by the PCC in Dyfed-Powys, focused on providing support and addressing the needs of those who commit low level offences (eligible for an out of court disposal).
North Wales	North Wales Women's Centre	North Wales Women's Centre supports women who have been diverted through the North Wales checkpoint diversion scheme to support and address the needs of women at risk of offending.
South Wales and Gwent	Future 4 Consortium: a consortium of four providers including G4S, Safer Wales, Llamau and Include	The Future 4 Consortium has delivered the Women's Pathfinder Whole System Approach and 18-25 Early Intervention Service in South Wales and Gwent since October 2019. This includes support for women at each stage of the CJS, including women at risk of entering the CJS, women diverted and women at the end or coming to the end of their statutory orders.

Cordis Bright carried out an independent evaluation of the Women's Pathfinder Whole System Approach and 18-25 Early Intervention Service in Gwent and South Wales between March 2021 and February 2022, which evidenced that the interventions have had wide ranging positive impacts on participants' life outcomes (see table 3). The evaluation associated the positive impacts that participants reported to the interventions' strong and persistent engagement with people; tailoring to individuals' needs around location, type, intensity, and timing of support provided; consistent, non-judgemental one-to-one support from caseworkers; caseworkers' supportive, rehabilitative and educational approach; and the option for participants to return for further support when their initial intervention has ended (Cordis Bright, 2022).

Table 3. The average score participants (n=417) rated each area in their life scale (where a score of 0 is worst and 5 is best) at the start and at the end of receiving support from the Women's Pathfinder Whole System Approach (Cordis Bright, 2021).

Outcome area	Score at start of support	Score at end of support	Change
Health and wellbeing	2.3	3.3	+43%
Life skills	2.6	3.4	+31%
Heathy relationships	2.9	3.5	+21%
Employment	2.2	2.5	+14%
Accommodation	3.6	4.1	+14%
Financial	3.6	4.0	+11%

North Wales PCC currently commission a checkpoint diversion scheme of which there is a pathway specifically for women in North Wales into the North Wales Women's Centre, to support and address the needs of women at risk of offending. North Wales Women's Centre have shared the below testimonies from women about their experiences with, and outcomes since, accessing support from their service. The testimonies are not exclusively from women who have used the diversion programme, but also those who had self-referred for support from North Wales Women's Centre with a range of potential issues such as financial difficulties, domestic abuse or substance use.

Testimony 1

I'm now 11 days sober and have learnt when to ask for help.

Testimony 2

I am able to manage my emotions better since getting support and know I can talk things through.

Testimony 3

It's good to talk to someone who can understand and doesn't judge.

Testimony 4

Thank you for calling the doctors for me because I wouldn't have done it and because I didn't think they would listen, but you made them listen.

As a key part of the Ministry of Justice Female Offender strategy, a 12-bed women's residential centre is due to open in South Wales in 2024 (subject to planning permission) with a £10 million investment from UK Government. The centre will provide local women who have committed low level offences with specialist support to address the root cause of their offending behaviour. The women will stay for up to 12 weeks, so the centre will support around 50 women a year, and during this time the women will have access to one-to-one mental health therapy and counselling to address trauma and addictions, as well as long-term support to secure employment and maintain family relationships when transitioned back into their community from the centre (UK Government, 2022). Keeping women out of the CJS and providing an environment in which they can access specialist support will not only help women change their lives, but will also have a positive impact on their children by avoiding the negative effects of having a mother or loved one in prison.

In addition, the Early Action Together Programme sought to facilitate the transformation of policing in Wales through a multi-agency, ACE-informed approach that enabled early intervention and root cause prevention of offending. This programme began in 2018, funded by £6.8 million from the Home Office as a part of the Police Transformation Fund, with involvement from four police forces in Wales, HMPPS and wider key partners to form a multi-agency response. The programme evidenced the positive impact of the ACE and Trauma-Informed Training Package on police and partners' understanding of ACEs, which have improved the way that vulnerable people across Wales are identified and supported by taking a holistic approach to offenders (Hardcastle, Bellis, and Hopkins, 2021). However, there is currently a lack of published research around the gendered and/or racial/ethnic contexts to the pathways into offending for those who have experienced ACEs, wider trauma in childhood and trauma in adulthood in Wales and their differences in contact made with services that may present opportunities for primary prevention and early intervention.

1.3 Study Aims

The study aims to identify the key factors influencing women's risk of coming into contact with the CJS, and the primary prevention and early intervention opportunities to address the identified factors. The three key research aims are to:

1. **Identify and understand the key risk factors influencing women's pathways to offending**
2. **Explore the potential opportunities for early intervention and primary prevention to prevent and mitigate the identified risk factors for women's offending**
3. **Identify the contact women in Wales have with different services prior to committing an offence and the factors influencing the offence(s) to understand the opportunities for primary prevention and early intervention**

2. Methodology

2.1 Literature Review

2.1.1 Literature Review One: Women's Risk Factors for Offending

A literature review was conducted to identify the key themes discussed in the literature as factors that influenced women's pathways to offending, and supplementary searches were then made for literature within each of the identified themes using additional search terms in combination with the search terms used in stage one. The search terms used in each stage are listed in table 4, and searches were made between January 2022 and March 2022. The literature searches focused on several databases (Scopus, Ovid, Science Direct, and Google Scholar), as well as searching for relevant grey literature by government agencies and third sector organisations. The eligibility criteria for literature included were: published in English, published after 2000, and focused on women in high-income countries. Not all of the literature was methodically screened for inclusion or exclusion, but literature meeting the inclusion criteria was selected (peer-reviewed journals (n=30) and grey literature (n=63)) to provide a summary of the background within each section as context for the case studies discussed later.

Table 4. Search terms used in stage one and two of literature review one.

Search stage	Search terms used
Stage One: searches to identify key themes	*"Female offending", "offending", "women", "criminal justice" "pathways", "background"*
Stage Two: searches to supplement literature in each key theme	*"Female offending", "offending", "women", "criminal justice" "pathways", "background", "poverty", "ACEs", "domestic abuse", "brain injury", "mental illness", "learning disability", "neurodiversity", "ADHD", "autism", "race and ethnicity", "Gypsy, Romany and Traveller"*

2.1.2 Literature Review Two: Primary Prevention and Early Intervention of Offending for Women

A second literature review identified opportunities for, and potential approaches to, primary prevention and early intervention to mitigate each of the risk factors for offending identified in the first literature review. A targeted search was made after identifying the following categories for sources of primary prevention and early intervention of offending to address the key factors highlighted in literature review one: Primary Prevention for Children of Women in the CJS; General Practitioners (GPs); Mental Health Services and Interventions; Brain Injury Support; Multidisciplinary Teams (MDTs); Supporting Neurodiverse Individuals; and Cultural Competency. The literature included peer-reviewed journals (n=9) and grey literature (n=39). The eligibility criteria was the same as in literature review one: published in English, published after 2000, and focused on women in high-income countries. The literature searches focused on several databases (Scopus, Ovid, Science Direct, and Google Scholar), as well as searching for relevant grey literature by government agencies and third sector organisations.

2.2 Case Studies

Case studies that explore the pathways to offending of women who have offended in Wales were collected to support the evidence found within the literature review, and explore how the international evidence-base applies to women in Wales. Case studies were used in this research as they allow for *"in-depth, multi-faceted explorations of complex issues in their real-life settings"* (Crowe *et al.,* 2011: 1). The use of collective case studies allows for insight into the experiences of different women in Wales specifically, which can be considered alongside research findings in the wider literature.

A women's pathfinder diversion programme provider recruited women who have completed the service's diversion programme to participate in semi-structured interviews lasting for a maximum of one hour to collect data to develop an anonymous case study of the participant's pathway to, and through, the diversion programme. An interview was offered to potential participants as either online or face to face with one researcher from Public Health Wales and one from HMPPS. Participants were asked to sign a consent form before attending the interview, which explained to them that participation was voluntary, discussions during the interview would not be shared with the service that provided the diversion scheme programme, and all data collected would be anonymised. Notes were taken throughout the interview, but interviews were not recorded and transcribed. After the interview the participant had the option to receive a call from their caseworker from the diversion programme provider to identify any needs for additional support.

In the semi-structured interview, participants were asked to discuss their answers to the following questions in the interview:

1. **What led you to be referred to the Women's Pathfinder Diversion Scheme?**
2. **Were you engaged with any services before the diversion programme?**
3. **How did you find the diversion scheme process?**
4. **Did you feel the caseworkers were female focused enough?**
5. **What outcomes do you feel you've had from the diversion scheme?**
6. **Were you referred to other services after finishing the diversion programme?**

Several women focused services in Wales were contacted with a request for case studies that represent the experiences of women who were at risk of offending before accessing their service for use in this research. Only one service was able to participate in the research, which was a women's diversion programme provider. The service provided three case studies about women who had completed the diversion programme in 2020 or 2021. The data was collected from an interview undertaken by a researcher from Public Health Wales with one participant, and three case studies were provided that had been written by service staff and anonymised. The four case studies are presented as follows:

2.3 Ethics

Public Health Wales Research and Development office granted research and governance approval for the study to be conducted before services were approached for recruitment of participants or to provide existing case studies of women who have used their service. Approval was not required from the National Research Council via HMPPS as no CJS staff or people in the CJS were involved in the research; only women who had offended but were diverted away from the CJS. Procedures and guidance in the data collection processes were adhered to including General Data Protection Regulations and safeguarding considerations when engaging with women who had offended. The participants were provided with a document summarising background information to the research project including the purpose, scope and intended outputs of the research, as well as a consent form before the interview. To address safeguarding concerns, in particular the risk of re-traumatisation, it was arranged that the participants' diversion scheme caseworker would call them after the interview with researchers to identify any need for offering further support. All data collected was anonymised when converted to a case study and information that may make the participant identifiable was not included in the case study.

The case study notes shared by the service were anonymised further by removing details that could potentially make the participant identifiable, such as occupation, the diversion scheme provider accessed or geographical locations, as well as personal information that was not necessary for addressing the research aims of the study, such as details regarding referrals made by caseworkers and referral outcomes. The relevant case studies were also shown to the service that provided the originals and participant interviewed to allow them to review and request any changes be made before publication.

3. Literature Review: The Factors Influencing Women's Risk of Coming into Contact with the Criminal Justice System

This section outlines the findings of the review of national and international literature evaluating factors in women's pathways to offending. The findings are categorised into the following key themes that arose as factors influencing women's risk of coming into contact with the CJS, which are discussed in turn:

- **Poverty**
- **Domestic abuse**
- **ACEs**
- **Mental illness and substance use**
- **Brain injury**
- **Learning disabilities and neurodiversity**
- **Race and Ethnicity.**

The above factors are often interconnected and intersecting with other factors not covered in this report such as level of educational attainment, disability status or homelessness, and therefore these should not to be viewed as isolated factors in women's pathways to offending.

3.1 Poverty

Offences committed due to 'economic necessity' and 'survival crimes' are regular themes appearing within the literature exploring the motivation for women's offences, regularly attributed to poverty within their family and child care needs (Pemberton, Balderston and Long, 2019; Wright *et al.,* 2012). In 2018, 56% of women sentenced to immediate custody under 6 months in Wales had committed the offence of theft (Prison Reform Trust, 2019a). The Disabilities Trust's discussions with women in HMP/YOI Drake Hall evidenced the significant impact of women's financial responsibilities to support dependent children on their risk of offending, as almost two in five women in prison who participated in the study said that their offending had been driven by the "need to support their children" financially (The Disabilities Trust, 2019).

Women are more likely than men to lack financial independence due to a higher risk of being unemployed, being a single parent, having mental health problems, alcohol abuse, and experiencing domestic abuse victimisation (Pemberton, Balderston and Long, 2019). Financial difficulties also inversely act as a risk factor for the presence of the aforementioned circumstances in women's lives that often reduce financial independence (Fahmy, Williamson and Pantazis, 2016; Maria *et al.,* 2018; Trust for London, 2021). The gendered differences in the prevalence of risk factors for financial difficulties is reflected in the differences in men and women's offences. Offences linked to financial need are more prevalent amongst women than men; in 2009, a UK Cabinet Office study of offenders found that 28% of women's offences were financially motivated compared to 20% of men's (COSETF, 2009). Women are also more likely than men to be prosecuted for first time and less serious, non-violent offences (UK Government, 2018).

> ***Offences linked to financial need are more prevalent amongst women than men …***

In 2019, 55% of women prosecuted at court in the UK had committed a summary non-motoring offence such as TV licence evasion, compared to 29% of prosecuted men. TV licence evasion was the most common offence that women in England and Wales were convicted for in 2019; 74% of convictions being of women, accounting for 30%

of all women's prosecuted crimes (compared to 4% of all men's prosecuted crimes) (Ministry of Justice, 2020). This is likely due to the often gendered duties of women in the household, leaving them more vulnerable to being charged with a household's non-payment offence as the more common household member to open the door to TV licencing inspectors (TV Licensing, 2017).

3.2 Domestic Abuse and Sexual Violence

Strong links have been evidenced between domestic abuse and many women's offences; consequently many women are imprisoned for lesser crimes than those they had been victims of before entering the CJS (Pemberton, Balderston and Long, 2019; Prison Trust Reform, 2021a). A study in London reported that 57% of women in prison had been a victim of domestic violence (London Borough of Barnet, 2019). However, these figures are likely unrepresentative of the true prevalence of domestic abuse victimisation amongst women in prison due to many women's fear of disclosing experiences of abuse. A far higher prevalence can be expected since the Women in Prison charity reported that 79% of women using their services have experienced domestic violence and/or sexual abuse (AVA Project, 2017).

… the Women in Prison charity reported that 79% of women using their services have experienced domestic violence and/or sexual abuse (AVA Project, 2017)

Women who have offended have a disproportionately high chance of having experienced violence or abuse in comparison to both men and women in the community, as well as men who have offended (Pemberton, Balderston and Long, 2019). Women's economic disadvantage can be significantly worsened by domestic abuse. Women's experiences of domestic abuse, sexual violence and coercive relationships show strong correlations with their offending (particularly for property and drug related offences) (DeHart *et al.,* 2013; Pemberton, Balderston and Long, 2019; Prison Reform Trust, 2017a). The links with domestic abuse and coercion to offend is reflected in the gendered differences in the proportion of offences committed to support another person's substance use. The Ministry of Justice found that 48% of female prisoners interviewed said that they had committed their offence to support another person's drug use, in comparison to 22% of male prisoners (Ministry of Justice, 2018c). Additionally, many women in prison in the UK have disclosed that their involvement with drug and alcohol abuse had begun before entering the CJS as a means to cope with their partner's abusive behaviour (often persisting beyond the end of an abusive relationship) (DeHart *et al.,* 2013; Prison Reform Trust, 2017a; Roberts, 2016).

The association between domestic abuse victimisation and offending is again highlighted in women's contrasting desistance outcomes after leaving prison whilst maintaining the family and intimate relationships they had before entering the CJS compared to men. Roberts (2016) evaluated the longitudinal effects of domestic abuse on women's offending through interviews with women who had offended, which found that women who had experienced domestic abuse victimisation often continued to commit offences with a causal relationship to the domestic abuse even years after the abuse ceased and any relationship with the abuser had ended (Roberts, 2016). Another study with women who had offended in England and Wales evidenced a difference in the factors that support desistance in comparison to those reported by men. Men often experienced a positive impact from the maintenance of family and intimate partner relationships on desistance, whereas women reportedly often experienced negative impacts on desistance due to abuse within these relationships. The accounts suggested that positive relationships with peer workers and education and employment opportunities had the greatest impact on preventing re-offending for women (Radcliffe and Hunter, 2016).

3.3 Adverse Childhood Experiences

ACEs are stressful events that occur in childhood, such as being a victim of abuse, neglect, or growing up in a household with a family member who is incarcerated, experiencing mental ill health, alcohol/substance use, or domestic violence. In Wales, around 50% of adults have reported experiencing at least one ACE, while 13.5% have reported experiencing four or more (Hughes *et al.,* 2017). Research has shown that the number of ACEs a person has experienced correlates with increased risks of mental illness and offending over the life course (Bellis *et al.,* 2016; Craig *et al.,* 2017; Huei-Jong Graf *et al.,* 2020; Testa *et al.,* 2021). For example, exposure to domestic abuse in childhood can also have long-term impacts on children's mental health and wellbeing that can persist into adulthood, increasing children's risk of developing risk factors for offending throughout their life-course (Advance, 2020). Individuals in Wales who have experienced four or more ACEs are 20 times more likely to have been incarcerated than individuals who have not experienced any ACEs (Bellis *et al.,* 2019).

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In a study with a cohort of male prisoners in Wales, it was found that 84.2% of the prisoners had suffered at least one ACE and 45.5% at least four ACEs. The study reported that as the rate of a prisoner's exposure to ACEs increased, the prevalence of lifetime mental illness diagnosis, self-harm or suicide attempts, and current low mental wellbeing also increased. Participants that had been exposed to four or more ACEs were more than 10 times more likely to report lifetime self-harm and almost three times more likely to have current low mental wellbeing in comparison to participants that had no ACEs exposure (Ford *et al.,* 2020).

There is limited and often contradictory evidence to confirm a gendered inequality in risk of having experienced ACEs (Vaswani, 2018). However, 53% of women in the CJS from England and Wales have reported having experienced emotional, physical or sexual abuse as a child, compared to 27% of male offenders (Williams *et al.,* 2012). Another study in Wales exploring the health outcomes associated with ACEs has stated women and girls are more likely to have experienced domestic abuse, sexual violence and other gendered forms of discrimination (Bellis *et al.,* 2016). Additionally, negative life outcomes amongst women who have experienced ACEs are exacerbated by a lack of funding for community based services to address women's needs for support and treatment, as well as a lack of staff training across all stages of the CJS to identify and appropriately respond to women who may have experienced ACEs (Prison Reform Trust, 2019b).

Intergenerational transmission of criminal convictions are mediated via psychosocial factors (Auty, Farrington and Coid, 2017). Table 5 outlines the key factors identified across four categories of a child's life that impact their future risk of offending, several of which across the four categories are directly and indirectly impacted by parental imprisonment (Public Health England, 2019). A mother's imprisonment also increases a child's risk of exposure to several of the risk factors for offending in table 5 at a greater rate than a father's imprisonment, with greater negative impacts on the child's life-course outcomes such as substance use or poor educational attainment (Kincaid, Roberts and Kane, 2019). A study found that the convictions of mothers and fathers are significantly related to the convictions of their male children which are mediated via the fathers' drug use, a father's conviction has an indirect association only with female children via cohabitation problems whereas a mother's conviction has an indirect association with female children's convictions as a result of harsh parental discipline (Auty, Farrington and Coid, 2017).

Table 5. The factors for children that increase their risk of offending within four categories (individual, family, school and peer group, and community) (Public Health England, 2019).

Individual	Family	School and peer group	Community
• Early malnutrition • Behavioural risk factors • Alcohol or drug use • Traumatic brain injury • Language difficulties	• Abuse • Emotional or physical neglect • Household alcohol or drug use • Household mental illness • Family violence • Family breakdown • Household offending	• Poor educational attainment • Truancy • Exclusion from school • Gang membership • Low expectations from teacher	• Deprivation • Poor housing • Unsafe areas • Poor social mobility • High crime rate • High unemployment • Racism

Childhood and adulthood sources of resilience moderate the outcomes of ACEs on future mental health, such as personal, relationship and community support, peer support, and understanding how to access community support (Hughes *et al.,* 2017). Therefore, there are opportunities to intervene and promote resilience factors early in childhood as well as later in adulthood to aid the prevention of negative ACE or trauma associated life outcomes, including contact with the CJS (see section 4.1. Primary Prevention for Children of Women in the Criminal Justice System).

3.4 Mental Illness and Substance Use

Many national and international studies have highlighted a strong and complex association between mental illness and offending behaviours amongst women and men, particularly relating to substance use often used as a coping mechanism (Ardino, 2012; DeHart *et al.,* 2013; Lynch *et al.,* 2017; NICE, 2016; Short *et al.,* 2018; Sierka, 2015). A study in the United States of America (USA) examined mental health as a mediator of the link between victimization and offending in women, which found that lifetime mental illness and substance use mediated the relationship between childhood and adulthood victimisation, adversity throughout the life course and the number of convictions a woman had received (Lynch *et al.,* 2017). These conclusions have been similarly made in UK based studies' research findings with women in the CJS (Light, Grant and Hopkins, 2013; Mental Welfare Commission for Scotland, 2019). A Ministry of Justice study also found links between mental illness and re-offending, as women who had symptoms of anxiety and depression before release from prison were more likely to re-offend than prisoners who did not experience these symptoms (Light, Grant and Hopkins, 2013).

> ***Substance use is one of the most prominent criminogenic factors for both men and women, which often relates to underlying and co-occurring mental health issues***

Substance use is one of the most prominent criminogenic factors for both men and women, which often relates to underlying and co-occurring mental health issues; though there are gendered inequalities in the reported prevalence amongst people who have offended (London Assembly Health Committee, 2017; Pemberton, Balderston and Long, 2019; Pickard and Fazel, 2013). In a study seeking to quantify crime associated with drug use across England and Wales, seeking to quantify crime associated with drug use, significant associations were found between offending and substance use, which reported that a stronger associative relationship was found amongst women in the CJS compared to men in the CJS. For example, women in the CJS who participated in the study used opiate and cocaine at 3.5 times the rate of women in the general population, whereas for men in the CJS the rate of opiate and cocaine use was 1.8 times higher than men in the general population (Pierce *et al.,* 2015).

Women in the CJS in England were also reported to have experienced mental ill health at higher rates prior to entering the CJS in comparison to men; 71% of women reported having a mental health problem compared to

47% of men in prison in 2019 (HM Inspector of Prisons, 2020). Other studies have also found stronger associations between criminal offences, trauma and substance use amongst women in the CJS, which has been linked to women's higher self-reported rates of mental illness and domestic abuse victimisation experienced in comparison to men in the CJS (DeHart *et al.,* 2013; Prison Reform Trust, 2017a). However, these findings should be understood in the context that these behaviours and outcomes may be underreported (DeHart *et al.,* 2013).

3.5 Brain Injury

Brain injury can be an acquired traumatic or non-traumatic injury; including any injury to the brain that occurred after birth. A traumatic brain injury (TBI) is "defined as an alteration in brain function, or other evidence of brain pathology, caused by an external force", whereas a non-traumatic brain injury can be induced by several pathophysiological pathways that cause damage to the internal structures and functioning of the brain such as stroke, infectious diseases or tumours (Brain Injury Association of America, 2022). There is extensive evidence to illustrate that people with traumatic and/or non-traumatic brain injury can commonly experience symptoms related to cognitive and behavioural difficulties that increase the risk of engagement in criminal behaviours (The Disabilities Trust, 2019). These symptoms can include:

- Poor memory
- A lack of concentration
- Impaired judgement
- Reduced impulse control
- Emotion dysregulation
- Problems with sleeping, anxiety and/or depression.

The Centre for Mental Health has estimated that having a brain injury increases the risk of offending by 50% and doubles the risk of developing mental health problems. The Centre also estimated around 60% of adult offenders and 30% of young offenders have a history indicative of a brain injury (Parsonage, 2016). A study with women who have offended in Canada found that the risk of receiving a serious charge for an offence was 39% higher for women with a TBI compared to women with no history of TBI (Matheson *et al.,* 2020). Several other national and international studies have evidenced causal inference between TBI and offending behaviour amongst women, as the cognitive and behavioural problems symptomatic of TBI can limit women's ability to regulate emotions and behaviours or interpret a situation and how to appropriately respond (McMillan *et al.,* 2021; O'Sullivan *et al.,* 2020; Woolhouse, McKinlay and Grace, 2018).

The Centre for Mental Health has estimated that having a brain injury increases the risk of offending by 50% and doubles the risk of developing mental health problems.

The Disabilities Trust's *'Making the Link'* Report highlighted the background and experiences of 173 women that were held in HMP/YOI Drake Hall prison in 2016 - 2018. The research findings from screening these women using the Brain Injury Screening Index tool found that 64% of women had reported a history indicative of brain injury, while 96% had been a victim of domestic abuse and 62% had sustained a TBI as a direct result of domestic violence victimisation. Other studies have also found links between domestic violence and head injury, for example, a study with women who have offended in the UK found that domestic abuse was the most frequently reported cause of TBI within the cohort (O'Sullivan *et al.,* 2020). This highlights a need for trauma-responsive support to identify and address the symptoms of TBI in women, since TBIs are commonly the result of traumatic experiences of victimisation. However, the report also stated that despite these findings, there is no mandatory routine screening for TBI, basic awareness training to enable staff to identify and respond to women with TBI, or dedicated TBI support within UK prisons (The Disabilities Trust, 2019).

3.6 Learning Disabilities and Neurodiversity

Neurodiversity refers to the broad diversity in how the population experiences, processes and interacts with the world. The term is often applied to capture the population with autism and/or neurological or developmental conditions such as attention deficit hyperactivity disorder (ADHD) or a learning disability, under the umbrella of neurodiversity (Baumer and Frueh, 2021). In 2016, people with a learning disability were estimated to account for around 2% of the general population in England, compared to 7% of the population who were in contact with the CJS (NHS England, 2016). However, other studies have estimated these figures to be significantly higher, estimating that 20-30% of the population in contact with the CJS have a learning disability. These studies have also found that a higher proportion of women who have have a learning disability (estimates ranging between 30-40% of the population of women who have offended in England and Wales) compared to the population of men who have offended (Criminal Justice Joint Inspection, 2021; Mottram, 2007; Loucks *et al.,* 2007).

The evidence base for a link between ADHD and women in the CJS has been growing internationally, despite the remaining lack of understandings around the aetiology of ADHD (Freckelton, 2020; Osterman, 2018; Rosler *et al.,* 2009). A study of female prisoners in England found that 41% had met the diagnostic criteria of ADHD, and those reporting ADHD symptoms were also more likely to report high levels of impairment related to ADHD symptoms (Farooq *et al.,* 2016). Although studies targeting diagnosis and screening of ADHD amongst women provide evidence of a significant prevalence, there are widespread discrepancies in the proportion of men and women diagnosed with ADHD across the UK, which has been accounted to the failure of diagnostic criteria to incorporate the gendered differences in its presentation and profile of symptoms (Young *et al.,* 2020). There are several complications in estimating the prevalence of neurodivergent conditions. For example, definitions of various conditions continue to evolve, there is widespread under-diagnosis (particularly amongst women) and many neurodiverse people have overlapping conditions of different severities. There is also a lack of research into the presentation and prevalence of neurodiverse conditions in women, as well as a lack of screening and diagnostic tools that are validated for use with women. Consequently, women face "recognition and/or referral bias" (Wilson *et al.,* 2016) and diagnostic evaluation outcomes are influenced by gender, likely due to the gendered differences in presentations and manifestations of neurodiverse conditions often unaccounted for by widely used non-sex-specific diagnostic tools (Wilson *et al.,* 2016; Young *et al.,* 2020).

Despite the barriers to diagnosis, there remains an over-representation of neurodiverse individuals amongst both men and women who offend based on estimates (Criminal Justice Joint Inspection, 2021). Neurodiverse individuals' over representation amongst the offending population can be attributed to multiple interacting factors, including higher exposures to the social determinants of ill health such as poverty, unemployment, poor housing conditions, social exclusion, and experiences of abuse, victimisation, and discrimination (LeDeR Programme, 2021; Public Health England, 2021). Additionally, people with learning disabilities are vulnerable to further forms of abuse to physical, financial, sexual or emotional abuse, such as coercive threats to leave the individual that might impair their ability to live independently or force them into institutionalisation (McCarthy, Hunt and Milne-Skillman, 2016).

Neurodiverse individuals' over representation amongst the offending population can be attributed to multiple interacting factors, including higher exposures to the social determinants of ill health such as poverty, unemployment, poor housing conditions, social exclusion, and experiences of abuse, victimisation, and discrimination

The Local Government Association in the West Midlands held a multi-agency consultation to establish how to improve outcomes for people with learning disabilities and/or autism, who have committed offences or are at risk of doing so. Seventy professionals employed across the CJS, including police, HMPPS, health, and social care, alongside experts by experience and advocates gathered to consider the issue. Several relevant themes emerged to highlight the key gaps across the CJS worsening neurodiverse people's care and life outcomes including risks of re-offending:

- A lack of understanding of each other's roles and responsibilities
- A lack of understanding of the needs of people with learning disabilities and/or autism

- Inconsistencies in offenders' access to treatment programmes and eligibility criteria that does not capture all who should be included
- No shared understanding or approach to risk identification and management
- Inconsistencies in the availability of liaison and diversion schemes
- Inconsistencies of onward referral opportunities where liaison and diversion schemes do exist
- Failures to address the underlying needs arising from anxiety, depression and loneliness
- Eligibility criteria for a diagnosis and access to specialist support that does not capture all that should be included (Hammond and Talbot, 2018).

3.7 Race and ethnicity

An extensive body of evidence from research in the USA has highlighted that racial/ethnic minority women are further disadvantaged along their pathways into the CJS in comparison to White American women and are over-represented within the population of women who have offended. In particular, experiences of racial discrimination and victimisation, higher exposure to violence, higher rates of mental illness and poverty, and harsher treatment throughout to CJS including more severe sentences than White women on average (Crenshaw, Ocen and Nanda, 2015; Ocen, 2012; Spohn and Brennan, 2011; Walt and Jason, 2018). However, there is a lack of research to offer robust insights into the intersectional experiences of racial/ethnic minority women and their pathways into the CJS within the UK specifically.

Women from racial/ethnic minority groups are significantly over represented in the CJS across England and Wales. In 2017, women who are Black, Asian or of another minority ethnic group accounted for 18% of the women's prison population in England, despite only making up 11.9% of the population of women in England and Wales (Prison Reform Trust, 2017b). The Ministry of Justice has reported that women who are from a racial or ethnic minority group have a 28% higher risk of imprisonment compared to White British women, and both Black and mixed ethnicity women have double the chance of being arrested than White women (Ministry of Justice, 2018c).

In 2017, women who are Black, Asian or of another minority ethnic group accounted for 18% of the women's prison population in England, despite only making up 11.9% of the population of women in England and Wales (Prison Reform Trust, 2017b)

In 2017, *'The Lammy Review: An independent review into the treatment of, and outcomes for, Black, Asian and Minority Ethnic individuals in the Criminal Justice System'* was published by the UK Government. This reported that the number of Black people in the CJS in the UK is more disproportionate relative to the general population than in the USA, with the overrepresentation of Black, Asian and Minority Ethnic groups costing UK courts, prisons and probation services an estimated £309 million per year. The report also highlighted that despite several pronounced pathways into offending and significantly higher rates of arrests across all racial and ethnic groups compared with the White groups, there was no clear explanation for the disproportionate representation of racial/ethnic minority people in custody or prisons (UK Government, 2017).

Racial/ethnic minority women have greater risks of exposure to a multitude of social determinants of CJS contact such as poverty, mental illness, and experiences of violence and discrimination (Bullock, 2019; Marmot *et al.,* 2020; UK Parliament, 2019b). Additionally, higher proportions of lone parent women with childcare needs are racial/ethnic minority women in comparison to White British women. For example, 18.9% of Black households in England and Wales were lone parents with dependent children in 2019/20 (the highest of all race/ethnic groups) (UK Government, 2020), while 91% of these parents in 2017 were women (Hall *et al.,* 2017). The intersectional experiences of marginalisation that racial/ethnic minority women have in the UK are also exacerbated by additional barriers to accessing support that may prevent offending in comparison to White women. For example, a lack of culturally appropriate support services with staff trained to respond to racial trauma (Prison Reform Trust, 2017b).

The marginalisation and stigmatisation of people that identify as Gypsy, Romany or Traveller (GRT), as well as their historical poor relationship with and mistrust of police, poses significant barriers to the GRT community's access

to social and economic resources, contributing to their overrepresentation across the CJS. In 2021, Gypsy/Irish Traveller women made up 6% of the prison population, which in several prisons is significantly higher; a survey reported that 9% of women at HMP Foston Hall, 9% at HMP Bronzefield, and 10% at HMP Peterborough had self-identified as Gypsy/Irish Traveller, though Roma women were not included in the ethnic monitoring options (Prison Reform Trust, 2021a). In total, 7% of the women in prison in England said that they were GRT in 2021, despite GRT women only representing an estimated 0.1% of the general population in England. However, the proportion of the prison population with a GRT background likely remains underreported due to fear that discrimination will follow disclosure (The Traveller Movement, 2021b).

South East Wales Women's Aid Consortium released a study in 2010 of domestic abuse amongst GRT communities, which found women and girls in these communities face additional barriers to accessing support. The Traveller Movement has reported that "there is no accepted evidence to suggest that the rates of violence and abuse against women is higher for Gypsy Roma and Traveller women than the settled population. However, structural inequalities such as discrimination, lack of educational attainment, unemployment, lacking access to accommodation and significant health inequalities make it more difficult for Traveller women to move out of violent or abusive relationships and seek help through mainstream services" (The Traveller Movement, 2021a).

Culturally within GRT communities, girls are expected to marry and have children at a young age; consequently, girls often leave education in their early teenage years with low literacy levels. In addition, women and girls roles in marriage are highly gendered with increased risks of experiencing domestic abuse, as well as it often being more difficult in these communities for women to leave an abusive relationship due to the stigmatisation of divorce and domestic abuse victimisation (South East Wales Women's Aid Consortium, 2010). Therefore, this would suggest that GRT women might face an increased risk of offending behaviours when considered in conjunction with the evidence presented in the previous section relating to domestic abuse (3.2. Domestic Abuse and Sexual Violence). This is also the case for Black and minority ethnic women in the UK, who similarly face barriers to accessing social and economic resources disproportionately to the rest of the population. These barriers can include cultural exclusion, a lack of fluency in the English language and low literacy levels (Centre for Women's Justice and Justice for Women, 2021).

The marginalisation of GRT people also exacerbates their risk of negative experiences and outcomes within the CJS. The HM Inspectorate of Prisons' 2014 report found that people who identified as GRT were more likely to feel victimised and less likely to feel safe in custody than people within the CJS who did not identify themselves as GRT (HM Inspectorate of Prisons, 2014). Additionally, the 2019/20 HM Chief Inspector of Prisons for England and Wales Annual Report included results from a survey used to assess the mental health of prisoners, which found the following inequalities amongst the Traveller prison population in comparison to the general prison population:

- 64% of Travellers that responded stated they had a mental health issue
- 45% of Travellers felt depressed, compared to 35% of non-Traveller respondents, whilst 31% of Travellers stated they have other mental health problems, compared to 23% of non-Travellers
- 22% of Travellers said they were feeling suicidal compared to 12% of non-Travellers
- 31% of Travellers stated they have other mental health problems, compared to 23% of non-Travellers (HM Inspector of Prisons, 2020).

Structural barriers for GRT women continue to impact their risk of offending after release from prison. In the Thames Valley area, probation officers reported that working and building trusting relationships with Traveller women who have offended was particularly difficult, as many of these women feared that anything they disclosed to their probation officer would be shared with their husband and other members of their community. Probation officers also reported that when they meet with Traveller women who have offended they are often accompanied by their partner who waits outside for them until the meeting is over, which officers believed could further discourage women from disclosing problems that may impact desistence such as domestic abuse or mental illness (Cottrell-Boyce, 2014).

4. Literature Review: Primary Prevention and Early Intervention Opportunities and Initiatives

This section outlines primary prevention and early intervention opportunities and initiatives found in the wider literature to prevent and address the factors in women's pathways to offending identified in the previous section. The findings are categorised in the following key themes:

- **Primary Prevention for Children of Women in the CJS**
- **Mental Health Services and Interventions**
- **GPs**
- **Brain Injury Support**
- **MDTs**
- **Supporting Neurodiverse Individuals**
- **Cultural Competency.**

4.1 Primary Prevention for Children of Women in the Criminal Justice System

The primary prevention of offending requires the prevention of factors emerging in childhood and adulthood that increase the risk of offending behaviours. Therefore, the collaborative approaches to preventing offending and re-offending by children (CAPRICORN) framework seen in figure 3 was developed by Public Health England to outline the necessary actions that should be taken to prevent risk factors and improve protective factors developing in all children's lives (Public Health England, 2019). The framework provides a foundation on which to build primary prevention tools that break the cycle of inter-generational offending by supporting the wider family and children of women in the CJS, before children make contact with the youth justice system.

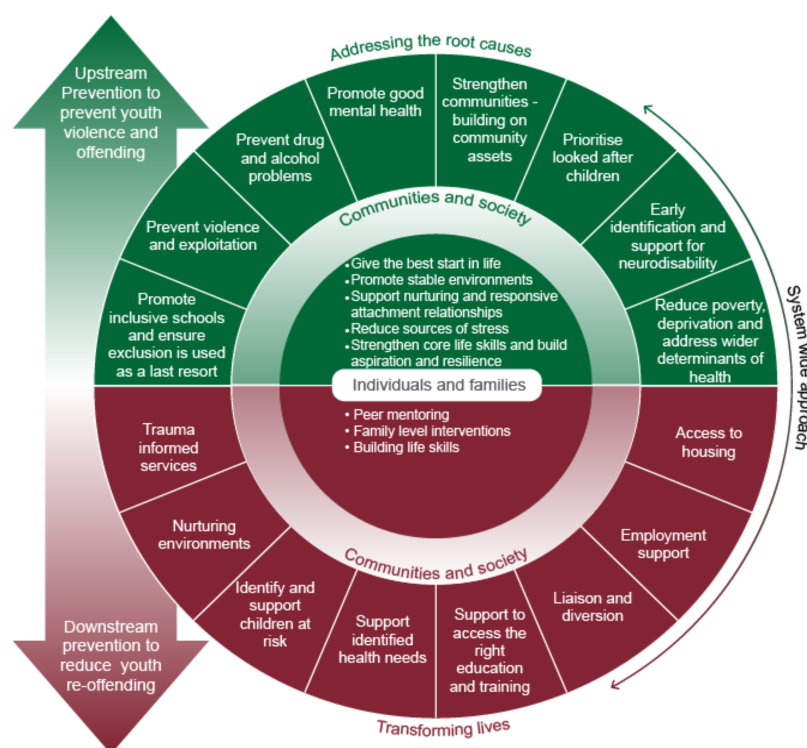

Figure 3. CAPRICORN framework (Public Health England, 2019).

Specialist support and support activities such as mentoring for children who have a mother in prison can improve a child's protective factors such as positive relationships with supportive adults and reduce the negative impacts of parental imprisonment on their environment, emotional health and wellbeing, relationships and education (Goldsmith, 2018). A mechanism to improve children's access to specialist support can include training all agencies that children of women in prison come into contact with, such as schools and police, to ensure staff are informed about the impact of maternal imprisonment on children. This can ensure children are accessing support that meets their needs, and the decisions made and interventions used by various agencies are informed by an understanding of the impact that having a mother in prison can have on children (Advance, 2020; Goldsmith, 2018). Additionally, peer support groups for children whose mothers are or have been imprisoned can provide children with a space where they can be supported and express their feelings of grief and anger to reduce feelings of isolation and shame (Advance, 2020). In Merseyside, England, for example, PSS (a social enterprise offering support to families of people in the CJS), provide a peer support group for children who have a parent in prison, as well as a group specifically for children with a mother in prison (Advance, 2020; PSS, 2022). A service user who accessed this service and engaged in their Family Links Nurturing programme, group sessions and one to ones reported that this had increased her confidence and future aspirations, which encouraged her to gain further educational qualification and improved her family relationships (PSS, 2022).

4.2 Mental Health Services and Interventions

In Wales, 25% of people are estimated to experience a mental health problem each year, though only 12% are estimated to receive any form of mental health treatment (Mind, 2016). A survey of people's experiences of accessing help, care and support during mental health crisis conducted across England by the Care Quality Commission found that "only 14% of people who have experienced a crisis felt the care received provided the right response and helped to resolve their crisis" (Care Quality Commission, 2015). Participants also stated that they had on average come into contact with three services during their crisis and 12% had encountered between six and ten services (Care Quality Commission, 2015).

A study found that 85% of the primary care workforce in Wales reported that a substantial barrier for primary care mental health services successful delivery of care is the significant waiting time for patients to access psychological therapies. People are also facing significant barriers to accessing secondary care services such as Community Mental Health Teams (CMHTs) or other specialist mental health support services when needed (Mind, 2016). However, Wales' *Together for Mental Health* report has stated that CMHTs "must make sure all people needing specialist services can access them quickly and easily" (Welsh Government, 2019b). Improvements are therefore necessary to ensure this obligation to provide all those in need of specialist mental health care is met, for example reducing waiting times through increased staff numbers and staff retention within mental health services.

A study found that 85% of the primary care workforce in Wales reported that a top barrier for primary care mental health services successful delivery of care is the significant waiting time for patients to access psychological therapies.

Community-based and led interventions can reduce strain on primary care and improve people's access to support that will improve their mental health and wellbeing (CPIC, 2019). These types of interventions often involve multi-sector partnerships, including community members and/or involve the delivery of services in community-based settings such as schools, homes or churches (Castillo *et al.,* 2019). For example, in Los Angeles, California, a depression collaborative care model named Community Partners in Care (CPIC) was established, which involved 1018 participants and 95 agencies working across five sectors (outpatient primary care, outpatient mental health, substance use treatment, homeless services, and other community services such as churches). Clients did not need to meet any specific criteria to be enrolled (Castillo *et al.,* 2019). This involved training local organisations such as hairdressers, churches and gyms on how to recognise depression and on cognitive behavioural therapy (CBT). An evaluation of the CPIC model's outcomes found that the intervention had decreased behavioural health related hospitalizations by 50% and decreased demand for out-patient visits, whilst increasing visits relating to depression in primary care and community based settings suggesting an increase in peoples' awareness of a need for seeking support and support accessibility (CPIC, 2019).

Another community-based mental health intervention with an evidence base for successful outcomes includes social prescribing, often delivered by third sector agencies. Social prescribing is "a means of enabling health professionals to refer people to a range of local, non-clinical services… recognising that people's health and wellbeing are determined mostly by a range of social, economic and environmental factors, social prescribing seeks to address people's needs in a holistic way" (The King's Fund, 2020). Social prescribing services provide patients with a link worker who can offer practical and psychosocial support to develop community networks, engage in social and creative activities, learn new skills, and volunteer, as well as offering support with issues relating to employment, housing, debt, and benefits (Maughan *et al.,* 2015). Therefore, social prescribing services can be used to improve a patient's wider socioeconomic problems such as debt or unemployment in order to improve their overall health and wellbeing (Maughan *et al.,* 2015; The King's Fund, 2022). The Welsh Government is currently consulting on a framework to describe social prescribing and a national model of social prescribing, as well as to identify necessary actions to embed and develop social prescribing services in areas where they are needed (Welsh Government, 2022).

The Social Prescribing Model seen in figure 4 illustrates the model developed through co-designing workshops, discussing topics such as learning from previous Mind services, with four local Minds in Cwn Taf Morgannwg, Brecon and District, Ystradgynlais, and Vale of Clwyd. The social prescribing pilot of this model by the four local Mind services offered support to over 2244 people. 590 service users provided monitoring data, which identified those reached by the service were 98% White, 1% Asian and 1% Mixed ethnicities, 2% of these people had a social, communication or learning disability, and 81% had experienced a mental health problem. The outcomes of the pilot included 99% of service users achieving their goals at least to some extent and an increased mental wellbeing score on the Short Warwick-Edinburgh Mental Health Scale for 85% of service users, which on average increased significantly from 15.87 on entering social prescribing services to 22.01 at follow up. Additionally, 26% of service users reported that if they had not accessed the service then they would have gone to their GP and 4% would have gone to NHS mental health services (Mind Cymru, 2021; Mind Cymru, 2022).

Our social prescribing model

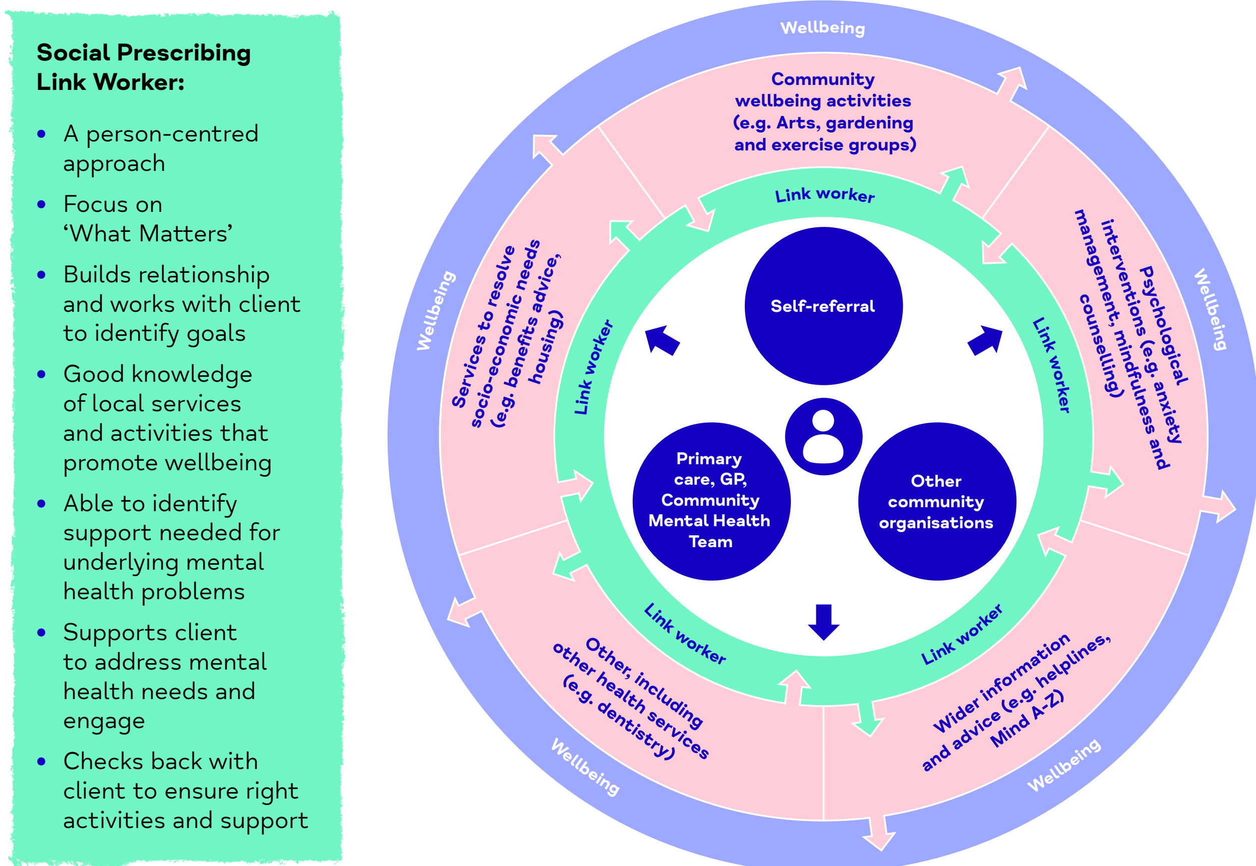

Figure 4. The social prescribing model developed by Mind Cymru (Mind Cymru, 2022: 2).

An evaluation of another social prescribing 6-week pilot implemented in Tower Hamlets in London, England found that patients had achieved the following outcomes as a result of the social prescribing intervention: begun volunteering or a hobby, attended a skills development course, gained a qualification, stopped smoking, and gained financial control (Hogarth *et al.,* 2013 in Health Dialogues, 2018). In a later evaluation over 8 months in 2018, it was found that the Tower Hamlets social prescribing intervention improved service users' wellbeing scores (measured by the validated assessment tool Measure Yourself Concerns and Wellbeing) and engagement in community based and peer-led activities, as well as demonstrating a 12.3% reduction in demand for GP appointments after six months of engagement in the programme (Ferguson and Hogarth, 2018). Additionally, another evaluation of a social prescribing pilot programme in London found that the intervention reduced the rate of appointments made with a GP by 33% after three months of seeing a social prescribing caseworker (Health Dialogues, 2018).

Several studies have also identified other methods to improve opportunities to access mental health support through peer-led and/or community based mental health support such as community groups, mentoring, befriending, self-help groups, online communities and support groups, which can also promote education around managing mental health and wellbeing and encourage the development of people's community networks (Lyons, Cooper and Lloyd-Evans, 2021; Mind, 2022). For example, the *Creating Connections* pilot programme ran from 2014 to 2016 in Cardiff and Newport, reaching 206 single parents with an aim to improve the mental wellbeing, social function and self-esteem of single parents through peer-led group support. 83% of the parents involved achieved at least one of their goals set at the start of the pilot programme, which were related primarily to employment, education, or volunteering (Mental Health Foundation, 2017).

4.3 General Practitioners

Around 20% of patients visiting their general practice in the UK are attending for a primarily social as opposed to medical issue, such as financial difficulties or domestic abuse (Torjesen, 2016). Therefore, on an individual level GPs can reduce their patient's risks of offending by understanding and responding to the social determinants of health (which can also function as determinants of offending behaviours) by signposting patients to appropriate specialist health and social support services (The Health Foundation, 2018).

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Wider multi-agency, non-health services can provide GPs with additional prescribing offers that address social determinants of health, for example the Advice on Prescription service outlined in the case study presented in figure 5. GPs' utilisation of social prescribing options when treating patients can be an opportunity to refer patients to support that addresses issues relating to mental illness, isolation, engagement with services and wider socioeconomic problems such as debt or unemployment. Although social prescribing services may be run by community-based, third sector organisations, GPs can improve utilisation of these services by referring patients who are presenting issues related to social factors to a social prescribing service offering a social model of health, in order to improve the patient's health and wellbeing (SCIE, 2022a).

Figure 5. A Case Study: The Advice on Prescription service commissioned by Liverpool Clinical Commissioning Group in 2016 to address patients' social problems.

The Advice on Prescription service provided by Citizen's Advice Liverpool embeds income maximisation within GPs' prescribing offer across 50 health centres (Kerr et al., 2019). The service aims to alleviate poverty amongst patients with long-term physical health conditions and/or mental health problems to address the social determinants of health. Referrals to the service are made by GPs and mental health services directly, most commonly through primary care (80% of referrals are made by the patient's general practice); which highlights the significant role of GPs in identifying and responding to those in need of social support. Referred patients then receive support for an average of four different presenting issues; a presenting issue for over 50% of service users is benefits/tax credit advice, as well as debt for 12% and housing problems for 7.5% of service users (Duckworth and Mahoney, 2019).

The service reported that 20% of clients had at least one dependent child under the age of 18, and that approximately two thirds of this group were single parents (of whom 92% were women) (Duckworth and Mahoney, 2019). An evaluation of the Advice on Prescription service's outcomes between 2016 and 2018 found the following was achieved for referred patients:

- An estimated £6.7 million in collective income maximisation
- An average household income increase of £762
- £2.7 million of collective debt managed
- £157,200 of collective debt written off
- 77% of referred patients reporting that they feel they have improved their capacity to manage their health (physical and mental) (Kerr et al., 2019).

4.4 Brain Injury Support

There are multiple models of rehabilitation for those with a brain injury, whilst practitioners favour a holistic model in community settings. This model incorporates an awareness of peoples' dynamic relationship with their environment and injuries that impact psychosocial, cognitive and physical abilities to understand and respond to environmental factors (Wilkie *et al.,* 2021). Clinical neuropsychologists can help to treat cognitive, behavioural and emotional problems relating to a brain injury, for example through behavioural modification programmes to raise the patient's awareness of their behaviour if they are developing problematic behaviours such as aggression. CBT may also be utilised to support patients to learn coping mechanisms for emotional problems to improve mental health and wellbeing (Fleminger and Worthington, 2016).

A literature review of psychological interventions for patients with a brain injury found that the majority of relevant research (58% of publications) was conducted and published in the USA, CBT was the most widely used approach for treatment of clinical mental illness (41.9%) and neuropsychological interventions were rarely used (4.8%) (Gomez-de-Regil, Estrella-Castillo and Vega-Cauich, 2019). Therefore, it would be beneficial to increase the research outputs in this area with a focus on evaluating brain injury rehabilitation services in Wales to determine best practice and opportunities for improving national policy and practice.

The Stroke Association states that "rehabilitation services, such as physiotherapy, occupational therapy, psychological support and speech and language therapy, are vital for stroke survivors to make the best possible recovery" (The Stroke Association, 2020: 6). However, people in Wales are reportedly struggling to access rehabilitation services following a stroke and there are geographical inequalities in access to these services (The Stroke Association, 2020). Additionally, the national stroke rehabilitation pathway in Wales does not specify the details of a standardised multi-disciplinary approach to stroke patients' psychological rehabilitation, though several NHS brain injury rehabilitation services across Wales are adopting this approach in their service provision to those with brain injury (Betsi Cadwaladr University Health Board, 2022; NHS Wales, 2017; Swansea Bay University Health Board, 2022).

The Stroke Association has consequently recommended that the Welsh Government tackle the staffing problems experienced across rehabilitation services, as well as create national standards for rehabilitations services (The Stroke Association, 2020). For example, NHS England adopts a national standardised multi-disciplinary approach in community settings to psychological rehabilitation for people following a stroke that aims to ensure "accessible clinical psychology/neuropsychology services with stroke expertise, alongside wider, step-down emotional and psychological support pathways for all patients" (NHS England, 2021: 28).

Brain injury can also have a significant impact on the relationships, family and friends of the individual, which creates a need for offering family education, counselling and support to reduce distress as well as improve their ability to support the individual with a brain injury (O'Keeffe *et al.,* 2020; Tyerman and Booth, 2001). Therefore, to improve outcomes for people with brain injury in Wales there should be improved access to specialist interventions for cognitive, emotional and behavioural problems including both face to face and online options, an emphasis on developing national standards for multidisciplinary rehabilitation service teams, and accessible peer-support groups for the individual suffering from a brain injury and their relatives and friends (Fleminger and Worthington, 2016; Wilkie *et al.,* 2021).

… there should be improved access to specialist interventions for cognitive, emotional and behavioural problems including both face to face and online options, an emphasis on developing national standards for multidisciplinary rehabilitation service teams, and accessible peer-support groups …

A roundtable discussion held by The Disabilities Trust following the *'Making the Link'* report's publication, considered how essential it is for professionals to be adequately trained to offer emotional support during women's disclosure of TBI histories, which may involve the description of traumatic experiences. Key recommendations that followed the discussion were to:

- Ensure collaboration between experts in domestic abuse and brain injury to take the discussion forward;
- Further research the prevalence, impact and causality of brain injuries in survivors of domestic abuse;
- Further research and development of sensitive, and trauma-informed brain injury screening methods, which are appropriate for use with domestic abuse survivors;
- Deliver training and awareness raising initiatives to all professionals who engage with survivors about brain injury (The Disabilities Trust, 2020).

4.5 Multidisciplinary Teams

A growing evidence base supports the implementation of multidisciplinary teams (MDTs) to improve patients' care and outcomes, consequently the *Fit for the Future* report published in 2019 to illustrate the Royal College of General Practitioners' visions for general practices in 2030 supports the development of MDTs based in general practices (Royal College of General Practitioners, 2022). MDTs are a mechanism through which to meet the needs of individuals with complex health and social care needs, by a range of experts from different disciplines (including mental health and social care practitioners) reviewing and managing care, based in the community and linked up with primary care (SCIE, 2022b).

A systematic review of MDT collaboration in primary care found that 52% of the literature reviewed had reported positive results when comparing collaboration against the non-collaborative alternative across MDTs, whereas 16% reported no difference and 32% did not present a comparison (Saint-Pierre, Herskovic and Sepulveda, 2017). Additionally, the following benefits of MDTs to both team members and patients have been identified by the Social Care Institute for Excellence (SCIE), including how they:

- Enable professionals and practitioners from different backgrounds to communicate better about each other's roles and responsibilities;
- Improve communication and trust between team members;
- Promote more holistic and person-centred practice through joint assessments and care planning;
- Result in resources being used more efficiently through reduced duplication, greater productivity and pre-

ventative care approaches;
- Improve information-sharing across teams and with the service user
- Provide a single point of access through a key worker or named coordinator
- Improve people's engagement with and through social prescribing
- Facilitate rapid access to specialist expertise in the community, including urgent care in a crisis and at transitions of care
- Enable access to a range of community services that support wellbeing, self-management and prevention (SCIE, 2018; SCIE, 2022b).

Neighbourhood Teams piloted as primary care-based MDTs across Manchester provides a case study for the development and implementation of MDTs. Practice integrated care teams (PICTs) were initially developed by the council and clinical commissioning groups to address the increasing number of people with multiple health conditions and in low income households. The PICTs included GPs, social workers, practice and community health practitioners such as district nurses and case managers, as well as specialist teams available to be called upon when needed to address the specific needs of individuals and families. Key workers were also identified to support the coordination of care. Professionals were required to collaborate more closely with one another and adopt a more outcomes-orientated approach with the individuals concerned. The lessons learnt from the MDT pilots, such as the need for improved engagement with people and communities and improved connections between MDTs and voluntary sector services, aided the development of integrated neighbourhood teams within the local care organisation. These teams have adopted an 'asset-based' approach, which focuses on communities' skills and capacities. The teams also work with the voluntary sector to help people to improve their resilience, independence and wellbeing (SCIE, 2018).

4.6 Supporting Neurodiverse People and People with Learning Disabilities

Individuals with learning disabilities and/or neurodiverse conditions have been evidenced to be at significantly greater risk of coming into contact with the CJS than individuals without a learning disability or neurodiverse condition. The Local Government Association evaluated the stories of neurodiverse people who had made contact with the CJS for the Greater Manchester Combined Authority Health and Justice Group (Learning Disability and Autism). The steering group members were interviewed to identify key challenges and best practice to prevent neurodiverse people coming into contact with the CJS. This identified systemic pathway issues from diagnosis, diversion to support and treatment for those with a learning disability or neurodiverse condition but who are not Care Act eligible. For example, an interview found that there are "several examples in the Working for Justice group of people who with support have stayed out of trouble, but have gotten into trouble as budget cuts hit and their support reduced" (Local Government Association, 2021).

A multi-agency and person centred approach to meeting the social and health needs of vulnerable people should be adopted to avoid people coming into contact with the CJS as a result of not having had their support needs met. However, opportunities to support and improve the life outcomes of those with a learning disability or neurodiverse condition who are not Care Act eligible are often missed (Local Government Association, 2021). A six month creative solutions forum pilot was implemented in Plymouth that aimed to design an integrated and bespoke plan around a person with complex needs and high risk behaviours. The forum reports to the Adult Safeguarding Board and is composed of expert members from mental health, housing, drugs, police,

> ***A multi-agency and person centred approach to meeting the social and health needs of vulnerable people should be adopted to avoid people coming into contact with CJS as a result of not having had their support needs met.***

and alcohol services. The forum is used as a last resort where organisations can refer people presenting high risk behaviours for offending, where the organisational thresholds may be acting as a barrier to the individual receiving bespoke support. The forum pilot reviewed 52 cases (27 women and 25 men) that were largely referred by police. Of these 52 cases, 47 people who had high risk behaviours for offending showed a reduction in risk after support from the forum and 5 people were not followed up with due to moving location. The pilot also found a significant reduction in the use of emergency services by those referred to the forum, for example, one individual had gone from an average of three police or ambulance responses per day to zero response per day. Additional benefits of the forum were noted by the pilot evaluation, such as improving data sharing between agencies and focused learning for future commissioning and agency responses (Local Government Association, 2021).

4.7 Cultural Competency

Cultural competency by services that work with women is:

> ***"where professionals develop an understanding and awareness of the woman's culture and how the interaction between their professional practices and the woman's cultural practices can influence her progress… This does not mean professionals need to have a vast knowledge and understanding of every culture but be open to explore and recognise the importance of culture for the woman they are working with… demonstrating they are trying to understand the woman's experiences through that cultural lens"*** (Phillips, Miles and Smyth, 2022: 4).

Racial/ethnic minority women face multiple structural disadvantages that increase the prevalence of risk factors for offending. Although there is limited research exploring the extent to which risk and protective factors for women at risk of offending vary by race/ethnicity and cultural background. The impacts of the structural disadvantages that racial/ethnic minority women face in the UK are worsened by the lack of culturally competent support services available, as well as the lack of social support and health services with staff trained to respond to racial trauma (Prison Reform Trust, 2017b).

5. Case Studies

Case studies that explore the pathways to offending of women who have offended in Wales were collected to explore how the international evidence-base found through the literature reviews applies to women in Wales and identify opportunities for primary prevention and early intervention.

5.1 Case Study One

P1 was diverted away from the CJS to a diversion scheme provider as an alternative to the case going to court after being arrested for theft of drugs from her workplace, which was motivated by a mental health crisis linked to a bereavement. P1 identifies the mental health problems she experienced were in response to the death of her child. At the time of the offence, she didn't identify herself that she was having a breakdown in her mental health and so did not seek support, instead self-medicating through painkillers and cannabis. The offence leading to her diversion to the programme was the first engagement she had had with the police or CJS.

Before P1's referral to the diversion programme, she had been engaged with her GP because of a Post-Traumatic Stress Disorder (PTSD) diagnosis and sleeping pill prescription. During her mental health crisis preceding the offence she did not want to "bother them" since the COVID-19 pandemic was already straining services and she was conscious of their time. However, she felt that her medication needed increasing to address the worsening symptoms of her PTSD but could not get a face to face appointment with her GP. A conversation was instead held over the phone with a GP who increased her medication, though without consultation or support from her registered GP.

During her mental health crisis preceding the offence she did not want to "bother them" since the COVID-19 pandemic was already straining services and she was conscious of their time.

P1 was also referred to a councillor before having committed the theft offence, but there was an 8-10 week wait for the first assessment appointment. She waited and then attended 6 counselling sessions, though no more were offered and her offence was committed within a month of these 6 sessions having been completed. Counselling was through the local GP referral to the local mental health team (within a small practice with a high demand for the service). P1 had the counselling sessions every week, then every month; these sessions were completed and counselling ended one month before she committed an offence diverting her to the programme. She felt that if counselling had carried on then they would have been able to notice her struggling with her mental health and drug use problem in order to intervene. The sessions were also all held virtually without any face to face contact, which she felt compromised the benefits she was able to get from the sessions.

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P1 was re-referred to counselling after contact with the diversion scheme provider and was offered another 6 sessions. P1 completed the diversion programme within 6 months and at around the same time that her additional counselling sessions had been completed. This caused her to struggle as both avenues for support were closed at the same time and the situation that had caused her suicidal feelings were not fully addressed or dealt with. She felt that while the diversion programme should have been concluded, the counselling should have been continued. She noted that she thinks that her caseworker, GP and councillor should have been in communication to consolidate the support she was receiving from each professional, identify her needs such as requiring further counselling, and sharing key information regarding her mental health and circumstances.

P1 expressed she feels the diversion programme is so tailored and personalised to an individual that a strong bond is built as she feels understood, but then it ends relatively abruptly; would have liked to speak to them after the programme but did not want to bother them and is unsure of if this is appropriate. There was no referral made to follow-on support and P1 felt that she would like to attend a peer-led support group for people affected by mental illness and/or bereavement, but there are no community-based groups in her area.

5.2 Case Study Two

P2 was involved in an incident whereby her neighbours alerted the police to her young children wandering outside the front of the house unsupervised. When attending the property, police found P2 had drunk a significant amount of vodka and was asleep upstairs. She was arrested for neglect and was referred to the Women's Pathfinder Project by a Check Point Navigator. P2's referral was received during the Covid-19 pandemic, therefore all contact/support has been by telephone and email.

During the initial phone call between P2 and her diversion programme caseworker it was apparent that she had been struggling with her mental health for some time and it was advised that she should speak to her GP and request a Community Mental Health Team (CMHT) Referral. P2 was referred to a provider of drug and alcohol counselling to address her issues around alcohol and her mental health. She has completed an initial assessment with them and is being directed to the Therapeutic Intervention Team. However, it took a considerably long time for referrals to CMHT and CAIS to begin meaningful activity after undertaking an initial assessment, which may have been due to delays related to the Covid-19 pandemic. Further into the sessions, P2 disclosed financial difficulties and was referred to Citizen's Advice Bureau who have contacted her to discuss her financial situation.

… it took a considerably long time for referrals to CMHT and CAIS to begin meaningful activity after undertaking an initial assessment, which may have been due to delays related to the Covid-19 pandemic.

P2 continues to access support from the diversion scheme provider's service. To date, P2 has not committed another offence. She is addressing her financial situation and engaging with alcohol and mental health services. P2 has commented that she feels more confident and feels hopeful for the future. P2 has recently mentioned that she feels much more positive and feels like things are 'falling in to place' now that she is more open to support in various areas.

5.3 Case Study Three

P3 was involved in a car crash and subsequently taken to the local psychiatric hospital since police and hospital staff suspected that this had been a suicide attempt. P3 was also arrested for having cocaine in the boot of her car at the time. Following this offence, P3 self-discharged from the Psychiatric Unit on medication and was then referred to the diversion scheme provider who discussed the consequences of the offence with her and the impact it could have had on her future career.

P3 was in need of support with rent payments as she was in receipt of minimal Universal Credit due to advanced loans and substantial rent arrears. Therefore, referral routes were completed for P3 to firstly address past debt issues and to gain a Tenancy Support Officer with the Housing association. The caseworker also motivated P3 to make a claim for PIP due to her disabling mental ill health. She was also encouraged to chase up ongoing support from the local CMHT due to being discharged from the Psychiatric Unit with no ongoing treatment or support. It was apparent that since P3's partner had died that she was really struggling with her mental ill health to a point where no matter how many services were supporting

P3, she still found it very confusing and difficult to cope with everyday tasks and life-skills.

P3 stated she had never had to do anything whilst her husband was alive and was getting so confused with everything and could not remember what she needed to do, the more she tried to do, the more she struggled with her mental health. P3 has severe mental ill health and was only recently offered the most suitable medication for PTSD and manic mood disorder. This hindered the progress which was dependant on how P3 was able to manage the variation in mood swings, motivation, and depression levels. The caseworker felt that it would have been more productive to have offered support on a face to face basis but due to COVID-19 this was not possible. P3 was also finding the isolation of the COVID-19 lockdown very difficult to deal with.

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P3, with ongoing emotional support is managing to deal with her mental health and accepting of the treatment required from the Psychiatric Unit and CMHT. P3 stated that she would not have known about the Discretionary Housing Payments or the Debt Relief Order if this had not been discussed with her during the initial meeting and is grateful for this. P3 believed that if it had not been for the diversion programme addressing her lack of income and the high number of outgoings with her, she would be facing further financial difficulties. P3 had a more positive outlook for the future at the end of the programme, was more confident to speak to the various support providers, and has not re-offended.

5.4 Case Study Four

P4 was referred by a domestic abuse officer following an incident that occurred between herself and her daughter. Additionally to this, P4 generally finds communication a challenge due to previously experiencing a stroke. The Red Cross were involved with P4 before the referral to the diversion scheme. P4 has expressed her concerns regarding the lack of communication with the police as she felt they have not taken into account her communication issues and haven't taken the time to make sure information given has been understood.

P4 has expressed her concerns regarding the lack of communication with the police as she felt they have not taken into account her communication issues and haven't taken the time to make sure information given has been understood.

P4 attended her first appointment with a worker from The Red Cross. They spoke about the incident between P4 and her daughter and explained that they were not sure exactly what was going to happen regarding police involvement. P4 and her Red Cross worker expressed the need for her to have an advocate to support her with communication. Once referred to the diversion scheme provider it was agreed that communication would be through her Red Cross worker due to P4's difficulties with her speech. This meant that it was more challenging to arrange meetings or convey information.

P4's caseworker has sourced information about advocacy services in the area which has enabled a referral to be made. There have also been enquiries made to the police to gain further information about the domestic incident that triggered the referral originally. P4 continues to be supported by the diversion scheme provider's service and is thankful for the support.

5.5 Summary of Case Study Findings

All four case studies highlight mental illness as a significant causal factors associated with any offence that a women had disclosed. This echoed the findings of the literature review, which found evidence of significant associations between women's risk of offending and mental illness. There were three case studies that suggested that the participant was experiencing cognitive impairment related to a psychiatric disorders, such as PTSD, while committing an offence. Cognitive impairment linked to a brain injury also arose in the case studies as a causal factor for an offence. Additionally, financial difficulties including poverty and debt that had created significant psychosocial symptoms such as anxiety and stress were experienced by several of the women discussed in the case studies.

Substance use was also a common theme in women's pathways into offending, as well as the offence itself. Three out of four of the case studies discussed how the service user had used alcohol or drugs in order to cope with mental illness, which had also been directly involved with each of their offences. The death of an immediate family member was described by two women who participated in the research as being a key determinant of their substance use and poor mental health escalating to a crisis point. Bereavement did not appear as a theme within the literature review searches, however after a targeted search around this theme after the case study findings, literature was found (Vaswani and Gillon, 2019).

Poor access to local services, particularly mental health support services and GPs, appeared to significantly impact women's risk of offending in both the case studies and wider literature. The case studies highlighted an absence of timely connections being made between mental health support services or interventions and those in need in the community before a crisis point is reached. Additionally, the case studies discussed that women had attempted to arrange a face to face appointment with their GP and/or a counsellor but could not access one before reaching crisis point. There were four reasons identified in the case studies for why women struggled to or chose not to arrange an appointment with their GP for support before offending:

1. COVID-19;
2. Perceived resource and time restrictions of GPs;
3. A lack of available GP appointments;
4. Previous experiences of feeling unheard by their GP.

6. Discussion

This section will provide a summary of the findings of the literature review in respect of factors which have been identified as contributing in terms of women's pathways to offending and opportunities and initiatives for primary prevention and early intervention. The findings from the case studies will be discussed in the context of the wider literature base and the implications for policy and practice will be outlined. This section will also highlight the strengths and limitations of the study, the impact of COVID-19 on women's risks of offending and briefly highlight where there is a need for further research.

6.1 Literature Review Findings

The key factors influencing women's risk of coming into contact with the CJS that have been highlighted in the literature sit within the following themes: poverty; domestic abuse; ACEs; mental illness and substance use; brain injury; learning disabilities and neurodiversity; race and ethnicity. However, research findings commonly illustrated that these factors overlap across themes and interact, often exacerbating the severity of women's risks of coming into contact with the CJS within a complex, inter-connected web of cumulative causal factors. For example, financial difficulties were evidenced to increase women's risks of mental illness and offending, all of which were factors also evidenced to be worsened by intersectional experiences of racial/ethnic minority women, unmet support needs relating to learning disabilities and neurodiversity, or gender-based violence (DeHart *et al.,* 2013; McCarthy, Hunt and Milne-Skillman, 2016; Pemberton, Balderston and Long, 2019; Public Health England, 2021; Prison Reform Trust, 2017a; Prison Reform Trust, 2017b). Additionally, a mother's imprisonment can create a cycle of inter-generational offending. Children whose mother is in prison are often more exposed to several risk factors for the development of offending behaviours such as being in the foster care system, having a parent in prison, experiencing abuse and trauma in childhood, and having poor educational attainment (Kincaid, Roberts and Kane, 2019; Vince and Evison, 2021).

In terms of the opportunities for primary prevention and early intervention that were identified in the literature review to reduce risks of offending, these can be summarized within the following categories: primary prevention for children of women in the CJS; GPs; mental health services and interventions; brain injury support; MDTs; support for neurodiverse individuals and people with learning disabilities; cultural competency. These highlighted the need for cross-sectoral communication and working to deliver interventions to ensure the support needs of women who have had complex, intersectional experiences and backgrounds have their support needs met, and prevent women from developing preventable risk factors for offending. Interventions were also identified for the primary prevention of offending amongst children whose mother is in prison, such as peer support groups, mentoring, support for children's carers, and awareness training for staff that children come into contact with.

6.2 Case Studies Findings

The case studies evidenced the following factors present in women's pathways to offending: mental illness, substance use, brain injury, bereavement, financial difficulties and poor access to health and social support services. The case studies also evidenced opportunities for early intervention amongst women who have offended in Wales, which suggests there is a need for reform in policy and practice across sectors to align with the best practice identified in the literature review. For example, findings supported evidence found in the literature review that a lack of referrals and communication between services, professionals and practitioners before offences were committed as well as during the diversion scheme may be worsening the preventable escalation of individuals' health and social problems that have associations with higher risks of offending. Therefore, improvements should be made to service accessibility and

person-centred outcomes, which may be achieved through the evaluation and expansion of existing specialist services, programmes, and targeted interventions, as well as adopting MDTs and ensuring cultural competence across services.

6.3 Strengths and Limitations of the Study

The case studies supplemented the literature review to provide insight into how the international evidence base applies to women in Wales' pathways to offending and accessing support, as well as the opportunities for primary prevention and early intervention that highlight a need for targeted improvements to policy and practice. However, a limitation of the case studies is that the sample size was small, and it was not possible to identify or evaluate who is represented in the data collected. Participants in each case study were not asked, and did not disclose, their race/ethnicity, ACEs, experiences of domestic abuse or whether they had any known learning disability, neurodiverse condition or brain injury, which limited the studies ability to evaluate the influence of all the risk factors for women's offending identified in the literature. Case studies were also gathered from only two geographical areas, so research was not able to provide insight into early intervention and prevention experiences within different regions of Wales. A larger number of case studies and case studies from each geographical area of Wales would have improved the quality and scope of the study. In addition, the women involved in the case studies were first time offenders, therefore the perspective and experiences of women who have committed repeat offences were not included.

6.4 COVID-19 Impacts

The public health measures introduced in response to the COVID-19 pandemic including national lockdowns worsened unemployment rates and lowered many household incomes, which have in turn increased household debt and rates of poverty (Blundell *et al.,* 2020; Citizen's Advice, 2021; Waters and Wenham, 2021; Mitha, 2020). The pandemic worsened experiences of adversity, and increased the prevalence of ACEs, mental illness and psychological distress (Addis *et al.,* 2021; Davillas and Jones, 2021; Office for Health Improvement and Disparities, 2022), with poor mental health reported to have most impacted young women during the COVID-19 lockdown in May 2020 (Henderson *et al.,* 2020; Kwong *et al.,* 2020). The prevalence of acts of domestic violence and sexual violence were also reported to have increased during the pandemic, with higher rates of victimisation being amongst women and girls (Bradbury-Jones and Isham, 2020; Criminal Justice Joint Inspection, 2022). Therefore, the COVID-19 pandemic has been evidenced to have exacerbated the prevalence and worsened the outcomes of many of the factors identified to negatively influence women's risks of offending.

Additionally, the increased barriers to accessing services and face to face appointments with health professionals, particularly GPs, have reduced opportunities for identifying and responding to women's needs for early intervention that could prevent offending (BMA, 2020). The increase in the prevalence of the risk factors discussed and other negative consequences of the COVID-19 pandemic such as increased barriers to accessing health and social services have also disproportionately impacted people facing structural disadvantages, particularly racial/ethnic minority people (UK Government, 2021) and people with a learning disability (Mencap, 2020). Therefore, the COVID-19 pandemic has worsened inequalities in and the prevalence of risk factors for offending, particularly amongst structurally disadvantaged women.

6.5 Implications for Policy and Practice

The research has highlighted several important gaps in our knowledge around women who offend in Wales and the evidence base to inform the development and targeting of successful primary prevention and early intervention initiatives to prevent offending. In particular, further research is required to fill the current gaps in the Welsh context around factors in women's pathways to offending and the related primary prevention and early intervention

opportunities to address each risk factor *(see Appendix 1 for further details)*. For example, efforts should be made to improve the accuracy in the data collected around race/ethnicity of women in the CJS, as well as data recording the prevalence of learning disabilities, neurodiverse conditions and brain injury through improved screening and diagnostic processes for women in the CJS and in the community to highlight support needs and intervention opportunities.

Primary prevention and early intervention opportunities identified in the literature review have the following implication for policy and practice within each key theme:

Primary Prevention for Children of Women in the CJS – reduce the negative impacts of maternal imprisonment and promote protective factors such as educational attainment and social inclusion through specialist support for families of women in the CJS, particularly their children, for example through raising the awareness and confidence of education staff in identifying and supporting children who have mothers in prison;

GPs – ensure GPs receive gender-informed training to better understand the health and vulnerability pathways into offending for women, are identifying and signposting patients presenting social issues impacting their health and wellbeing, and are utilising social prescribing options to address patient needs;

Mental Health Services and Interventions– improve access to mental health services and treatments, as well as community-based and peer-led support, and improve the provision of lower level mental health support to reduce escalation in to more complex mental health needs and demand on specialist mental health services;

Brain Injury Support – support people to address cognitive, behavioural and emotional problems relating to a brain injury by improving access to psychological interventions, legislate a national standard for brain injury rehabilitation support services, and ensure gender-informed screening tools are used to identify needs;

MDTs - development of MDTs composed of a range of experts from different disciplines based in general practices to meet the needs of individuals with complex health and social care needs

Support for Neurodiverse Individuals – improve the identification and support offered to neurodiverse individual including both those who are and are not Care Act eligible, using ensure gender-informed screening tools;

Cultural Competency – services that women come into contact with before the CJS should train staff to have cultural competency in order to enable staff to be responsive to the needs and experiences of racial/ethnic minority women, promote equity in outcomes of women accessing their services and avoid re-traumatisation of women being supported.

7. Conclusions

The research identified several potential factors that influence women's pathways to offending within a review of wider national and international literature and case studies with women who have offended in Wales.

In the literature review, these factors included financial problems, ACEs, mental illness, domestic violence and sexual violence victimisation, substance use, bereavement, brain injury, learning disabilities and neurodiversity, and racial-ethnic marginalization, whereas in the case studies these factors included financial problems, mental illness, substance use, bereavement, and brain injury.

Early intervention and primary prevention opportunities and approaches to prevent offending have also been identified in this study through both the literature review and case studies, such as interventions that seek to address the social determinants of health and improvements to the accessibility of mental health services and a range of support and treatments options. Additionally, a whole systems approach centred around and led by women-focused services such as those involved in the Women's Pathfinder have been evidenced in the case studies to successfully prevent women in Wales from re-offending and divert them sustainably away from the CJS.

8. Appendices

Appendix 1. The gaps and need for further research in women's risk factors for offending and primary prevention and early intervention opportunities in the Welsh context.

Risk Factor	Gaps in research in Wales
Poverty	• The extent to which initiatives and policies targeting poverty would reduce the social and economic costs of women entering the CJS, as victim, perpetrator, or both. • The alternative approaches that could be adopted to TV licence evasion convictions that would take into account the shared household responsibility for the offence and financial difficulties often underpinning it • Opportunities to identify and signpost patients to support services who are presenting finance-related issues that are impacting their health and wellbeing at their general practice
Domestic Abuse	• An understanding of the prevalence of domestic abuse victimisation amongst women entering the CJS or whole system approach initiatives that seek to address the root causes of women's offending • An evaluation of the impact of various services' staff training to identify and understand how experiences of domestic abuse may contribute to the risk of women coming into contact with the CJS
ACEs, Mental Illness and Substance Use	• The mental health, ACE and trauma background of women that have offended in Wales • The extent of gendered variances in definitions and perceptions of different mental illnesses that are used to self-identify whether they have a mental illnesses or related symptoms • The training staff across services receive to enable a gender-informed approach to support women who have offended or who are at risk of offending that present symptoms of mental illness • The extent to which mental health assessments and support for women and girls in the community at risk of offending is being offered before contact is made with the CJS and the outcomes of these interventions • The existing use and opportunities for implementing MDTs • GPs awareness and referral rates of social prescribing options • The geographical inequalities in access to local mental health and substance use services and interventions • The presence and outcomes of peer-led mental health support in communities • The cultural competency of mental health services, professionals and interventions
Brain Injury	• The existing services offering support to women with brain injury, their impact and the extent to which these services are collaborating across sectors including criminal justice • The screening processes of brain injury amongst women in the community and the opportunities for early detection and treatment of brain injury in women • The prevalence, impact and causality of brain injury amongst female offenders • The extent to which earlier brain injury diagnosis and support reduced the risks of offending • If and how staff are trained to be trauma-informed when engaging with women with TBI who are survivors of domestic abuse • The benefits of developing a national standards for multidisciplinary rehabilitation service teams
Learning Disabilities and Neurodiversity	• The opportunities to screen and diagnose neurodiverse conditions to offer support for individuals before any contact with the CJS is made • Research and investment into the development of effective gender responsive services and programmes working at the intersection between services for neurodiverse women, and education, health, social care and CJS services • The presentation and prevalence of neurodiverse conditions in women • Validated screening and diagnostic tools for use with women to identify neurodiverse conditions and women's individual needs • The understanding staff in the CJS have of the needs of people with learning disabilities and neurodiverse conditions and the support that could be offered to them • The different presentation and outcomes of the direct impacts of a neurodiverse condition on offending behaviours, in comparison to the impact of the unmet underlying needs of neurodiverse individuals such as mental illness or social exclusion
Race and ethnicity	• An intersectional understanding of offending pathways for women of different races and ethnicities • The difference in the needs, access to support, and touchpoints with services that women from different racial and ethnic backgrounds have prior to making contact with the CJS • Data recording of racial/ethnic minority women's experiences, outcomes and representation across the CJS • The cultural competence of services that women might access prior to making contact with the CJS

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