Understanding drivers of the impact of diversion programmes and community mental health interventions on women's incarceration and wellbeing: a realist approach

Charlotte Brady

Thesis Submitted for the Degree of Doctor of Philosophy

UCL

2024

Declaration

I, Charlotte Brady, confirm that the work presented in this thesis is my own. Where information has been derived from other sources, I confirm that this has been indicated in the thesis.

Signed: Charlotte Brady

Word count (exclusive of abstract, impact statement, contents, tables and figures lists, glossary, acknowledgements & reference list): 86,516

Abstract

Background: The incarceration of women with mental health conditions has complex roots in multiple disadvantage and intersectionality. As the ‘criminalisation of mental health’ has attracted attention globally, several interventions, including ‘diversion programmes’, have been designed to direct women away from the criminal justice system and into health and social care systems. For diversion to achieve intended outcomes, both the diversion programme and the health and social care mechanisms need to function effectively, as an integrated system of tailored support. The aim of this PhD was to understand, for both of these areas of intervention, what works, in which contexts and for whom.

Methods: The project was guided by realist methodology and underpinned by intersectional and feminist theory. I organised my approach in two parts. First, I synthesised the available evidence on the effectiveness of diversion programmes using a realist methodology, to get a deeper understanding of the contexts and mechanisms that drive effectiveness of diversion programmes. Second, I undertook a realist evaluation of a community-based intervention named "It Takes A Village" (ITAV). ITAV represents an ambitious approach to working across systems to deliver integrated, interdisciplinary care in a London borough, for women with complex needs who are risk of incarceration and recidivism. The realist review of diversion programmes allowed me to develop an understanding of what works, in which contexts and for whom in the context of diversion, which I used to inform the design of my realist evaluation. Within the evaluation I applied case study methods to the realist evaluation cycle to explore the everyday workings of ITAV and define an explanatory model for the intervention. I completed 33 interviews with professionals, 13 interviews with service users, 74 hours of observation and 41 meetings over the course of 18 months. I used thematic network analysis to analyse qualitative data.

Results: The realist review highlighted four essential principles: that successful diversion requires connections and coordination between services across the healthcare system; that the development and maintenance of relationships should be incorporated within programmes to maximise their effectiveness; that major risk factors for recidivism remain relevant for offenders whether or not they have mental illness; and that diversion programmes provide an opportunity for stabilisation of an individual’s life, and effective programmes should enable this. The realist evaluation of the community-based intervention highlighted three complementary principles:

effective service provision requires a developed understanding of women with complex needs; service users need to feel heard and supported by services to build trust in the system and foster engagement; and appropriate service delivery for women with complex needs relies on flexible, cross-agency collaboration.

Conclusions: The women directly involved in my research had slipped through the cracks in the system at multiple junctures and all required greater access to appropriate support. This was exacerbated by the lack of funding directed towards services, which drives a focus on firefighting when women are in crisis, rather than investing in preventative measures or treatment at earlier points of potential intervention. Two findings have practical implications. Firstly, designing effective diversion programs requires a critical focus on the 'system' element. Identifying and diverting women with complex needs from the criminal justice system is insufficient without a comprehensive system addressing their underlying issues. Secondly, support systems should be tailored to individual needs, emphasising flexibility rather than rigid pathways. This involves expanding eligibility criteria, improving service coordination, and implementing proactive, preventative outreach before a woman reaches a point of crisis. Further research is required to understand intersectional and gender-responsive considerations in the development of programmes designed to support women with complex needs.

Impact Statement

This PhD has resulted in contributions to the fields of programme evaluation and realist methodology, enabling meaningful improvements in diversion programs and systems change interventions. Through evidence synthesis of the drivers of effectiveness or diversion programmes, and the development of a programme theory for a UK-based service change intervention, this work has improved the evidence available to programme designers and policy makers. Contributions to the application of methodologies in the realm of realist evaluation approaches, have paved the way for more comprehensive and dynamic evaluations, offering a deeper understanding of drivers of programme effectiveness and facilitating evidence-based decision-making. Our work has far-reaching implications, with potential applications beyond our specific programs, ensuring a lasting impact on future systems change initiatives.

The following are examples of the specific contributions of this work.

- Publication of an Evidence Synthesis: The publication of the realist synthesis of the effectiveness of diversion programmes, provides programme designers and policy makers with a valuable resource to inform and improve their diversion programs. By consolidating existing knowledge, identifying best practice, and highlighting gaps in the current literature, this synthesis offers evidence-based recommendations and paves the way for more successful and impactful diversion programs.
- Development of a programme theory for a service change intervention based on a realist evaluation: Recognising the need for a programme theory that allows for ongoing evaluation of a live systems-change programme, I have developed a robust framework to articulate the drivers of effectiveness for a boundary-spanning intervention. Although specific to the intervention that has been implemented in London, this model is adaptable, designed to identify causal mechanisms, and capture contextual factors that drive programme outcomes, so could be used as the initial programme theory for realist evaluations of similar interventions. By providing evaluators and practitioners with a robust model for the ongoing evaluation of systems-change efforts, more informed decisions can be made more rapidly, to continuously improve the effectiveness of their initiatives.

- Synthesis of early Indicators of success and challenges of the ITAV intervention: Aligned to my aim of fostering real-time improvements in active programmes, I have developed and intend to present to programme staff my findings of key indicators of success and challenges related to ITAV, a live systems-change intervention. By reporting back on these indicators, I'm enabling the programme managers and decision-makers to proactively identify areas that require intervention or adjustments. This iterative approach promotes continuous learning, facilitates data-driven decision-making, and maximises the potential for programme success.
- Contribution to Methodology Development - Realist Evaluation Approaches: I have built upon existing realist approaches through i) applying realist evaluation techniques to live programs; and ii) building on how realist approaches can interact with case study frameworks.

Overall this PhD contributes to programme design and methodological approaches in the context of women, mental health and criminal justice, through the publication of an evidence synthesis, producing a programme theory for the ITAV intervention (for use in the ongoing evaluation of ITAV, and with potential application to other similar interventions), developing early indicators related to the ITAV intervention, and the development of realist evaluation approaches and application. The knowledge and tools I have provided could empower stakeholders to make data-driven decisions, enhance program effectiveness, and ultimately improve outcomes for those who engage with diversion programs and systems change interventions.

Contents

List of tables

List of figures

Glossary

Term	Definition
Agency	The capacity of individuals or groups to act, make choices, and exert influence within their social and cultural contexts, often shaped by the constraints and opportunities they face.
Boundary-spanning services	Boundary-spanning services refer to activities and functions that bridge the gap between different entities, organizations, or sectors, facilitating communication, coordination, and exchange of information or resources.
Context	The “backdrop” of programmes and research. Examples of context include cultural norms and history of the community in which a program is implemented, the nature and scope of existing social networks, or built program infrastructure. They can also be trust-building processes, geographic location effects, funding sources, opportunities, or constraints. Context can thus be broadly understood as any condition that triggers and/or modifies the behaviour of a mechanism.
Context-Mechanism-Outcome configurations	A statement, diagram or drawing that spells out the relationship between particular features of context, particular mechanisms and particular outcomes.
Criminal justice system	The system of institutions, laws, and procedures that are designed to detect, prosecute, and punish individuals who have engaged in criminal behaviour, including law enforcement, courts, and correctional facilities.
Criminality	The quality or state of being involved in criminal behaviour, typically referring to the engagement in activities that are deemed illegal or prohibited by law.
Criminogenic risk factors	Factors or characteristics that increase the likelihood of an individual engaging in criminal behaviour or experiencing recidivism, such as a history of substance abuse, lack of education, or limited social support.

Criminology	The scientific study of crime, criminal behaviour, and the social, psychological, and environmental factors that contribute to the commission of crimes.
Demi-regularity	Demi-regularity means semi-predictable patterns. The term was coined by Lawson (1997), who argued that human choice or agency manifests in a semi-predictable manner - “semi” because variations in patterns of behaviour can be attributed partly to contextual differences from one setting to another.
Deterrence	The use of punishments, such as imprisonment or sanctions, to discourage individuals from engaging in criminal behaviour by instilling fear of consequences.
Diversion programmes	Programmes designed to divert individuals away from the traditional criminal justice system and towards alternative interventions or treatments.
Dynamic risk factors	Risk factors that can change over time and have a direct influence on an individual's level of risk for engaging in certain behaviours or experiencing negative outcomes. Unlike static risk factors, which are relatively stable and unchangeable (such as age or gender), dynamic risk factors can be modified through intervention or changes in the individual's circumstances or behaviour.
Essential principles	Thematic clusters of hypotheses.
Evaluation framework	A conceptual framework or model that guides the realist evaluation process and helps to organize the data collection, analysis, and interpretation of findings.
Evidence synthesis	The process of systematically reviewing and synthesizing existing research studies and other relevant evidence to draw conclusions and generate new insights.
Feminist theory	A body of theory that critically examines and challenges the social, political, and cultural structures that perpetuate gender inequality, and seeks to promote gender justice and equality.
Gender	A social construct that encompasses the roles, expectations, and behaviours associated with being male or

	female, and how these roles are shaped by social, cultural, and historical contexts.
Hypotheses	A logical supposition, a reasonable guess, an educated conjecture. It provides a tentative explanation for a phenomenon under investigation." Hypotheses can be developed and used at many levels in realist research – for example, hypotheses about the main ideas in program theory, about mechanisms, about the aspects of context that will influence whether and how mechanisms work.
Intersectional analysis	An approach that examines how multiple social identities intersect and interact to produce unique experiences of oppression, privilege, and power.
Intersectionality	A theoretical framework that recognises and examines how different social identities, such as race, gender, class, and sexuality, intersect and interact to shape individuals' experiences and social inequalities.
Mechanism	Underlying entities, processes, or structures which operate in particular contexts to generate outcomes of interest.
Middle range theories	A theory that is specific enough to generate hypotheses (for example in the form of propositions) to be tested in a particular case, or to help explain findings in a particular case, but general enough to apply across a number of cases or a number of domains.
Oppression	The systematic mistreatment, marginalization, and disadvantage experienced by certain social groups based on their social identities and structural inequalities.
Outcome	A result or consequence.
Power dynamics	The ways in which power is distributed, exercised, and contested within social, political, and interpersonal relationships, often shaping social hierarchies and inequalities.
Programme theory	The theory about what a program or intervention is expected to do and the theory about how it is expected to work. Realist program theory goes a little further and includes descriptions of contexts, mechanisms and outcomes

Realism	‘Realism’ refers to a philosophy of science. It sits, broadly speaking, between positivism (‘there is a real world which we can see and understand directly through observation’) and constructivism (‘given that all we can know has been interpreted through human senses and the human brain, we cannot know for sure what the nature of reality is’). Realism agrees that there is a real world and that our knowledge of it is processed through human senses, brains, language and culture. However, realism also argues that we can improve our understandings of reality because the ‘real world’ constrains the interpretations we can reasonably make of it. While our knowledge will always be partial and imperfect, it can accrue over time. Below, we introduce key ideas in realist philosophy, how they apply to social programmes and what they imply for the role of researchers and reviewers.
Realist evaluation	An approach to evaluation that focuses on understanding how and why interventions work or don't work in specific contexts by exploring the underlying mechanisms and contextual factors.
Realist review	A systematic approach to evidence synthesis that focuses on understanding the underlying mechanisms and contextual factors that contribute to program outcomes.
Recidivism	The relapse or return to criminal behaviour by individuals who have previously been involved in criminal activities and have completed a period of punishment, such as incarceration or probation.
Re-entry	The transition process that individuals undergo when they are released from incarceration and reintegrate into the community, often involving challenges related to employment, housing, and social support.
Rehabilitation	The process of assisting individuals involved in criminal behaviour to address the underlying causes of their criminality and reintegrate into society in a law-abiding manner.

Social identities	The various aspects of an individual's identity that are shaped by social, cultural, and political forces, such as race, ethnicity, gender, class, sexuality, and disability.
Systems change intervention	An intervention designed to bring about systemic changes in a complex social or organizational system by targeting multiple interrelated components or factors.
Theoretical framework	A conceptual framework or model that guides the realist review and helps to explain the interactions between context, mechanisms, and outcomes in diversion programmes.
Trauma-informed approach	A trauma-informed approach is a framework for understanding and responding to the needs of individuals who have experienced trauma. It recognises the widespread impact of trauma on physical, psychological, and emotional well-being and emphasises creating a safe and supportive environment for healing and recovery.

Acknowledgements

‘If you've got my back, I'll go on.’ – Frank Turner

First, I’d like to thank my supervisors, Rochelle Burgess and David Osrin. I will be forever grateful for your mentorship and guidance throughout my PhD. Your expertise and encouragement have been invaluable, and I could not have got to this point without your help. I am thankful for your kindness, guidance, and challenge, to push me beyond my comfort zone and improve my work as a result. I hope to be fortunate enough to work with you in the future as I move forward in my career.

Second, to the caring, inspirational women who participated in my research. Sharing your stories was not always easy, and I am thankful for the trust you placed in me to do so. You have taught me a great deal about your lives and experiences, but also about myself, the world we live in, and the importance of supporting each other. I truly hope that the knowledge gained from this research can contribute to improving the lives of women in meaningful ways. Thank you once again for your participation, and for your contribution to this work.

To my colleagues and 'frolleagues’ at the Wellcome trust, for your flexibility, compassion, and friendship. I am grateful for your endless understanding when I have had to rearrange meetings and workloads to accommodate my PhD, and for being such supportive and caring co-workers. A specific mention must go to Tim Jinks, for enabling me to take on this challenge. I can confidently say I would not have got to this point without your belief and encouragement.

Special thanks are reserved for my family and friends. To my parents Julia and Kevin Chapman, for your unwavering support. Thank you for your guidance, your patience, and your love. My brother Tom Chapman, a ‘five star man’ whose interest in my research has been a real source of motivation. It is not always easy to explain the complexities of a PhD, but you have always taken

the time to understand what I'm working on and ask thoughtful questions. My cats Frank and Bruce, who had a terrible impact on my productivity but a delightful impact on everything else. The Brady bunch, for being consistently supportive, caring and welcoming me into your family. My fantastic friends, who beautifully balanced the stress of my PhD by being a consistent source of fun, laughter, and general distraction. In particular, the wonderful Sophie Carton, who I cannot imagine having gone through this – or frankly anything - without.

Finally, to my amazing husband Scott. I hope you already know how deeply I appreciate everything you have done for me, both throughout this PhD journey and beyond. I unequivocally could not have done this without your unwavering support, from taking on more than your fair share of our life admin, to the emotional support you have given me on countless occasions. I am forever grateful to have you as my partner, someone I can always rely on. You bring the perfect mix of selflessness and silliness, and I look forward to sharing many more adventures with you.

Chapter 1 Introduction

This is a thesis about women with mental health conditions who have been - or are at risk of being - in contact with the criminal justice system. The focus is on how to reduce incarceration and provide appropriate treatment to improve outcomes related to wellbeing and offending behaviour, through promoting a more holistic approach to treatment and support.

I introduce the thesis by providing an overview of the intersections between mental ill-health, gender and criminal justice. I introduce the context to these fields, describing the research questions to be addressed and summarising how I applied realist methods to do so.

1.1 Context

Worldwide, more than 10 million individuals are in prison at any given time and more than 30 million circulate through prison annually (Fazel 2016). The link between incarceration and mental health conditions is now drawing attention globally, with increasing concerns around the detrimental impact of incarceration and the lack of mental health interventions adapted for prisons, alongside policy issues including overcrowding and other failures to meet human rights in prison settings (Fazel 2016).

Evidence suggests that incarceration results in a deterioration in mental well-being through factors including overcrowding, isolation and subsequent impacts on levels of stress and distress (Holmes and Rahe 1967, Hayes 1989, Joukamaa 1997). Rates of mental illness during incarceration have been found to be higher among women than men. Women are at greater risk of receiving a mental health diagnosis while incarcerated (James 2006, Al-Rousan, Rubenstein et al. 2017), and diagnosis describes a wider variety of mental disorders (Al-Rousan, Rubenstein et al. 2017). Studies comparing men and women have found that mental health disorders are more common in women, with odds ratios of 2–3 times those in men in prison samples (Maden 1990, Teplin 1990, Teplin 1990, Teplin 1996, Steadman, Osher et al. 2009). This suggests that women inmates may face different concerns to men and, as a result, have different needs.

We also know that mental health conditions correlate with other types of disadvantage. In England, around 40% of people who experience contact with the

criminal justice system, homelessness and substance misuse in a given year also have a mental health problem (Foundation 2015). Individuals with multiple needs have often been exposed to additional forms of trauma, which may result from neglect, psychological abuse, physical abuse, sexual abuse during childhood, community violence, domestic violence and abuse, combat-related trauma, and disasters (Hopper, Bassuk et al. 2009). Trauma may impact a person's capacity for coping, as well as their sense of safety, ability to self-regulate, their sense of self, perception of control and self-efficacy, and interpersonal relationships (SAMHSA 2014). Lived experience of trauma and homelessness have also been shown to lead to reluctance to accept interventions (Magwood, Leki et al. 2019). As such, without treatment in other settings (e.g. health and social care) diversion from the criminal justice system may succeed in - at least temporarily - keeping a woman with a mental health condition out of prison, but not in addressing the underlying issue(s) behind the offending behaviour. The fact that women with mental health conditions who come into contact with the criminal justice system often have multiple support requirements and interdependent needs expands the issue of mental health and incarceration beyond the criminal justice systems, and it is insufficient to think of the incarceration of these women as solely an issue of reducing rates of imprisonment.

There has been an increased focus on developing mental health interventions for prison populations—particularly in high-income countries—including pre-arrest diversion services, mental health referral while incarcerated, and mental health provisions on release (Forrester, Till et al. 2018, Bird and Shemilt 2019). However, diversion programmes and the provision of appropriate treatment and support are particularly complex given the challenges in engagement and the need for cross-system, multidisciplinary structures and practices. There is variation in effectiveness of programmes aiming to do this, and limited understanding of how to operationalise interventions to effectively support this population (Broner, Lattimore et al. 2004, Sirotich 2009, Lange, Rehm et al. 2011, Bonkiewicz, Green et al. 2014).

1.2 Purpose and structure of thesis

The thesis makes a contribution by synthesising and increasing the limited evidence base around diversion and mental health programmes for women with complex needs and experiences of trauma. This evidence is required to support and enable the delivery of more effective mental health interventions and diversion programmes for women in the UK and globally. However, a limitation of the literature is that evidence

is most commonly focused on high-income countries, which has resulted in the high-income country focus of my research. Specifically, the thesis aims to contribute evidence around why interventions aimed at supporting women with complex needs are effective for some but not others, by reviewing what works to improve their outcomes, how change happens and under which contexts.

My work is rooted in a realist evaluation of one such intervention, *It Takes A Village ("ITAV"*), which has been developed in a central London borough and represents an ambitious approach to working across systems to deliver integrated, interdisciplinary care for women with complex needs, some of whom have experiences of incarceration. In an environment where funding for support services is being squeezed, services need robust evidence on how interventions are implemented and the impact – if any – that they have, so an evaluation was required to understand and demonstrate impact. ITAV is a live intervention, primarily focused on achieving systems change. Because this takes time to have material impact the research project had two key objectives. The first was to develop an overarching programme theory for the intervention, which describes how ITAV as an intervention may achieve impact, for whom and within which contexts, and can be used to evaluate ITAV over a longer period. The second was to undertake a preliminary synthesis of the evaluation, to identify whether there was evidence that ITAV was making progress towards its aims. Throughout this evaluation, my goal was to provide evidence of the factors that either enable or hinder the effective functioning of the programme, as well as suggest potential improvements.

1.2.1 Research questions

Two Primary Research Questions structured the project:

1. How do the key mechanisms associated with the delivery of interventions that include diversion as a component interact with contextual influences and with one another to explain the successes, failures and partial successes of diversion programmes as an intervention to improve the outcomes of women offenders with mental health conditions?
2. How does the operationalisation and implementation of an intervention aiming to deliver integrated, interdisciplinary care for women in a London borough influence the outcomes of women with multiple disadvantage who

are at risk of coming into contact with the criminal justice system, within which contexts and for whom?

Primary Research Question 1 was addressed through a realist synthesis of the available literature on diversion programmes globally. Primary Research Question 2 was addressed through a realist evaluation of ITAV.

The component questions related to the Research Questions are articulated within the overarching structure of my research questions in Figure 1.

Figure 1: Structure of research questions

Primary research question 1:
How do the key mechanisms associated with the delivery of interventions that include diversion as a component interact with contextual influences and with one another to explain the successes, failures and partial successes of diversion programmes as an intervention to improve the outcomes of women offenders with mental health conditions?

Component research questions:

- What are the active strategies used in diversion programmes?
- What are the important contexts that determine whether mechanisms produce their intended outcomes?
- How are the experiences and needs of those with mental health issues met through diversion programmes?
- How do organisational and system contexts influence implementation of diversion interventions?

Primary research question 2
How does the operationalisation and implementation of an intervention aiming to deliver integrated, interdisciplinary care for women in a London borough influence the outcomes of women with multiple disadvantage who are at risk of coming into contact with the criminal justice system, within which contexts and for whom?

Component research questions:

- How, if at all, does service use change following implementation of ITAV?
  - Who does service use change for?
  - In which contexts does service use change?
  - Through what mechanisms does this change happen?
- How, if at all, does service delivery change following implementation of ITAV?
  - Who does service delivery change for?
  - In which contexts does service delivery change?
  - Through what mechanisms does this change happen?

1.2.2 Thesis structure

The thesis has nine chapters. The first three chapters provide an introduction to the topic and a summary of relevant theory, five outline methods and results, and a final chapter concludes by summarising findings and discussing potential areas for future research.

Chapter 2 Literature review

2.1 Introduction

In this chapter I present a review of key concepts that structure the thesis. This work is differentiated from the later realist review, as it is not structured by a particular methodology, but serves the purpose of creating a deeper understanding of context, linked to my application of case study and realist methods (see Chapter 4 for description of these methods).

The key areas of focus in this chapter are women, deterioration of mental health, increased recidivism in some individuals and the personal, social, and financial costs to communities. Here I discuss why the linkage between mental health conditions and women at risk of incarceration requires attention. I provide background to the issues surrounding mental health conditions in the criminal justice system and current efforts to address them. I also describe the high prevalence of mental health conditions within prison populations and their variability across geographic contexts and the impact of incarceration. I discuss the gendered nature of incarceration and mental health in relation to risk factors for offending, the impact of incarceration, and the knock-on impact that incarceration has on an individual's role as a caregiver. I discuss multiple disadvantage and treatment availability for this group. Finally, I discuss the resultant proposition of interventions, which take numerous forms with differing levels of effectiveness.

2.2 Mental health conditions in prisons

This section of the thesis provides a summary of evidence related to mental health conditions in the context of the criminal justice system. Unless otherwise specified, these figures incorporate all genders. This is because the most comprehensive evidence is often either aggregated or focused solely on men, as men constitute a larger proportion of the incarcerated population and most research and data collection efforts in the criminal justice system have focused primarily on male inmates. I follow this with a section on women in the criminal justice system, which is more specific to the population being studied in this PhD.

Evidence suggests a clear linkage between the existence of a mental health condition - or conditions - and being incarcerated (Fazel 2016). It also suggests that

incarceration results in a deterioration in mental well-being (Hayes 1989, Joukamaa 1997, Fruehwald, Matschnig et al. 2004, Humber, Webb et al. 2013), exacerbating the issue in a context where there is a lack of mental health interventions adapted for prisons (Fazel 2016).

While rates vary across global settings, prevalence of mental health conditions is common in prison settings everywhere. North American (USA and Canada) studies of sentenced prisoners have reported overall current prevalence of mental health conditions of 46–88% (Bland, Newman et al. 1990, Chiles, Cleve et al. 1990, Coté and Hodgins 1990, Jordan, Sclenger et al. 1996, Brink, Doherty et al. 2001, James and Glaze 2006, James 2006, Wilper, Woolhandler et al. 2009, Al-Rousan, Rubenstein et al. 2017). In Europe, estimates of overall prevalence in sentenced prisoners have been reported to be 33 to 57% (Gunn and Maden 1991, Maden, Swinton et al. 1994, Europe 2023). In the UK in 2017, 36% of the monthly prison population reported a mental health condition (NAO 2017), however an older study in the UK found that as many as 90% of prisoners over 16 years old suffered from a mental illness, with 70% having two or more diagnoses (Singleton, Meltzer et al. 1998). Australian and New Zealand studies have found aggregated rates of mental illness in prisons to range from 38% to 53% (Hurley and Dunne 1991, Butler, Allnutt et al. 2005, Butler, Andrews et al. 2006, Tye and Mullen 2006). It should be noted in making these comparisons that North American, Australian and New Zealand studies used the Diagnostic and Statistical Manual 'DSM' (III, III-R and IV) (APA 1987), whereas the European studies used the International Classification of Diseases 'ICD' criteria (ICD 1993). Prevalence rates are not commonly studied or consistently reported outside these regions, leaving a gap in the evidence around mental disorders in low- and middle-income countries. However, a 2019 study reviewed severe mental illness and substance use disorders in prisoners in low- and middle-income countries and found that the estimated one-year prevalence of psychosis was 6·2%, of major depression 16·0%, of alcohol use disorders 3·8%, and of drug use disorders 5·1% (Baranyi, Scholl et al. 2019).

Measuring prevalence is challenging and varied methodologies are used across different settings. There are a number of ways in which the prevalence of mental health conditions is measured within a prison population, including (i) self-declaration by inmates; (ii) screening based on the DSM-IV by clinical staff stationed within prison environments; and (iii) diagnostic interviews and questionnaires administered by researchers and clinicians (Black, Gunter et al. 2007, Gunter, Arndt et al. 2008, Black,

Gunter et al. 2010). The Mini International Neuropsychiatric Interview (MINI) diagnostic interview is extensively used in newer prison studies (Fazel 2016), but briefer screening tools are also used, such as the Brief Jail Mental Health Screen (BJMHS) developed by Steadman and colleagues (Steadman, Scott et al. 2005) in the United States and the English Mental Health Screen (EMHS), a brief, four-item screen developed by Gavin et al. (Gavin, Parson et al. 2003) in the United Kingdom.

While each method presents its own issues, seminal work by Teplin (1996) argues that rates within incarcerated populations may underestimate true prevalence in criminal populations for at least three reasons (Teplin 1996):

1. People with severe mental illness may have been identified and diverted to psychiatric examination or treatment before being imprisoned;
2. People who are not included might have more psychiatric morbidity, through either refusal to participate or through prematurely terminating data collection;
3. Symptoms may be underreported during interviews.

Studies also differ in their categorisations of mental health conditions, most significantly in disorders of focus and diagnostic procedures (Fazel, Hayes et al. 2016, Fazel and Seewald 2018). Few studies have aggregated all psychotic disorders and most focus on specific disorders, making it challenging to provide an estimate of overall prevalence (Andersen 2004). This thesis refers to mental health conditions across diagnoses unless otherwise specified and is not limited to severe mental illness.

Commonly experienced – and therefore studied - conditions include psychotic disorders, major depression, alcohol misuse and drug misuse.

Schizophrenia and psychotic disorders are more common in prison inmates than in the community. Schizophrenia prevalence has been found to range between 1% and 4% in prison populations in Western countries (the USA, UK and the Netherlands), compared to 0.3% - 0.9% in community samples (Myers, Weissman et al. 1984, Hodiamont, Peer et al. 1987, Levav, Kohn et al. 1993, McCreadie, Leese et al. 1997, Bijl, Ravelli et al. 1998, Baillargeon, Penn et al. 2009). The prevalence of psychotic

disorders more broadly[1] has been reported at 2% to 5% in a systematic review and meta-regression analysis (Baillargeon, Penn et al. 2009, Fazel and Seewald 2012), though one study reported 10% for 'schizophrenia and other psychotic disorders' among women prisoners (Parsons, Walker et al. 2001).

Mood disorders are of comparable or slightly higher prevalence in prison studies than the general population. The prevalence of mood disorders[2] varies across prison studies (6% to 64% in the following cited studies), though this is largely due to differences in inclusion criteria. For example, some studies separately focused on presentation of individual diagnoses such as depressive episodes (Bland, Newman et al. 1990, Teplin, Abram et al. 1996, Corrado, Cohen et al. 2000, Brinded, Simpson et al. 2001, Tung, Hsiao et al. 2019), while others aggregate mood disorders to include a greater range of depressive disorders such as substance-induced mood disorders (Andersen, Sestoft et al. 1996, Jordan, Schlenger et al. 1996, Baillargeon, Penn et al. 2009). This variability is also seen in community population studies, due to geographical differences as well as methods of measurement (Jenkins, Bebbington et al. 1997, Bijl, Ravelli et al. 1998, Sandager, Nygård et al. 1999, Ayuso-Mateos, Vazquez-Barquero et al. 2001). Studies comparing prison and community samples have found higher prevalence of both depressive episodes and syndromes in prison samples than in the community (Brinded, Simpson et al. 2001, Fovet, Plancke et al. 2020).

Anxiety disorders are also more prevalent in prison populations than in the general community. There are similar variances in the reporting of anxiety disorders[3] depending on inclusion criteria applied to specific disorders and the methodology selected. Rates of neurotic or anxiety disorders range from 6% to 41%, with most studies reporting 10% – 20% (Pondé, Freire et al. 2011, Vicens, Tort et al. 2011, Naidoo and Mkize 2012, Adrian, Alvarado et al. 2013, Fovet, Plancke et al. 2020).

[1] Schizoaffective disorder, Schizophreniform Disorder, Brief Psychotic Disorder, Delusional Disorder, Substance-Induced Psychotic Disorder, Psychotic Disorder Due to a Medical Condition and Paraphrenia

[2] Mood disorders include major depression, dysthymia (dysthymic disorder), bipolar disorder, mood disorder due to a general medical condition, and substance-induced mood disorder

[3] Most commonly, Generalized Anxiety Disorder, Obsessive-Compulsive Disorder (OCD), Panic Disorder, Post-Traumatic Stress Disorder (PTSD) and Social Phobia (or Social Anxiety Disorder)

Community studies vary in the same way, but broadly find the prevalence of anxiety disorders to range from 0.9% to 28.3% (Baxter, Scott et al. 2012).

Dependence on alcohol and drugs is common and often co-occurs with other mental health conditions in prison populations. Mental health conditions are associated with greater likelihood of substance abuse or a history of substance abuse (Regier, Farmer et al. 1990, SAMHSA 2002, Cook, Wayne et al. 2014, Al-Rousan, Rubenstein et al. 2017), and a high prevalence of drug or alcohol abuse and dependence is a predominant finding in studies of prisoners and offenders (Bland, Newman et al. 1990, Corrado, Cohen et al. 2000, Brinded, Simpson et al. 2001, Pondé, Freire et al. 2011, McIntosh, Rees et al. 2022).

This demonstrates that the most commonly reported disorders have usually been found to be more prevalent in prison populations than in the community, suggesting a link between incarceration and mental health conditions. Some of the data are collected from screening as people enter prisons, which would suggest that those with mental health conditions are more likely to be incarcerated. However, there are other points of data collection during imprisonment, rates of recidivism are often high (Naidoo and Mkize 2012, Fazel, Hayes et al. 2016), and imprisonment has a negative impact on individuals (discussed below), so the link between incarceration and mental health conditions may not be linear.

In fact, evidence suggests that incarceration has a detrimental impact on an individual's mental well-being, through the effects of prison-related factors (e.g. overcrowding and isolation) and the subsequent impact on levels of stress and distress (Holmes and Rahe 1967, Hayes 1989, Joukamaa 1997). Incarceration is conceptualised as the fourth most upsetting event on the Holmes/Rahe Social Readjustment Rating Scale (Holmes and Rahe 1967), and the prison-related factors described above have also been found to be risk factors for suicide in prison (Hayes 1989, Joukamaa 1997).

Work in the field of mental health in prison studies suggests that the highest risk of suicide occurs in the first three months of imprisonment (Hayes 1989, Dooley 1990, Kerkhof and Bernasco 1990, Marcus and Alcabes 1993, Shaw and Turnbull 2006, Radeloff, Hövel et al. 2021), whereas suicide in later phases is relatively uncommon, which aligns with decreasing psychiatric symptom severity in contexts of imprisonment over time (Zamble and Porporino 1988, Harding and Zimmerman 1989,

Hurley and Dunne 1991, Zinger 1999, Andersen, Sestoft et al. 2000). This suggests an initial phase of exposure, which is most damaging, before a period of adjustment.

The impact of incarceration on repeat offences is highly debated in the field, with studies showing mixed results. In the United States, while studies have found that incarceration has no effect on recidivism (Green 2010, Loeffler 2013), others such as Aizer (2015) found that juvenile incarceration resulted in lower high school completion rates and higher adult incarceration rates (Aizer 2015). Mueller-Smith found that incarceration increased recidivism rates using data from Texas (Mueller-Smith 2015), and Harding et al. (Harding, Morenoff et al. 2017) also found that imprisonment is associated with future imprisonment, though the majority of this effect was generated by parole violations rather than prison admissions for new felony convictions. A 1993 review on the topic also found variation in results of studies on the effects of incarceration (versus other sentencing options) and the length of time served on recidivism, and concluded that they may be specific to the offender (Song and Lieb 1993). Such mixed findings support the theory that variability in effectiveness related to reducing criminal behaviour may depend on a wide range of contextual factors, and the risk to an individual's mental health through incarceration suggests that alternatives should be considered.

Beyond the direct impact that incarceration has on individuals, crime imposes substantial financial costs on society. Two methodologies are typically used for quantifying the costs of crime. The "bottom up" method is used to estimate the cost of victimisation after a crime has occurred. The types of harms experienced by the victim are identified and the tangible and intangible costs of making a typical victim 'whole' again are estimated. The "top down" method relates to trade-offs in resource allocation, and tries to attach a monetary value to the public benefit that citizens receive in exchange for devoting extra resources to crime prevention instead of alternative uses.

Aggregate annual financial costs have been estimated at c.£1.1 billion in the UK (Piquero 2013) and AUS$1.14 billion in Australia (Allard 2014) based on a "bottom up" cost methodology; and $265 million and $529 million in the USA (Cohen 2019), depending on whether a "bottom up" or "top down" methodology is used.

Criminal trajectory research has shown heterogeneity among offender populations in both severity and frequency of offending (Piquero 2008). Therefore although reporting

aggregate costs, or average costs of crime per person, is helpful to provide an overarching view, it may fail to account for the variability in costs across offender subgroups (Day 2019). Importantly, these analyses focus on criminal trajectories from adolescence and place importance on early intervention. However, this also demonstrates that the costliest group of offenders are those who repeatedly engage in criminal activity over their lifetime, and that early intervention does not always happen in practice. It therefore remains relevant and beneficial to look at interventions at a later stage.

This is particularly pertinent for individuals with mental health conditions, which is the leading cause of clinical expenditure in correctional facilities (Kouyoumdjian, McIsaac et al. 2015) and those at greater risk of recidivism, hospitalisation, and suicide upon release (Scott 2000). The material size of these costs indicates that there is a benefit in considering alternative pathways for women with mental health issues.

2.3 Women in the criminal justice system

Mental health issues are prevalent among women prisoners, with regular reports of conditions such as post-traumatic stress disorder, depression, and self-harming behaviours (WHO 2009). Prevalence rates of mental health conditions during incarceration are noted to be higher among women than men, with women at greater risk of receiving a mental health diagnosis while incarcerated (James and Glaze 2006, Al-Rousan, Rubenstein et al. 2017), and with a wider variety of mental disorders (Al-Rousan, Rubenstein et al. 2017), with rates reaching up to 90% (Taylor 2004, Bastick and Townhead 2008). Evidence indicates that female prisoners are more prone to self-harm and suicide compared to male prisoners (WHO 2007), with women found to be 14 times more likely than men to engage in self-harming behaviours in England and Wales (WHO 2007).

A significant proportion of women in prison struggle with alcohol or drug dependencies, and it is estimated that at least 75% of women arriving in prison have a drug- or alcohol related issue when arrested (Fowler 2002, WHO 2007). Rates of problematic drug use have been found to be higher among women than men (WHO 2007), and in Europe, it has been found that female prisoners are also more likely to inject drugs, therefore increasing their risk of contracting bloodborne viruses such as HIV (EMCDDA 2004). These gender disparities suggest that women inmates are

likely to have varying mental health concerns from male inmates and as a result, may have different needs.

Existing evidence around the gendered aspects of incarceration (Smart 1978, Carlen 1983, Worrall 1990, Carlen 2002, McIvor 2004) has tended to focus on the ways in which men and women are treated by the criminal justice system (Walklate 2001, Carlen 2002, Gelsthorpe 2004, Society 2004), and how differently men and women might experience custody (Carlen 1983, Stevenson and Padel 1988, Caddle and Crisp 1997, Devlin 1998, Chesney-Lind and Pasko 2004). Additional considerations in the literature also point to the following factors as gendered: impact of incarceration, parenting roles (real or perceived) and risk factors for exposure to incarceration (Willis and Rushforth 2003, Thornton, Graham-Kevan et al. 2010, Van Voorhis, Wright et al. 2010). In addition to the impact on women themselves, several studies have shown that children of substance abusing or incarcerated parents consistently experience behavioural problems throughout their lives (Hissel, Bijleveld et al. 2011, Wildeman and Turney 2014). Long-term effects include greater risk of psychopathology, illegal drug use, having a criminal conviction, and becoming incarcerated themselves (Gifford, Eldred Kozecke et al. 2019).

Research has shown that when fathers are incarcerated their children are more often cared for by their mothers, which may provide a protective buffer against the trauma of losing a parent to prison (Dallaire and Wilson 2010). This may be especially true when noncustodial or absentee fathers are incarcerated. However, when a mother is incarcerated, her child is more likely to be physically displaced to live with other relatives (e.g., grandparents) or placed in foster care (Mumola 2000). This means that maternal incarceration is more likely to have an immediate physical effect on a child, such as lower financial resources, instability, and a change in living arrangements, as well as the immense psychological impact from a traumatic separation from their mother (Mumola 2000). Also, because there are fewer women's prisons it is more likely that women will be held in facilities further away from their children's residence, making visits much more difficult (Prison Reform Trust 2022, UK House of Commons 2022).

As well as the impact of imprisonment being different for men and women, lower numbers of women offenders indicate that the selection processes into crime may also differ. Studies have shown that women offenders who come in contact with the justice system have often also experienced adverse childhood experiences (Katz

2000, Mullings 2002, Nilsson 2003, Simpson 2008), and have often been victims of more serious offences than those for which they are convicted (Jewkes, Jordan et al. 2019). Adverse childhood experiences connect to more systemic and interpersonal social difficulties involving, for example, families characterised by long-term poverty, alcoholism, drug addiction, mental illness, child neglect, and physical and sexual abuse (Holsinger 2000, Mullings 2002, Belknap 2006).

There is a growing understanding that factors involved in women offending may be different from those for men, with an acknowledgement that men's and women's lives are shaped by different experiences, some of which are biological in origin and others of which are embedded in social and cultural practices (Fineman 1995, Auty, Farrington et al. 2017). This suggests that women offenders are likely to have additional needs which are not restricted to the treatment of mental health conditions, linked to wider forms of disadvantage.

2.3.1 Mental health conditions and multiple disadvantage

The correlation of mental health with other types of disadvantage is widely acknowledged, and is a factor that shapes the intervention (ITAV), which is evaluated in this thesis. We know that mental health conditions correlate with other types of disadvantage, and a key aim of the thesis is to evaluate an intervention focused on addressing these issues in a UK context. In England, around 40% of people who experience homelessness, substance misuse and contact with the criminal justice system in any given year also have a mental health problem (Lankelly Chase Foundation 2015). Individuals with multiple needs have often been exposed to additional forms of trauma, which may result from neglect, psychological abuse, physical abuse, sexual abuse during childhood, community violence, domestic violence and abuse, combat-related trauma, and disasters (Hopper, Bassuk et al. 2009). Trauma may affect a person's capacity for coping, as well as their sense of safety, ability to self-regulate, their sense of self, perception of control and self-efficacy, and interpersonal relationships. Lived experience of trauma and homelessness have also been shown to lead to reluctance to accept interventions (Magwood, Leki et al. 2019), and reports from both England (McManus, Bebbington et al. 2016) and Wales (Survey 2015) suggest that only one in eight adults with a mental health condition are currently receiving any kind of treatment.

Trauma exposure is acknowledged as being a driver of offending behaviour in women, which has increased awareness of the need to incorporate trauma-informed practices both in prison and other treatment services, for women with multiple disadvantage (Gallagher, Nordberg et al. 2019). Trauma informed approaches refer to a framework for understanding and responding to the needs of individuals who have experienced trauma. They recognise the widespread impact of trauma on physical, psychological, and emotional well-being and emphasise creating a safe and supportive environment for healing and recovery. This may include improvements to physical environments, for example improving conditions in prisons for those who are incarcerated (Jewkes, Jordan et al. 2019), and moving support and treatment services to comfortable spaces (e.g. the home or community), for those who are not (Edmund and Bland 2011, Wilson, Fauci et al. 2015, Kahan, Lamanna et al. 2020).

There are additional challenges for those with multiple disadvantage and mainstream services are often unable to effectively engage this group or address their long-term recovery. This means that people with complex needs often go without the help they require, and services can even have the effect of reinforcing earlier traumatic experiences and causing further harm (Revolving Doors Agency 2015). This group of individuals rarely receive the treatment they need and 'fall through the cracks', missing help from specialist services such as mental health or drug and alcohol treatment (Dobson 2019, Lamb, Moreton et al. 2019).

Many services have a history of expecting people to engage with one service at a time, leaving many people unable to get support that takes account of the compounding impact of their experiences and often resulting in poor outcomes (Collaborate CIC 2022). People from Black and Global Majority backgrounds are more likely to experience poverty, the criminal justice system and poor care due to structural inequalities and systemic racism (Halliday 2022). Race has been shown to be a determinant in the type of care some people receive and how they are perceived by professionals (Knight, Bunch et al. 2021). We also know that gender and sexuality (Bachmann and Gooch 2018) and care experience individually play a huge role. We do not have a full picture of the aggregate impact of several inequalities as there is a tendency to focus on and capture data on issues individually. It is important that these structural compounding factors - and the need to improve the gaps in our understanding of them - are both understood and taken into account when considering the best way to improve the support on offer. The problems are systemic and manifest across agencies to reflect the context they are operating in (from a community,

economic and structural perspective), so cannot be considered through the narrow frame of individual organisations, people or practices (Dobson 2019).

2.4 Bringing together diversion and treatment - diversion programmes as a mechanism for managing complexity

Incarceration has been shown to be ineffective at reducing crime (Stemen 2017), and we have seen that it has a severe direct impact on individuals, which is complicated by related and interdependent treatment needs that contribute to offending behaviour and worsen outcomes for women with multiple disadvantage. Prison also creates barriers to accessing treatment and we have already seen that this population are unlikely to seek support and struggle to access appropriate treatment even when they do seek help. To effectively intervene therefore requires: (i) clear routes to enter treatment pathways for those who otherwise may not seek access to treatment and may come into contact with the criminal justice system; and (ii) a system that supports treatment across multiple needs. One way in which this has been attempted is through the use of diversion programmes.

Diversion programmes are initiatives designed to divert people with pre-existing mental illness from the criminal justice system into mental health services. Diversion programmes vary in their structure and procedures and operate at various points in the criminal justice process. A useful distinction is whether the intervention engages with a potential offender before or after booking. Pre-booking programmes allow police officers to divert offenders with mental illness instead of proceeding to make an arrest - commonly without filing any charges - and are often reliant on police-community partnerships (Steadman & Naples, 2005; Case, Steadman, Dupuis, & Morris, 2009). Common examples of pre-booking diversion services include programmes of specialist training for police officers and specialised crisis teams, which are intended to provide effective home-based treatment for acute mental health crises. Post-booking programmes occur after arrest and allow for the diversion of offenders at multiple points along the criminal justice pathway (Steadman & Naples, 2005; Case, Steadman, Dupuis, & Morris, 2009). Common examples include problem-solving courts which seek to address the underlying problems that contribute to criminal behaviours (mental health and drug courts), specialised parole or probation, suspended sentencing and community service. Diversion programmes also vary in their eligibility criteria, as some are targeted to address specific criminal activity or challenges (e.g. the problem-solving courts referenced above) (Case,

Steadman, Dupuis, & Morris, 2009). I elaborate on diversion programmes in a UK specific context in 2.4.1.

Diversion programmes include two broad interlocking areas of intervention (Draine and Solomon 1999): the diversion mechanism, or the means by which an individual suffering from mental illness is identified and diverted, and the system (e.g. mental health services) to which the person is diverted. The appeal of diversion programmes is their potential to reduce the prevalence of mental health disorders in prisons, increase access to appropriate services for people with mental health conditions, reduce recidivism in the long term and increase public safety, all with potential cost savings (Steadman, Barbera et al. 1994, Heilbrun, DeMatteo et al. 2012, Kane, Evans et al. 2018).

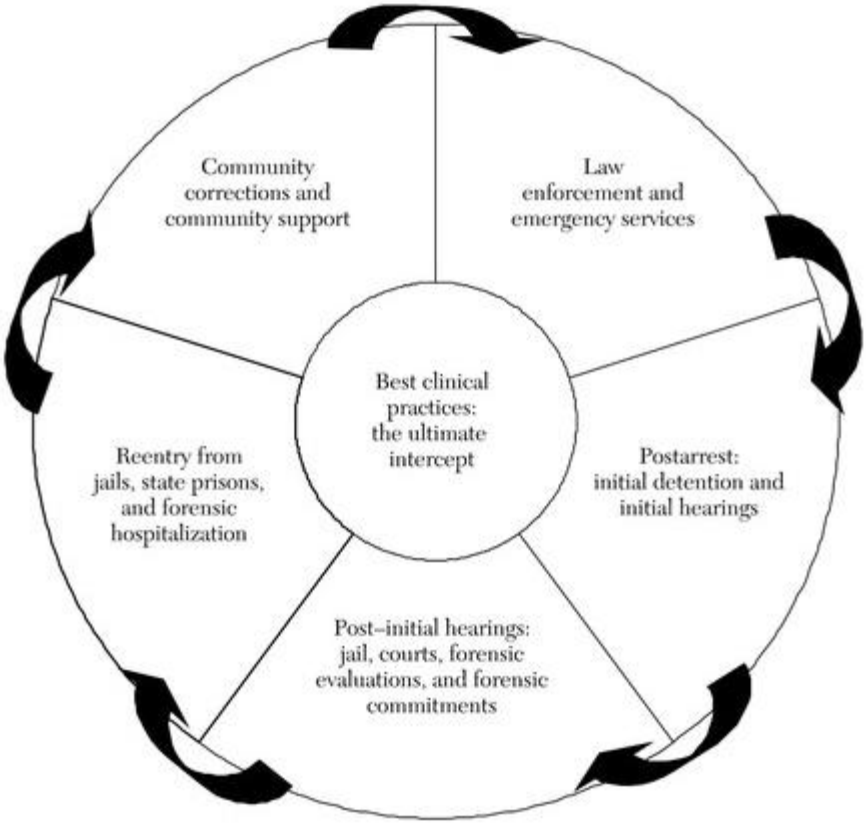
The need for diversion is grounded in two main theories: labelling theory and differential association theory. Labelling theory suggests that labelling an individual with a negative term may lead them to exhibit associated undesirable behaviour, and therefore that processing individuals through the criminal justice system may have adverse effects by stigmatising and ostracising them for offences that could have been handled outside the formal system (Centre for Justice Innovation 2016). Differential association theory suggests that criminal behaviour can be learnt through association, such that individuals can learn antisocial attitudes and behaviours by associating with peers who exhibit them (Charles & Associates 2017).

Three categories of theory inform the implementation of diversion programmes (Zehr 1990, OJJDP 1997, Adler School and Rights 2011, Lilly, Cullen et al. 2015). Retributive theories suggest that criminal behaviour is the result of rational choice and focus on changing the offender's behaviour and justice system perceptions in order to prevent re-offense. Emphasis is placed on demonstrating why someone should not commit crime, and informs the use of sanctions as deterrence, consistent experiences and education on the criminal justice system process (OJJDP 1997, Adler School and Rights 2011, Akers and Sellers 2013). Rehabilitative theories suggest that crime is the result of social context. Emphasis is placed on providing treatment and support to offenders that take into account their unique needs. This seeks to address criminal behaviour by providing resources for treatment and encourages facilitated interactions, use of social pressure and skill development (OJJDP 1997, Lilly, Cullen et al. 2015). Reparative theory suggests that crime is both a result and a cause of community strain. The focus is on avoiding stigmatising processes, addressing

underlying conditions and remedying harms caused to affected parties. Reparative theory emphasises the relational nature of crime and crime prevention and aims to promote the wellbeing of the offender by avoiding stigmatising language and processes and providing structured opportunities. It seeks to repair community ties damaged by the offense by engaging those affected as decision-makers and fostering meaningful dialogue focused on identifying and addressing the needs of affected parties (Mongold 2014, Lilly, Cullen et al. 2015). Although these theories do not focus specifically on people with mental health conditions, they help us to understand some of the potential mechanisms at play, and how they could support or hinder the ability of diversion programmes and health and support systems to improve outcomes for women with complex needs.

In considering the optimal point of interception for diversion, Munetz & Griffin built upon the work of Landsberg et al (Landsberg 2004) and Steadman (Steadman 2003) to develop the Sequential Intercept Model. This model is intended to address Steadman's observation that people with mental illness often cycle repeatedly between the criminal justice system and community services. It specifies five intercept points to reflect the flow of individuals through the criminal justice system and the interactive nature of mental health and criminal justice systems (Figure 2).

Figure 2: the Sequential Intercept Model (Munetz and Griffin 2006)



The model posits a comprehensive, effective mental health treatment system focused on the needs of individuals with serious and persistent mental disorders as the 'ultimate intercept' and the most effective means of preventing the criminalisation of people with mental illness. It argues that the system should have an effective base of services that includes competent, supportive clinicians, community support services such as case management, medications, vocational and other role supports, safe and affordable housing, and crisis services, with greater adoption of evidence-based treatments which are integrated and used consistently.

Ultimately, diversion programmes can act as a 'boundary spanning' service, integrating service provision across borders between remits. This could be the role of an organisation or individual(s), but effective placement and use of "boundary-spanners" at system and service levels can bring integration to services and is thought to be critical for success (Wertheimer 2000), as challenges related to joint working and inter-agency communication can limit the effectiveness of interventions (Morant, Lloyd-Evans et al. 2017). Staff assigned to boundary-spanning roles at the system level can help identify and bring together stakeholders to plan next steps for a treatment or support pathway and lead on implementation, whereas service level boundary-spanning staff can join different systems on a case-by-case basis. These

teams are critical to ensuring referrals from the diversion programme reach the support and treatment systems that will offer the greatest benefit to programme participants. Justice and mental health professionals cross the boundary between systems to provide appropriate treatment for persons with serious mental illness and substance abuse problems, but they require training and support to build the appropriate skills and networks.

The components of an effective system described as the 'ultimate intercept' and through a boundary-spanning role, are considered further in both the realist review and realist evaluation in this thesis.

2.4.1 The UK's Liaison and Diversion services

Later in this thesis I evaluate the operationalisation of an intervention aiming to reduce offending behaviour and improve outcomes for women in a London borough, so the UK context of diversion is relevant to this work. The UK's Liaison and Diversion (L&D) services aim to identify those with mental health needs and other vulnerabilities who are in the criminal justice system and refer them to appropriate support services. L&D services have been available in some form since the 1990s, but the model for their services was variable, and they were not consistently available (RAND Corporation, 2021).

Liaison and Diversion services are commissioned by the devolved health service arrangements across the UK and as such, differ in their implementation across the four nations (NHS England, 2024). However, there is a single criminal justice system for Wales and England, and the programme shares materials and findings with colleagues in Wales (NHS England, 2024). In 2014, NHS England launched the national Liaison and Diversion Operating Model for L&D services, which was then implemented nationwide (RAND Corporation, 2021), and recent publications state that this has now achieved 100% coverage across England and Wales (James & Hamilton, 1991).

The National Model for L&D provides 24-hour, seven days per week services for people of all ages in the adult and youth justice pathways, covering a range of health issues and vulnerabilities including mental health, physical health and learning disabilities. The service aims to ensure parity and fairness of treatment for these individuals by diverting them away from the criminal justice system and towards health

and support structures through a range of interventions including timely mental health assessments, tailored care plans, and access to rehabilitative services. Trained professionals, such as liaison and diversion practitioners, psychiatric nurses, and social workers, engage with individuals in contact with the criminal justice system, aiming to build a nuanced understanding of mental health needs. The diversification of these services extends to the provision of expert testimony within legal proceedings, aiming to contribute towards a more informed and equitable criminal justice process.

2.4.2 Effectiveness of diversion programmes

Studies relating to the effectiveness of diversion programmes suggest variable effectiveness, not only for specific interventions, but also for specific outcomes. As described above, diversion programmes may be pre- or post-booking. A systematic review of evidence on pre-booking diversion of people with mental health problems identified five economic evaluations and concluded that pre-booking diversion may lead to overall cost savings per diverted individual compared with treatment as usual, with a cost shift to health services (Bird and Shemilt 2019). However, there is conflicting and limited evidence on the extent to which pre-booking diversion improves subsequent mental health outcomes or reduces the risk of reoffending. There was evidence of increased mental health service use (Broner, Lattimore et al. 2004), and group participants were more likely to have been hospitalised for a mental health condition than a control group at 3 and 12 months after diversion (Broner, Lattimore et al. 2004). The review found mixed evidence on the risk of arrest after 3 months and an increased risk of arrest after 12 months (Broner, Lattimore et al. 2004). One of the four studies included in the review found no significant effect of diversion on arrests up to 6 months after the index police contact (Bonkiewicz, Green et al. 2014). However, the review only included two outcome studies, reflecting the limited evidence base.

For post-booking programmes, a systematic review by Lange et al. (Lange, Rehm et al. 2011) found a high degree of effectiveness for jail-based diversion in reducing recidivism (Hoff, Rosenheck et al. 1999, Lamberti, Weisman et al. 2001, Shafer, Arthur et al. 2004, Gordon, Barnes et al. 2006, Case, Steadman et al. 2009, Rivas-Vazquez, Sarria et al. 2009), and moderate effectiveness in reducing the number of days incarcerated (Hoff, Rosenheck et al. 1999, Steadman, Deane et al. 1999, Broner, Mayrl et al. 2005) and substance use (Hoff, Rosenheck et al. 1999, Broner,

Mayrl et al. 2005), increasing service utilisation (Shafer, Arthur et al. 2004, Broner, Mayrl et al. 2005) and quality of life (Cowell, Broner et al. 2004). Another review found little evidence for a reduction in recidivism, but strong evidence of a reduction in jail time (Sirotich 2009). Lange and colleagues (Lange, Rehm et al. 2011) also suggested that mental health courts had a high degree of effectiveness in reducing recidivism (Cosden, Ellens et al. 2003, Trupin 2003, Herinckx, Swart et al. 2005, Moore 2006, McNiel and Binder 2007, Ferguson, McAuley et al. 2008, Hiday 2010, Steadman 2010) and increasing service utilisation (Trupin 2001, Boothroyd, Poythress et al. 2003, Trupin 2003, Herinckx, Swart et al. 2005), moderate effectiveness in reducing the number of days incarcerated (Cosden, Ellens et al. 2005, Frailing 2010, Steadman 2010), reducing substance use (Cosden, Ellens et al. 2003, Ferguson, McAuley et al. 2008, Frailing 2010), and improving mental health status (Cosden, Ellens et al. 2005, Ferguson, McAuley et al. 2008), but limited effectiveness in increasing quality of life (Ferguson, McAuley et al. 2008). These findings suggest that in establishing a diversion programme it is important to be clear about how public health objectives are balanced with criminal justice and cost saving objectives. These should be reflected in measuring the effectiveness of diversion programmes.

2.5 Multi-agency approaches

As well as requiring routes to enter support services through diversion, the services themselves have to be fit for purpose. For women with multiple disadvantage, this means having access to a range of areas of support depending on need, with appropriate consideration of how their needs interact with each other; for example, the correlation between drug and alcohol misuse and mental health conditions, and what this means for treatment programme design.

2.5.1 Benefits and challenges in effective multi-agency approaches

In 1998, Payne put forward an argument for multi-agency working within local authorities: '… the case for treating social problems in a holistic fashion is overwhelming. People know, in a simple everyday fashion, that crime, poverty, low achievement at school, bad housing and so on are connected' (Payne 1998). Much of the literature regarding multi-agency working is extremely positive about the benefits that multi-agency approaches can bring (across the areas of improved services, direct outcomes and prevention, including linkages to service access), and there are references to multi-agency approaches in numerous Government

strategies, particularly in relation to health and social care (Richardson and Asthana 2006).

However, several challenges with multi-agency working have also been identified, and in particular reflect the complexities (social, financial, structural) involved when professionals engage collaboratively. Atkinson et al. found that key areas of complexity include funding and resources, roles and responsibilities, competing priorities, communication, professional and agency cultures and management (Atkinson, Wilkin et al. 2002). Issues around economic resource in both the development and delivery of projects and programmes include conflicts over which agency is responsible for providing funding, limited resources dedicated to multi-agency work in general, and issues in continuity and sustainability. Human resource is also cited as a challenge, as multi-agency working is considered to be particularly time-intensive compared to working within a single agency. Communication was identified as challenging across job levels and most commonly where those involved in multi-agency working were most disparate at an operational level. Conflicting professional and agency cultures was considered to be a particular challenge by those working at a strategic level.

Stevens (2013) found that these challenges remained in an empirical review of the literature and policy on multi-agency approaches in the context of safeguarding (Stevens 2013). Specifically, they identified a need for clarifying the roles and responsibilities of agencies, information sharing, lack of prioritisation, having clear and transparent processes and lack of legislation to mandate multi-agency approaches.

Conversely, Atkinson et al. (2007) analysed key success factors required for effective multi-agency working, which involved not only the systems and procedures being established (e.g. staffing and communication structures), but also the more personal qualities of the professionals involved, such as their commitment and drive (Atkinson, Jones et al. 2007). Enthusiasm and commitment to multi-agency working driven by a genuine belief and willingness to be involved was identified as being key to effective collaboration. Other key factors included (i) understanding the roles and responsibilities of other agencies, (ii) the need for common aims, (iii) communication and information sharing and (iv) leadership or drive at strategic level. They concluded that meaningful investment of resources and an attitudinal shift towards increased flexibility in approaches is required for multi-agency working to be effective, and also

that there is substantial variation in existing models of multi-agency working that would benefit from more consistency around vocabulary and practice.

2.6 Chapter summary

In this chapter we have seen that mental health conditions are highly prevalent in prison populations, and this is particularly true for women. Incarceration causes stress and increased risk of suicidal behaviour, as well as increased recidivism in some individuals. Meanwhile, crime poses a significant cost to communities. In addition to the evidence presented on mental health being of particular concern for women offenders, women also differ from men in their risk factors for offending, the impact of incarceration, and through the knock-on impact it has on their role as a parent.

Co-morbidity is common and women with multiple disadvantage are likely to have related and interdependent treatment needs that contribute to offending behaviour and worsen outcomes. Women who offend often have multiple support needs requiring treatment, but encounter barriers in doing so which result in a lack of engagement.

To address the over-representation of people with mental health conditions in prison populations, a solution that has been proposed is diversion programmes, which take a number of different forms, but ultimately aim to divert people from the criminal justice system to mental health services. Diversion programmes have been found to be effective overall, though this can be variable across different measures. There is limited understanding of the drivers of variation and what makes interventions effective for certain groups of individuals, but we know that for diversion programmes to be effective there needs to be a focus on the system people are diverted into as well as the diversion mechanism itself. Specifically, the system needs to have the capacity and capability to address the multiple needs of women with complex disadvantage.

Chapter 3 Key concepts and theory

3.1 Introduction

In this chapter I present a review of the key theoretical concepts that underpin the thesis. The literature review in Chapter 2 introduced the complexity in drivers of the effectiveness of interventions aiming to divert women away from the criminal justice system, and of systems designed to provide appropriate treatment to potential offenders with complex needs. This points to a clear need for frameworks that can help to navigate the myriad of contexts, pathways and approaches for addressing the mental health needs of women who are at risk of offending behaviour.

In designing a theoretical framework for this work, I primarily explored theory on intersectionality as well as related concepts in gender, feminism and female criminality. The framework I developed is presented in section 3.5 and describes how theoretical considerations were applied in structuring the research project and throughout the thesis. I discuss these relevant contributing theories here.

3.2 Intersectionality as a core aspect of feminist theory

Feminist theory confronts injustice based on gender and takes a woman's experience as its starting point by centring women and issues that women face in contemporary society. The key goals are to examine the power differences between men and women, ascertain the power in relationships and end oppression through social change (Flax 1999) through placing gender differences at the centre of investigation and considering the result of these differences in any given context.

Differences in gender and variations between men and women have consistently been a focus of debate across a variety of disciplines including biology, sociology, psychology, anthropology and neuroscience (Rippon 2019). Essentialist theories of gender suggest that there are innate differences between men and women which are constant and unchangeable. These differences have been posited as the natural order (Connell 2009, Rippon 2019), with theorists suggesting that there are inherent differences in the sexes other than reproductive organs. Both Structuralist and Poststructuralist theories of gender provide a critique of the essentialist approach (Alsop, Fitzsimons et al. 2002) to bring focus to 'constructions of gender' or 'doing gender'. These theories of gender argue that gender is something that a person does

rather than something that is innate or imposed upon them, creating social and behavioural differences between men and women that are not pre-determined (West and Zimmerman 1987, Connell 2009).

Feminist structural oppression theories posit that women's oppression and inequality are a result of capitalism, patriarchy and racism, and socialist feminists agree with Marx and Engels that the working class is exploited as a consequence of capitalism, but seek to extend this exploitation not just to class but also to gender (Armstrong 2020). This has linkages to women in the criminal justice system and specifically the women discussed later in this thesis, as we know that marginalised women involved in criminal behaviour tend to be disproportionately poor, non-white, unemployed or under-employed, with low levels of education and a history of drug problems, family violence and sexual abuse (Kim, Johnson et al. 2011). We also know that these women face multiple forms of oppression such as ingrained racism, sexism, economic disadvantage, abuse, exploitation and the broader undervaluation of women in society (Kelly 1994, Collins 2000).

In the 1970s this recognition of these multiple forms of oppression came to the forefront, as feminist theorists began promoting the suggestion that gender was unhelpfully being viewed and analysed as a single category of inquiry (McCall 2005). Women who were experiencing the reality of living through a heteronormative, liberal discourse on feminism began questioning why feminist writings focused solely on white, middle-class women who were formally educated, observing that women of colour were being overlooked (Shields 2008). Womxn scholars of colour began to challenge traditionally held feminist-based beliefs by claiming that women on the margins were not being considered in feminist discussions (Bedolla 2007). This prompted a shift from studying various individual aspects of a person's identity such as race, gender, class, age and ethnicity as separate issues (Berger and Guidroz 2009), to considering how these aspects intersect and overlap within a social context.

The term 'intersectionality' was introduced by Kimberlé Crenshaw to frame the lived reality of oppressed individuals, specifically the experiences of African American women. Crenshaw constructed her early work from a legal perspective to challenge the tendency of treating race and gender as mutually exclusive categories of experience, with the theoretically invisible black woman as the archetype in demonstrating the importance of acknowledging multiple intersecting identities (Crenshaw 1989). Intersectionality theory therefore seeks to acknowledge the many

ways that racial and gender oppression was - and is still being - experienced as double discrimination (Stockfelt 2018, Goodwin, Interligi et al. 2019). Crenshaw describes the constant battle Black women face with respect to both race and gender oppression, specifically where the compounded nature of their experience is absorbed into the collective experiences of either group, or being considered as too different for each, resulting in Black women having their needs and perspectives placed at the margin of both the feminist and black liberationist agendas. In Crenshaw's writing on intersectionality, politics and violence against women, she claims that Black women's lives are more complex than race and gender in isolation:

> *"the intersection of racism and sexism factors into Black women's lives in ways that cannot be captured wholly by looking at the race or gender dimensions of those experiences separately" (Crenshaw 1991) pg. 1244*

Black women struggle with discrimination within not just one of their identity categories, but two or more, which makes it difficult for those who experience oppression to a lesser degree to fully recognise and understand. Black women sometimes experience discrimination in ways similar to white women, and sometimes they share similar experiences with Black men, but often they experience double-discrimination – the combined effects of practices which discriminate on the basis of race and on the basis of sex – which is not the sum of race and sex discrimination, but where discrimination by race *and* gender occurs simultaneously.

Intersectionality connects to social injustice as it directly challenges anti-oppressive practice and supports the epistemological practices of those with compound social identities (Haskins, Ziomek-Daigle et al. 2016). It also affirms that people may be members of various communities and it is possible to know and have experienced both oppression and privilege at the same time as a result of the intersections among identities. Although Crenshaw focused primarily on the intersecting workings of race and gender and did not explicitly address how other identities such as sexuality, nationality and class further compound an individual's experiences, she did argue that because we all exist within "the matrix of power", intersectionality is applicable to all individuals.

> *"Intersectionality represents a structural and dynamic arrangement; power marks these relationships among and*

between categories of experience that vary in their complexity."
(Crenshaw 2011) pg. 230

This has been expanded upon since and intersectionality has been adopted in many disciplines and has exposed how single-axis thinking undermines legal thinking, disciplinary knowledge production and struggles for social justice (Cho, Crenshaw et al. 2013), acknowledging that people consist of many different types of identities with multiple layers created from past experiences, social relations and varying power structures (Women's Rights & Economic Change 2004). McCall goes on to define intersectionality as:

"the relationships among multiple dimensions and modalities of social relations and subject formations – as itself a central category of analysis" (McCall 2005) pg. 1771

And Bowleg depicts intersectionality broadly, as:

"a theoretical framework that posits that multiple social categories (e.g., race, ethnicity, gender, sexual orientation, socioeconomic status) intersect at the micro-level of individual experience to reflect multiple interlocking systems of privilege and oppression at the macro, social-structural level (e.g. racism, sexism)" (Bowleg 2012) pg. 1267

Socioeconomic class is now considered to be a critical factor in intersection-driven discussions, particularly for women of colour. Brah and Phoenix argue that:

"if we consider the intersections of 'race' and gender with social class … the picture becomes even more complex and dynamic"
(Brah and Phoenix 2004) pg. 80

Intersectionality is highly relevant to the thesis as the group of women it describes often have multiple areas of disadvantage (in terms of health, socio-economic disadvantage and race as well as gender), which can act as a barrier to consistently accessing support for both related and interdependent treatment needs that contribute to offending behaviour and worsen outcomes.

In summary, intersectionality theory provides a key framing for the interaction between dynamics of nationality, racial identity, socio-economic class, disability and

sexuality and gender. It is therefore a key theory in the development of my research, given the complexity of the lives of women with mental health conditions who come into contact with the criminal justice system.

3.3 Female criminality theory: an intersectional lens

Gender is an established and central topic in criminology and studies of criminal justice (Heidensohn and Silvestri 1995). It is recognised that dominant theories of crime (e.g., anomie, cultural transmission, conflict) are essentially theories of lower class, male criminal behaviour, which is a problem given offending behaviour - and the motivators of that behaviour - differs for men and women (Steffensmeier and Allan 1996, Francis, Soothill et al. 2004, Kim, Gilman et al. 2019). In 2014, Islam et al aimed to summarise existing theories that do relate to female criminality (Islam, Banarjee et al. 2014), which include masculinisation theory (criminal behaviour in women is driven by masculine behaviour), opportunity theory (involvement in criminal activities increases when women have different opportunities), marginalisation theory (victimisation of women instigates them to commit crime), and chivalry theory (lower rates of female criminality exist because of the more lenient treatment of female offenders by criminal justice personnel). In reviewing the methods used to generate these theories, Islam et al concluded that marginalisation theory was the only theory that was reliable and potentially valid.

Marginalisation theories have linkages with structural oppression and post-structural feminist theories and include both economic and social strands. Economic marginalisation theory (Chesney-Lind and Daly 1988) argues that women are motivated to commit crime as a rational response to poverty and economic insecurity, and that the major causes of female crime are unemployment, poorly paid employment, inadequate welfare payments and the increasing number of female-headed households with large numbers of children (Small 2000). According to Smith's (1980) seminal article "Women, crime and deviance", in a capitalist social structure, females commit crime as a result of their socialisation process and economic marginalisation, which results in women committing crime to address economic needs cited in Islam et Al (2014) (Islam, Banarjee et al. 2014). Meanwhile feminist theorists have emphasised early childhood experiences of women's physical and sexual torture and related this to female criminality (Simpson 2000).

Intersectional criminology is a relatively new area of focus which Potter (2015) defined as:

> *"A perspective that incorporates the intersectional or intersectionality concepts into criminological research and theory and into the evaluation for crime-related policies and laws that govern the 'administration of justice'" (Potter 2015) pg. 3*

This provides a broad conceptual descriptor to consider how factors such as sexism, racism, homophobia and other prejudices shape individuals' experiences within the criminal justice system. Prior research suggests that Women of Colour are treated differently within the criminal legal system due to gendered and racialised stereotypes related to femininity and criminality, and face greater suspicion and harsher treatment from criminal legal practitioners than white women who are more commonly unsuspected, let go or given lighter sentences (Hitchens, Carr et al. 2017). An intersectional lens has also been used to understand women's experiences of intimate partner violence (Arnold 1990, Potter 2006, Potter 2008, Richie 2012), pathways to crime (Bernard 2013), drug networks (Evans 2019) and being incarcerated (Willingham 2011, Williams, Spencer et al. 2020). However, less is known about women's experiences and perceptions of the legal system and process.

Bernard (2012) introduced a framework to address the idea that Women's criminality may be driven by their constrained realities. The framework focuses on:

> *"The ways in which power structures and systems of oppression work to circumscribe the life experiences of persons socially located at the intersections of multiple vulnerabilities" (Bernard 2012) pg. 4*

This approach claims that intersections of social roles and relationships including oppression and privilege are a primary contributing factor to decisions about criminality, and that the decision to engage in crime is influenced by a combination of factors, regardless of an individual or group's economic status. We know that not all marginalised women resort to crime and that some affluent women seek illegitimate means to achieve their goals. This challenges the assumption that the impact of these factors on the ability of individuals to cope with the complexity of their vulnerabilities can be mitigated through obedience to the law and conformity to social norms. Reiman (2003) adds that, for marginalised women, a distinguishing feature when

compared to a more privileged female offender is that their opportunities and agency to commit crimes differ in quality and consequences (Reiman 2003).

The women discussed in later chapters of this thesis have multiple vulnerabilities and have been involved in offending behaviour, which Bernard's framework suggests can be explained based on an understanding of the process of 'doing identity' or the process of 'becoming somebody' while navigating social complexities and inequalities. Doing identity requires complex and advanced decision-making capabilities to identify pathways that are reasonable and feasible given an individual's social location, circumstances and context (Bauman 2000). Establishing these pathways is far more challenging for individuals facing multiple vulnerabilities, resulting in the process of doing identity being constrained by their lack of opportunities and capacity to navigate them.

This complexity of social location, context and intersectional disadvantage suggests that, when seeking to understand drivers of offending behaviour in women, each factor and how it interacts with others should be considered and understood. In crime-based studies, feminist researchers have been at the forefront of incorporating an intersectional approach, and several criminological studies have demonstrated the importance of doing so (Bui 2004, Smith 2005, Diáz-Cotto 2006, Villalón 2010). However, in 2010, Kathleen Daly argued that, although there have been a few attempts at applying intersectionality in criminological research, *"intersectional analyses are more an aspiration for the future than a research practice today"* (Daly 2010) and this viewpoint was reiterated in a British context in 2017 (Parmar 2017).

Aside from much of the work done by critical and feminist criminologists, the field of criminology has often ignored or disregarded the importance of power dynamics in socially constructed identities and how they relate to crime, criminality and formal responses to offending behaviour (Daly 2010). As Bernard's framework suggests, intersectional criminology could unlock understanding of drivers for offending behaviour and advance prior applications of intersectionality to contexts of multiple vulnerability, which is relevant to the women discussed in this thesis.

3.4 Intersectionality and mental health care

Given that mental health conditions are also shaped by a range of social and cultural realities, it follows that intersectional frameworks could be of value to the mental

health landscape, in changing treatment and practice. Intersectionality theory maintains that we cannot accurately forecast health outcomes or social experience solely along individual axes (Warner 2008), as constructs of identity are not independent of one another and should be measured as interlocking mechanisms. Within the mental health literature, some attention has been paid to the value of using intersectionality to conceptualise these differences, specifically within therapeutic settings. Robinson (1993) argued that disadvantaged gender, race, class and cultural positions could result in feelings of powerlessness and that counsellors may encourage empowerment through discussing these intersections with their clients (Robinson 1993). She believed that this could enable an individual's acceptance of their realities that allowed them to reframe their situation and resist the internalisation of negative behaviours and attitudes. This is relevant to this thesis as we move on to discuss what appropriate treatment looks like for women with multiple disadvantage and evaluate an intervention which aims to provide it.

Discourses of ethnic specificity and specialisation may also lead mental health care providers to simply assume that consulting room encounters will include cultural and language barriers, leading to `race anxiety`, a situation in which they may not feel able to offer available mental health care expertise and treatments because they feel ill prepared and worry about being inappropriate and possibly accused of racism. The result of this may be that clients are referred to services available within their own cultural `communities', which could mean poorer mental health care. Clients may avoid services within their cultural communities if confidentiality is considered to be an issue. In this setting, mental health practitioners from within the cultural community may not question accepted cultural practices that have negative consequences for health. For example, when culture is prioritised over gender, problems like domestic violence and female circumcision can be defined as a private matter, i.e., as `culturally specific' practices that are the concern of a particular cultural community and therefore are not addressed by the health care system.

Finally, there are concerns that policies and laws, e.g., regarding immigration and residency status, could result in certain women being excluded from the health care system. Burman (2004) suggests that an intersectionality framework that draws attention to similarities as well as differences can serve to disrupt the processes that obscure or exacerbate certain health-related problems, impede adequate care and exclude some people from the mental health care system (Burman 2004).

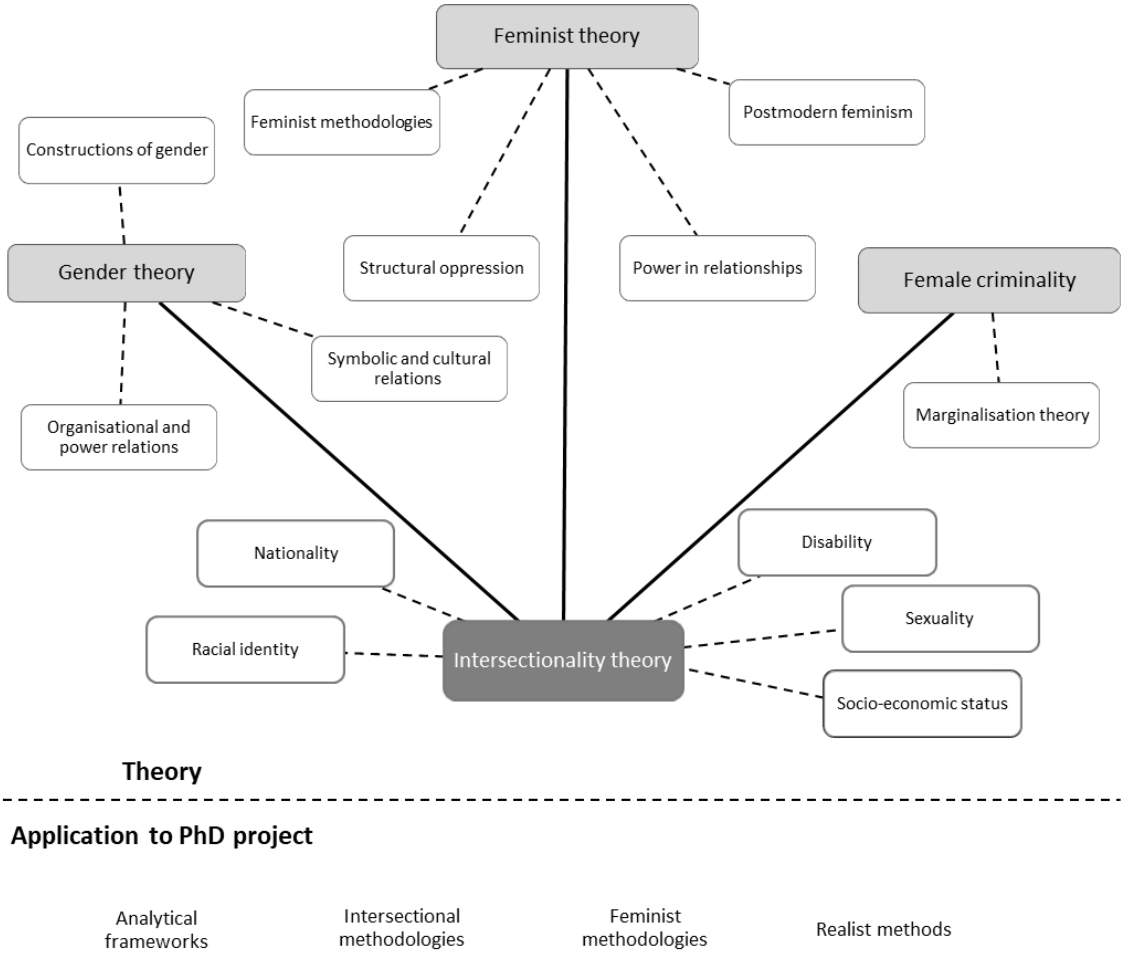
Viewing access to appropriate healthcare through an intersectional lens is highly relevant to the group of women discussed in this thesis, both through the potential challenges they face in accessing treatment and support, and through the service provision itself, which may not be appropriately designed or delivered for them.

3.5 Thinking through the complexity of women's lives: a theoretical framework

Throughout this chapter I have argued the value of an intersectional approach within literature relating to women within the criminal justice system. I have shown that intersectionality is based on the underlying assumption of heterogeneity within groups of 'men' and 'women' and recognises that individuals are defined by multiple, intersecting dimensions, such as gender, class, ethnicity, (dis)ability, sexuality and age (Hammarström, Johansson et al. 2014). This approach was developed as a critique against the dichotomous way of dividing gender without analysing differences within the group of men and within the group of women (Crenshaw 1989, Hankivsky and Cormier 2009, Hankivsky 2012), with the important insight that not all women experience oppression in the same way. This links to theories of female criminality, most notably economic marginalisation theory which posits that women are motivated to commit crime as a rational response to poverty and economic insecurity and, as such, class dynamics and social stability interact with gender to impact the risk of criminal behaviour. Intersectionality can also explore underlying themes across gender and feminist theory in relation to structural oppression, organisational and power relations. All of these theoretical concepts can be brought together to help to understand how to improve outcomes for women with multiple disadvantage, from both a criminal justice (through reduced offending behaviour) and a health perspective.

Figure 3 presents a theoretical framework to demonstrate how the ideas relate to each other and how I apply them in the thesis. Specific application to the research design and execution is discussed in detail later (4.6).

Figure 3: theoretical framework



Each of these theoretical domains is relevant when considering the complexities of women with multiple disadvantage. Intersectionality requires an understanding of the disadvantages that a woman may have, to determine how best to address their needs. Intersectionality can provide, not only a theoretical basis for evidence and analysis, but also tools for researchers to use in research design and analysis. Gender theory provides a strong foundation for considering several dynamics that could be at play when considering the needs of women and risk factors for criminality. *Constructions of gender* offer potential explanations for behavioural differences between men and women which could help to explain socialisation processes leading to criminal behaviour, engagement with treatment programmes and recovery needs. *Organisational and power relations* in criminal justice proceedings are relevant in considering how women are perceived by courts, juries and social care systems, particularly for women who are not seen to align their behaviours with typical gender roles, creating an intersection with *symbolic and cultural relations*. *Marginalisation theory* provides a valuable perspective in recognising the complexity of individuals in

relation to drivers of criminal behaviour. This aligns with feminist theories of female oppression (structural, relational and cultural) and provides insight into gendered risk factors. Each of these concepts has a place in working with the complexity of appropriate diversion and treatment for women with multiple disadvantage.

I applied the theoretical framework to the research methods through (i) integrating relevant theoretical concepts in the development and application of analytical frameworks; (ii) an intersectional approach to research design through the focus on a specific study population; (iii) feminist methods of interrogation and analysis; and (iv) the application of realist methods to ensure that individual contexts (including gender, intersectionality and support needs) are understood.

3.6 Chapter summary

The primary theoretical basis for this thesis is intersectionality, informed by concepts from feminism, gender and female criminality. In this chapter, I have explored intersectionality within the space of feminist, criminology, and mental health literature, as the complexity and severity of the issues faced by the women at the heart of the thesis means that for interventions to effectively tackle them their design should draw upon evidence across these overlapping domains.

Intersectionality highlights the significance of the complex interactions between contextual factors. Addressing this complexity and examining how context impacts the success of interventions can be facilitated by employing realist approaches, which emphasise the importance of examining contextual influence and how this leads to specific outcomes. The application of the theoretical framework, including the role of realist methods is discussed in the following chapter.

Chapter 4 Methodology and research design

4.1 Introduction to chapter

In this chapter I introduce my use of realist methodology, discussing its application in synthesis and evaluation activities and how this is applied to the detailed design of my research. I provide an overview of how I addressed my research questions including the data collection approaches that were used, before revisiting the theoretical model previously presented in 3.5 and how intersectionality and feminist methodologies are applied in the context of this research.

To begin, I address the realist methodology that will be applied across the thesis as a whole, before describing specific approaches to each aspect of the work.

4.2 Methodological considerations: Critical realist philosophy in the context of intersectionality

"Realism is a methodological orientation, or a broad logic of inquiry that is grounded in the philosophy of science and social science" (Pawson 2006) pg. 17

'Realism' refers to a philosophy of science which falls between positivism ('there is a real world which we can see and understand directly through observation') and constructivism ('given that all we can know has been interpreted through human senses and the human brain, we cannot know for sure what the nature of reality is') (Wong, Greenhalgh et al. 2012). Realism agrees that there is a real world and that our knowledge of it is processed through human senses, brains, language and culture. It also argues that we can improve our understanding of reality because the 'real world' constrains the interpretations we can reasonably make of it. While our knowledge will always be partial and imperfect, it can accrue over time (Wong, Greenhalgh et al. 2012).

Within this philosophy, ideas about the world are considered "theories", capable of being rationally tested for their ability to accurately characterise reality (Jessop 2005). To further build on these theories, the nature of "reality" needs to be considered. A key idea from critical realism is that reality is stratified into three levels (Collier 1994., Benton and Craib 2010, Easton 2010, Pawson 2013): (i) The Real: The stratum of mechanisms, powers, and tendencies; (ii) The Actual: The stratum where sequences

of events occur; and (iii) The Empirical: The level of observable and experienced events, which comprise a small subset of the “Actual” stratum (Collier 1994.). Within this framework, events are considered to be the actualisation of causal mechanisms (Vogel 2014.), and to produce knowledge means to develop explanatory theories for why and how patterns of events – empirically observed but happening in the actual stratum – occur. The role of critical realist research is to uncover this through developing an understanding of the causal processes (mechanisms) that produce them (Pawson and Tilley 1997, Fletcher, Jamal et al. 2016).

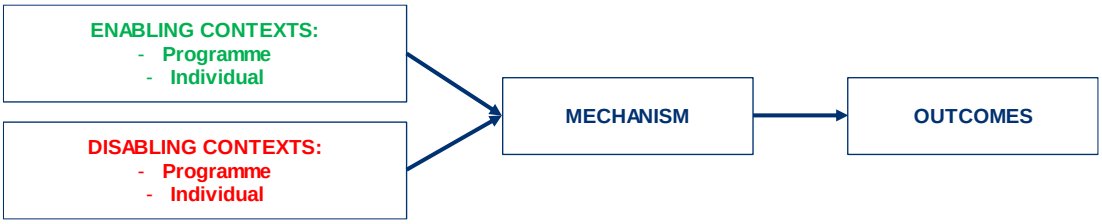
Critical realism holds that events are driven by mechanisms, described as “generative” (Collier 1994., Vogel 2014.), under which a view of predetermination (i.e. where manipulation of one factor leads to a change in another) can only be achieved in a “closed system” (Vogel 2014.), in which one mechanism is completely isolated from other causal processes (Collier 1994.). However, with social phenomena it is difficult to determine how the various causal mechanisms could be isolated experimentally (Pawson and Tilley 1997), as individuals cannot be isolated or closed off. Social systems are therefore considered “open”, with mechanisms interacting in complex causal webs (Collier 1994.). When exploring causality within an open system, such as in a complex health and social care programme, evaluators need to identify the mechanisms at play and theorise how they interact with the context they are operating in and other mechanisms to produce a recorded outcome (Pawson and Tilley 1997, Matthews 2009). Patterns of outcomes in open systems become “demi-regularities”, with the influence of context making them only semi-predictable (Randell, Honey et al. 2017).

Realist approaches support analytical engagement with complexity, through providing a systematic and structured approach to understanding how interventions work in complex social settings. This is particularly useful when considering intersectionality, as realism recognises that interventions aimed at addressing social inequalities must be sensitive to the intersections of different social identities, such as race, gender, class, sexuality, and disability, and allows researchers to explore the multiple ways in which social identities intersect and how this intersectionality influences the effectiveness of interventions. Realist and intersectional approaches are also compatible as they both advocate for the adoption of multiple methods in designing an approach to data collection and both allow for the analysis of how different contexts interact with each other to enable or disable mechanisms.

To understand the relationship between context and outcome, realism uses the concept of 'mechanism', which can be defined as '… underlying entities, processes, or [social] structures which operate in particular contexts to generate outcomes of interest' (Wong, Westhorp et al. 2013). Dalkin et al. add detail to the way in which mechanisms are considered and describe differences in where the force of change is located (Dalkin, Greenhalgh et al. 2015). Bhaskar's philosophy suggests that causal mechanisms sit primarily within the structural component of the social world and are therefore centred within the power and resources that lie with the great institutional forms of society (Bhaskar 1978), whereas other realists, such as Pawson and Tilley (Pawson and Tilley 1997), argue that mechanisms are identified at the level of human reasoning, which in turn results in mechanisms having different meanings depending on the scope of the intended explanation. Throughout this thesis, the approach has been to consider structural, intervention-based contextual changes, which can create an enabling environment for mechanisms.

Variation in contextual factors and how they interact with mechanisms is an explanation for variation in the effectiveness of interventions. This structure is used to describe context-mechanism-outcome configurations, which explain what makes a programme more or less effective at achieving its intended outcomes. Figure 4 depicts this structure, and a brief glossary of terms that will be used in this chapter can be found in the Glossary, which is largely composed of definitions from RAMESES II training materials (Wong, Westhorp et al. 2013).

Figure 4: Context mechanism outcome structures



In summary, realism holds that mechanisms matter because they generate outcomes, and that context matters because it changes the mechanisms by which an intervention produces an outcome. This means that both contexts and mechanisms need to be researched to draw conclusions on what makes an intervention effective or otherwise.

4.3 Realist synthesis and evaluation

Realist syntheses or reviews have emerged as a strategy for synthesising evidence and providing explanations for why interventions may or may not work, how, for whom, and in what contexts (Pawson, Greenhalgh et al. 2004, Pawson, Greenhalgh et al. 2005), utilising the concept of Context-Mechanism-Outcome configurations. The aim of a realist synthesis is *'…to articulate underlying programme theories and then to interrogate the existing evidence to find out whether and where these theories are pertinent and productive…'* (Pawson 2006). Focusing on what it is about an intervention that makes it work (or not) in a given context should enable implementation researchers to work at the level of mechanisms of action (Rycroft-Malone, Fontela et al. 2010). The premise is that in certain contexts individuals are likely (although not always certain) to make similar choices, and therefore particular contexts influence our choices such that patterns emerge ('demi-regularities'), which can be defined through middle-range theories (Pawson 2006) ('programme theories').

Traditional systematic review approaches have been criticised for being too specific and inflexible (Pawson, Greenhalgh et al. 2004, Pawson, Greenhalgh et al. 2005, McCormack 2007, Rycroft-Malone 2012), which is important given the complexity of implementing health and social care interventions. As a result, their application to evaluating the evidence of whether interventions work (or not) often results in limited answers such as 'to some extent' and 'sometimes' (Pawson, Greenhalgh et al. 2004, Pawson 2006, Rycroft-Malone 2012). We saw earlier that there is variability in effectiveness of diversion programmes, which makes realist approaches particularly appropriate for these interventions. A comparison of realist and systematic reviews can be found in Table 1 .

Table 1: key differentiators between systematic and realist reviews (Future learn 2022)

	Systematic review	Realist review
Aim	EVALUATIVE – to assess the effectiveness of an intervention or summarise the evidence around a topic	EXPLANATORY – to explain how an intervention works, in what contexts, for whom, and why
Intervention type	Typically single, discrete	Complex
Methodological approach	LINEAR – a systematic literature search is followed by statistical synthesis, meta-analysis, or descriptive summary of findings	NON-LINEAR - one or more systematic literature searches are supplemented by lived experience of stakeholders in an iterative process of theory-driven synthesis to unpack candidate theories that explains how an intervention works
Types of evidence	Empirical quantitative and/or qualitative research depending on the research question. Evidence from experimental studies are generally prioritised over non-experimental studies, except in descriptive reviews summarising the evidence around a topic	Evidence may include research and non-research information, such as opinions from subject matter experts, stakeholders, and policy papers
Sources of evidence	Typically peer-reviewed journal literature	Typically multiple sources, including peer-reviewed journal literature, interviews, focus groups, grey literature, policy reviews, and guidelines
Rigor	Very rigorous	Very rigorous

Critical realism argues that a symbiotic relationship exists between people and society, and that each enables and depends on the other (Collier 1994, Vogel 2014). The result of this is that as the wider system evolves this may enable or disable the ability of a social programme to generate change (Pawson and Tilley 1997). Realistic evaluation emerged from critical realism thinking as an approach to help structure evaluations of complex programmes with appropriate consideration for the social processes that might impact them (Pawson and Tilley 1997, Pawson 2006).

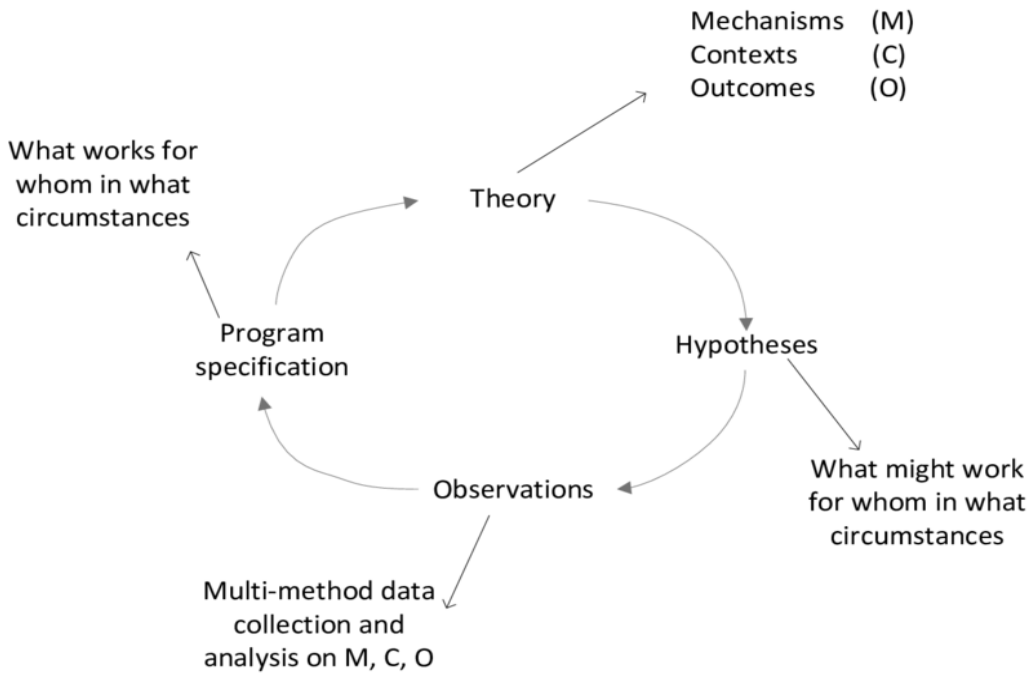
Realistic evaluation is a framework created to support researchers to develop a clearer understanding of how complex social programmes work to achieve their outcomes, through theory-driven evaluation (Lacouture, Breton et al. 2015) focused on asking the question of “why a programme works, for whom, and in what circumstances” (Pawson and Tilley 1997). It provides a clear framework to guide

researchers through a theory-driven evaluation cycle that aims to evaluate, develop and refine programme theories underpinning the programme being evaluated and explain 'what it is about a programme that makes it work' i.e. how, why and under what conditions a programme is most effective (Pawson and Tilley 1997).

To take a theory-driven approach, Pawson and Tilley propose that evaluations begin by developing "initial programme theories" which take the form of context-mechanism-outcome configurations as initial hypotheses for how a programme brings about changes to a social phenomenon within a given context (Pawson and Tilley 1997). These programme theories are then utilised as a framework against which to generate data and to test in the course of the evaluation (Pawson and Tilley 1997, Marchal, Dedzo et al. 2010, Marchal, van Belle et al. 2012, Lacouture, Breton et al. 2015).

The guiding framework for the realist evaluation cycle has four key steps, shown in Figure 5 (Pawson and Tilley 1997).

Figure 5: the evaluation cycle, Pawson and Tilley



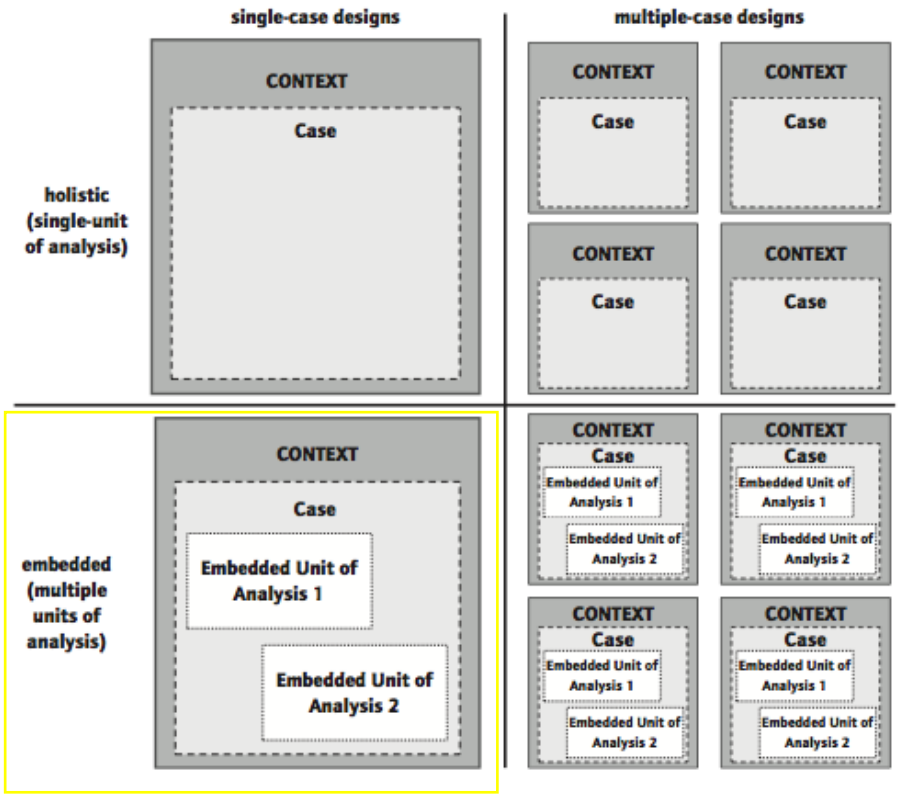
Realistic evaluation is a flexible model which advocates for the choice of method being led by the type of theory to be tested (Pawson and Tilley 1997). A mixed-methods approach is preferable (Vogel 2014), allowing for the incorporation of quantitative and qualitative data. Once generated, data should be tested against the initial programme

theories with the purpose of confirming, falsifying, adapting or refining them (Pawson and Tilley 1997). Through this process of development and refinement, context-mechanism-outcome configurations can be grouped around stages of a social programme to form an explanatory model. These groupings can then be compared across contexts, to develop general statements about how a programme functions (Byng, Norman et al. 2005) - commonly described as “middle-range theories” - being suitably close to original data to remain operational for applied research, whilst also providing crosscutting lessons that can then be applied to the design of other interventions (Wong, Westhorp et al. 2013, Jagosh, Bush et al. 2015, Robert, Samb et al. 2017). These middle-range theories can then act as the “initial programme theory” for future evaluative activities, such that evaluations build on each other in an iterative way (Pawson and Tilley 1997).

4.3.1 Putting evaluation in context: Applying a case study design to realistic evaluation

A case study methodology allows for the investigation of a contemporary phenomenon in depth, within its real-life context. Case study approaches benefit from theory-driven data collection and analysis (Yin 2003). This is compatible with realist evaluation, which seeks theoretical propositions about what works, for whom and in what contexts. As discussed, realist evaluations advocate for applying methodologies most suited to the theory being tested and case studies have been used successfully in combination with realist evaluation principles (Marchal, Dedzo et al. 2010, Rycroft-Malone, Fontela et al. 2010, Williams, Burton et al. 2013). Case study research is also recognised as being particularly useful when the focus is on seeking answers to ‘why’ and ‘how’ questions to understand complex social phenomena (Yin 1994), which also makes it compatible with an intersectional approach. Figure 6 summarises the types of case study design, highlighting the embedded, single-case study model, which I selected for this study.

Figure 6: Basic types of design for case studies, COSMOS corporation



I chose to apply a case study methodology to the realist evaluation cycle in my evaluation of the ITAV intervention, to allow me to generate an in-depth description of the intervention being tested. This was structured as a single case as this is the most effective structure for longitudinal studies that review the same case at specific intervals (Yin 2003). In addition, a multiple-case study would not have been appropriate as, although a number of organisations are participating in the intervention, the intervention is structured as a partnership centred around a single intervention and there will not always be clear boundaries between the work of the participating organisations. The intervention is specifically aiming to blur these boundaries through services working more closely and flexibly together.

The study was designed to have embedded units of analysis as, although it focuses on a single intervention, I wanted to analyse outcomes relating to the type of participating organisation (specifically, differentiating between voluntary and statutory organisations), as well as service users. Each of these groups was therefore treated as a single unit of analysis. A central principle of realist methodology is that programmes work differently in different contexts (Pawson and Tilley 1997), and

embedding these units of analysis could allow for the evaluation of differences across contexts related to the type of study participant.

A common issue for an embedded design is that a case study focuses too much at unit of analysis level and does not return to the larger unit of analysis, i.e. the intervention as a whole. I mitigated this risk in two ways. Firstly, through the approach to analysis, by applying a Thematic Network Analysis (discussed further below), which allows for the required hierarchy of analysis up to the development and articulation of Global themes (Attride-Stirling 2001). Secondly, through engagement with the leads of the intervention, who were focused on the strategic level, to ensure that any material gaps were identified in bringing together information across units.

4.3.2 Analysis of realist data using thematic network analysis

Realist approaches advocate for developing theories based on several partial understandings by synthesising a large amount of data from a variety of sources. This is a strength of the methodology, as it allows for a rich, in-depth engagement with all available evidence, but also provides a challenge in how that data should be robustly collated and analysed. To do this effectively, requires a systematic but flexible analytical approach that can enable engagement with a high volume of varied data.

A Thematic Network Analysis (Attride-Stirling 2001) is a structured way of thematically analysing qualitative data, described in detail by Attride-Stirling (2001):

> *"Thematic analyses seek to unearth the themes salient in a text at different levels, and thematic networks aim to facilitate the structuring and depiction of these themes" (Attride-Stirling 2001) pg. 387*

A thematic network analysis provides an organising system of themes and a structured approach to extracting them from the original narrative. Stirling defines the three levels of themes as follows:

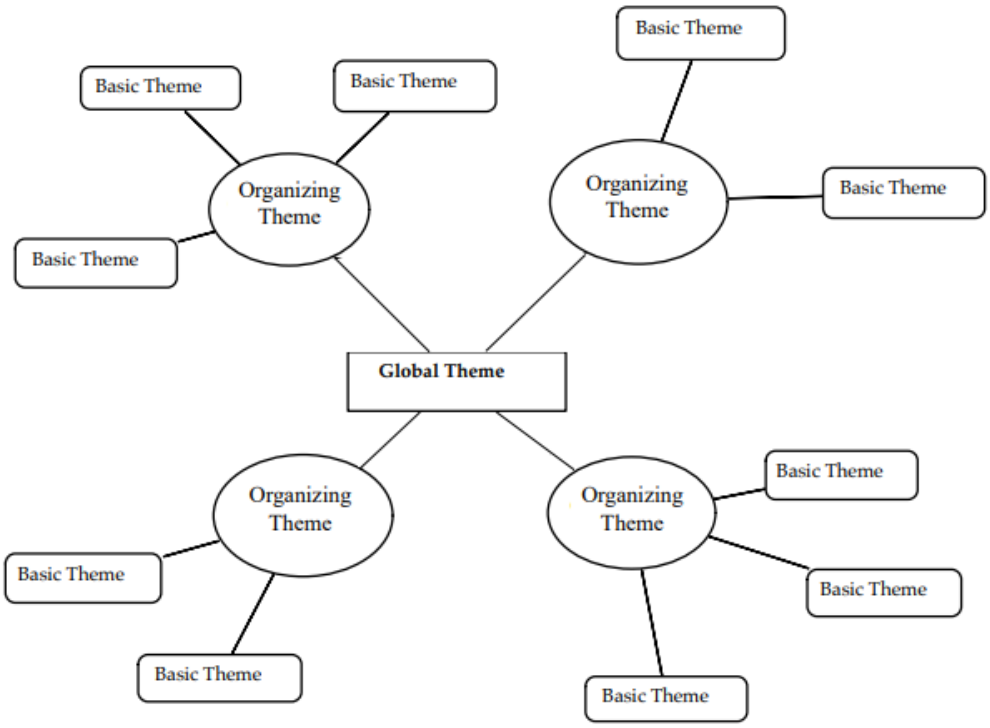
Basic theme: The most basic or lowest-order theme that is derived from the textual data. Basic themes are simple premises characteristic of the data, and on their own they say very little about the text or group of texts as a whole. In order for a basic theme to make sense beyond its immediate meaning it needs to be read within the context of other basic themes. Together, they represent an organising theme.

Organising Theme: A middle-order theme that organises the basic themes into clusters of similar issues that summarise the principal assumptions of a group of basic themes. They are more abstract and enhance meaning and significance. A group of organising themes constitutes a Global Theme.

Global Theme: Global themes group sets of organising themes that together present an argument, or a position or an assertion, about a given issue or reality. They are macro themes that summarise and make sense of clusters of lower-order themes abstracted from and supported by the data. Each global theme is the core of a thematic network: an analysis may result in more than one thematic network.

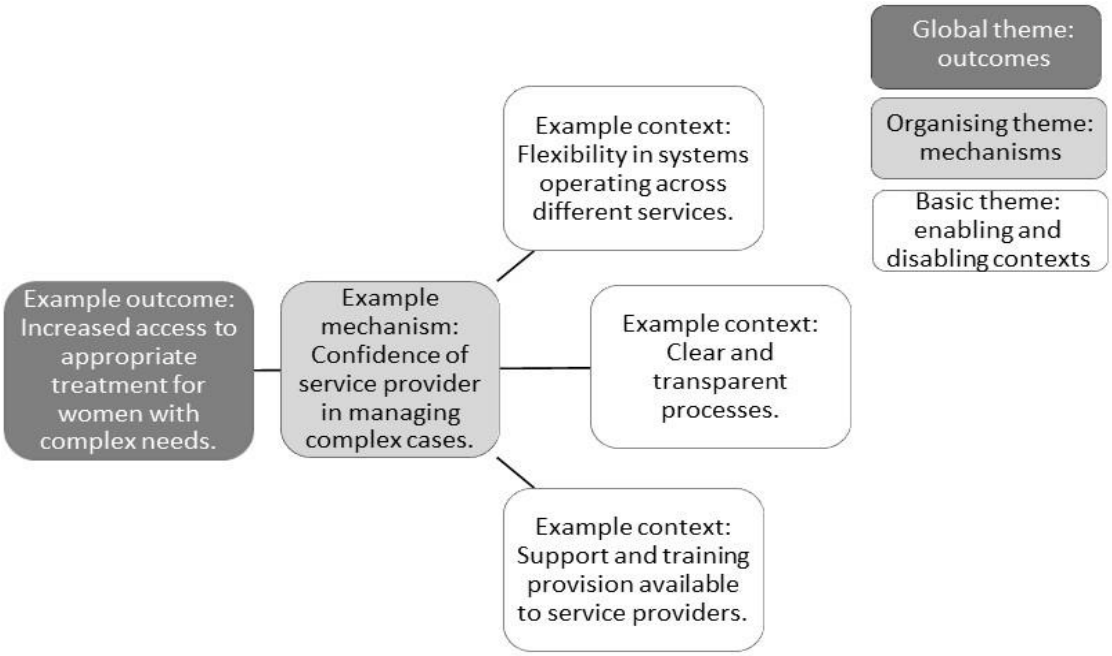
The thematic network is developed by beginning with the basic themes and working up towards global themes. Together, this creates a "web" of themes, depicted in Figure 7 (Attride-Stirling 2001).

Figure 7: structure of a thematic network



This is compatible with a CMO heuristic (Pawson and Tilley 1997), whereby contexts, mechanisms and outcomes can be articulated through basic, organising and global themes. An example of this is provided in Figure 8.

Figure 8: example of organising through a CMO heuristic in line with a thematic network analysis.



This approach allowed me to maintain the CMOC structure throughout my analyses and explicitly link data collection and analysis to programme theories. Once the individual CMOCs were established, I could then group them using the thematic network analysis structure to form hypotheses and essential principles.

The process for grouping CMOCs to form Essential Principles and Hypotheses is discussed in further detail with a worked example from the realist synthesis in 5.9.

4.4 Data collection throughout the thesis

The thesis addresses the Research Questions outlined earlier in two ways, as articulated alongside the data collection methods and sample sizes in Table 2. The research questions and approaches are connected through the subject matter and are underpinned by realist principles.

Table 2. Summary of approaches to addressing my research questions

Research question	**Approach**	**Data collection methods**	**Sample**
How do the key mechanisms associated with the delivery of interventions that include diversion as a component interact with contextual influences and with one another to explain the successes, failures and partial successes of diversion programmes as an intervention to improve the outcomes of women offenders with mental health conditions?	Realist review focused on understanding diversion programmes	• Iterative searching of multiple databases • Interviews with subject matter experts	• 3552 abstracts reviewed • 350 full texts reviewed • 69 included articles • 12 expert interviews
How does the operationalisation and implementation of an intervention aiming to deliver integrated, interdisciplinary care for women in a London borough influence the outcomes of women with multiple disadvantage who are at risk of coming into contact with the criminal justice system, within which contexts and for whom?	Realist evaluation of a boundary spanning intervention (ITAV)	• Interviews and questionnaires with service users and practitioners • Observations (review of materials, participation in meetings and training)	• 33 practitioner interviews • 13 service user interviews • 74 hours of observation • 41 meetings attended

4.5 Ethical approvals

Most research projects require UCL Research Ethics Committee approval, and there are separate approval pathways for high- and low-risk applications which are organised around the vulnerability faced by participants within the research space. There are a set of criteria for determining whether a project is deemed to be high-risk, including but not limited to: research with vulnerable groups, the inclusion of intrusive interventions and the use of deception (University College London, 2023).

The realist review included stakeholder engagement, so ethical approval was required by the UCL Research Ethics Committee. This was a low-risk application as interviews were held only with academics and professionals working in the field, they were felt to be non-vulnerable populations, as such did not meet criteria set by the university requiring a high-risk application. The application was approved in July 2020 [id: 16793/001].

The realist evaluation also included stakeholder engagement, as interviews were held with vulnerable women (service users) as well as service providers working in the field. This was a high-risk application requiring ethical approval from the UCL Research Ethics Committee [id: 16793/002] given the highly vulnerable nature of study and the sensitive nature of the qualitative interviews. In addition to UCL approval, I also had to acquire approval from the relevant local authority. While undertaking the process of seeking ethical approval, the Covid-19 pandemic emerged in the UK. This necessitated a shift in ethical approval such that interviews could be undertaken online rather than in person. The application was approved by UCL and the relevant local authority in October 2020. An amendment to my ethical approval was sought and approved in October 2021 to allow me to interview service users in person (following the Covid-19 outbreak), given the challenges inherent in engaging with this group.

In advance of interviews relating to the evaluation I talked through an accessible format information sheet and consent form with potential participants to ensure there was a clear understanding of what was involved and how their contributions would be used, and participants were given the opportunity to ask questions before signing consent forms. Interviews were recorded using Microsoft Teams for the purpose of transcription, and transcriptions were made available to interviewees on request. Following completion of this work, findings were circulated to all interview participants.

The main consideration in securing ethical approval for the evaluation was that research participants would be asked to discuss their experiences, including interactions with mental health services, interactions with the criminal justice system and services received from the programme being studied, which could bring up distressing memories and feelings. I planned to deal with this by:

- Offering to the participant in advance that they could attend with a friend, family member or professional to support them if wished.

- Ensuring that participants knew they could pause or stop the interview at any time. Should it appear that a participant was getting upset or distressed, I would remind them of this to allow them to cease talking about the topic.

- Offering alternative methods of answering questions, for example the opportunity to respond through writing or drawing.

Should the interviewee become increasingly distressed, I planned to ask them if they wished to seek support from a member of the programme team and provided them with details of alternative support services. If needed I would refer to the relevant Community Mental Health Team, ideally with consent.

Outside of formal approvals which focus primarily on confidentiality, data management, dissemination and informed consent, planning for interviews with vulnerable participants necessitated additional consideration (Bracken-Roche, Bell, Macdonald, & al., 2017; Gordon, 2020). First, I considered potential power imbalances related to the misalignment of priorities between interviewee and interviewer and related to the fact that women were being compensated for their time. I mitigated this through capturing and sharing all feedback raised by participants to the ITAV programme team, even when not relevant to my research, and by being clear with participants that they could close interviews whenever they wanted, so that they did not feel compelled to continue speaking to me to ensure that they receive their compensation. Second, I was conscious that the women I was interviewing came from different cultural and social backgrounds to me which is documented as a barrier in conducting interviews. I mitigated this through following guidance on cross-cultural interviewing, such as being transparent about the content and structure of the interview, incorporating choice in how the interview is conducted (in terms of location and whether this is in-person or remote), providing space for women to share their

personal stories, and gaining advice from experts in the ITAV team before undertaking the interviews (Sands, Bourjolly, & Roer-Strier, 2007). Finally, I was conscious of the need to consider my positionality, which I reflect on in greater detail in 9.5.3.

4.6 Application of theoretical framework

As introduced in Chapter 3 and presented in Figure 3, I developed a theoretical framework in this thesis to articulate relevant theoretical considerations that were applied to the design of this PhD project. Below, I discuss how I applied this theory to research design.

The application of intersectionality in diverse contexts has been increasingly represented in literature (Crenshaw 2015, Gillborn 2015, Griffin, Cunningham et al. 2016, Jones and Day 2019, Ramos and Brassel 2020) and there is evidence that an intersectional approach can more effectively inform strategies to eliminate inequalities across multiple dimensions (Weber and Parra-Medina 2003). Intersectionality functions as a lens through which issues of identity and their relationship to power dynamics and systems can be framed (Crenshaw 2015), which is relevant in the context of women with mental health conditions given the power imbalances inherent in system access and involuntary detention, whether that be related to the criminal justice system or hospitalisation.

Collins and Bilge suggest that intersectionality is an analytic tool that *"gives people better access to the complexity of the world and of themselves"* by rendering us able to account for the organisation of power and the shaping of our lives by multiple simultaneous and mutually influencing axes of social division like race, gender and social class (Collins and Bilge 2016) pg. 2. Similarly, Yuval-Davis claims that intersectionality *"should be considered the most valid theoretical approach to study social stratification"* (Yuval-Davis 2015) pg. 92, suggesting two primary reasons for this: (i) intersectionality contemplates the multiple mutually constituted social divisions in effect in any organised system of power; and (ii) it acknowledges that the social, political, historic and economic context determine the salience and the effects of these social divisions. An intersectional approach should therefore be simultaneously concerned with the categories affecting most people's lives (e.g. gender), whilst also being attentive to the impact of categories that shape decisively the life of minorities (e.g. sexuality). At the core of intersectionality as an analytical framework is that categories cannot be fundamentally disaggregated as they do not represent individual

differences but intersecting hierarchies within systems of social power, such that according to their intersectional locations an individual may simultaneously experience privilege and disadvantage (Nash 2008, Hancock 2013). The women at the heart of this thesis are from minoritised communities, both in terms of race and social class, so understanding how these contexts impact their lives is critical to understanding how to achieve positive outcomes in relation to their care and diversion from the criminal justice system. When considering methodologies intersectionality therefore presents a level of complexity, but understanding and applying intersectionality enables consideration of how an individual's 'multi-layered self' impacts perceptions of identity and their experiences, such that it is possible to *"socially locate individuals in the context of their 'real lives'"* (Berger and Guidroz 2009) pg. 123. In practice, this means that, instead of focusing on identity characteristics as singular points of analysis in isolation of each other, we can consider how the relationship between these identity characteristics reflect an individual's own lived experiences (McCall 2005).

Intersectionality in research methodologies calls for a focus on enabling consideration of how an individual's multi-layered self, impacts perceptions of identity and their experiences (Shields 2008). I incorporated this in the research design primarily through my qualitative research (compatible with intersectionality as it allows for asking "how" questions), by being attentive to the impact of multiple categories that shape the life of study participants; and by - as McCall proposes - adopting multiple methods, aiming to generate several different, partial understandings of the significance of intersectionality in a given context.

What this looked like in practice in the ITAV evaluation was the use of in-depth interviews to understand how different elements of both the study participants' lives, and the intervention itself, shaped their experiences of the support systems that they were seeking to access. This also meant that, although I applied categories of analysis through the coding framework, I also considered the relationship between these categories in my analysis. To achieve this, I used multiple codes for relevant pieces of data–- for example I coded for "gender" and "race", but also for "gender and race" – and undertook an analysis of the interactions between coded pieces of data. I also prompted for consideration of structural and social divisions through interviews, including the impact of multiple identities that could lead to oppression in the context of power structures. Finally, I structured the service user questionnaires (and subsequent discussion) around the goals of the individual, to acknowledge

intersectional criminology theory that this is more important than consideration of shared cultural goals in understanding motivation of criminal activity.

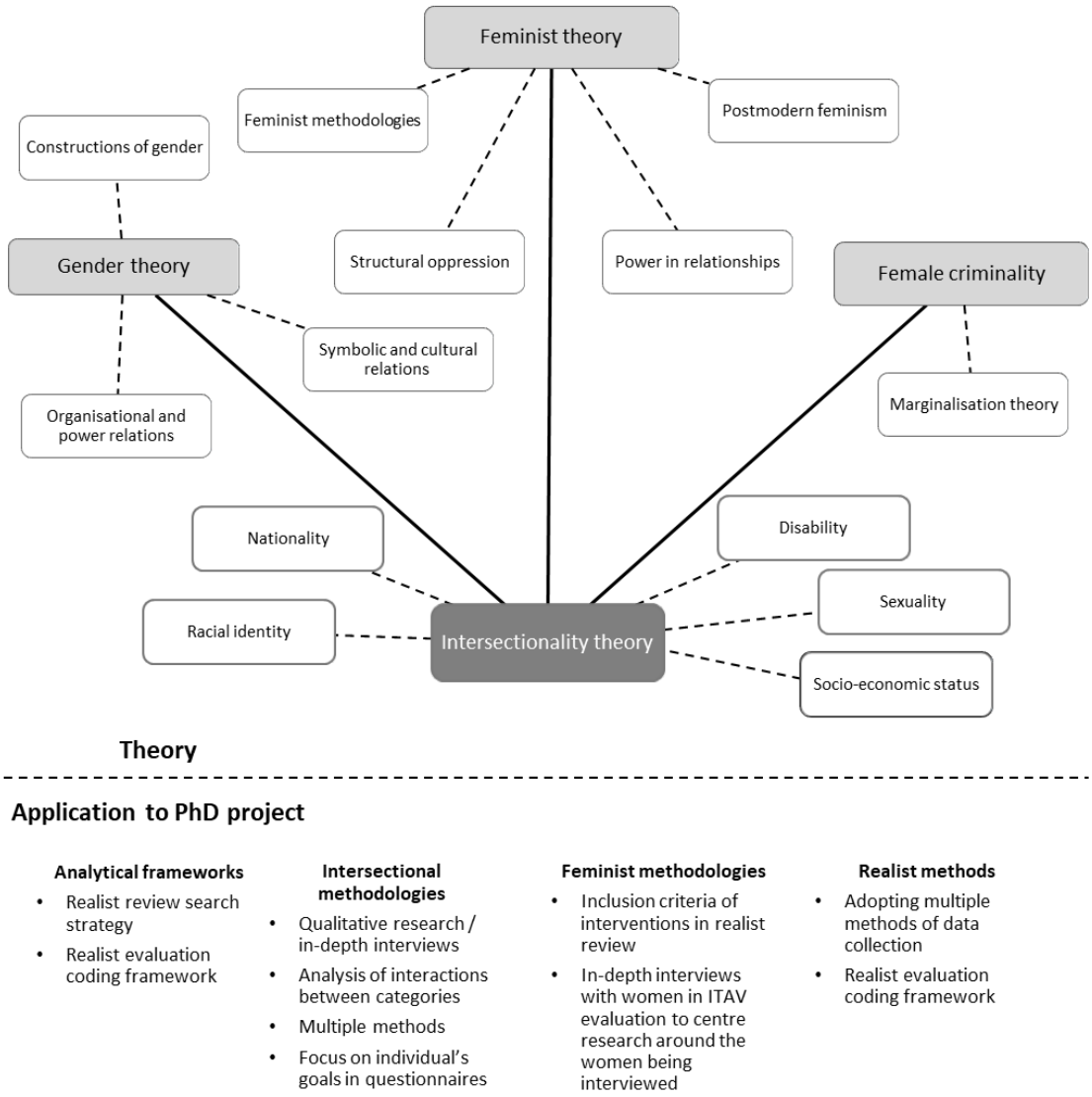
Some branches of intersectionality would advocate against excluding men in analysis focused on women, to help in identifying differences in power structures between the experiences of men and women. However employing an intersectional analysis in research does not always involve focusing on assuring a diverse study sample has been arranged, but can also be applied with a sample of individuals who belong to the same racial and sex/gender group (for example, a study investigating Asian-British women's experiences as victims of violence, in which only individuals who identify as Asian-British women participate) (McCall 2005, Bauer, Churchill et al. 2021). This is also in line with feminist methodology principles of placing women at the centre of investigation.

I applied this approach to the realist review, where studies focused on women, as well as mixed gender studies were eligible for inclusion, with a focus on identifying and articulating differences in outcomes and experiences between genders where they were identified. Similarly, in the ITAV evaluation I focused on women service users, with one participant who was gender non-binary. I decided to proceed with this approach to enable focus on differences within the category of gender and how they interact with other intersectional characteristics such as race and socio-economic status, whilst ensuring an in-depth understanding of the experiences of women within the study.

Analytical frameworks provided the opportunity to further incorporate key theoretical concepts. First, the theory-based searches informing initial programme theories within the realist review approach (described in 5.3). Some specific examples of this are: (i) the inclusion of marginalisation in targeted searches to acknowledge intersectional and feminist criminality theory around risk factors related to marginalisation; (ii) the inclusion of co-morbidity and holistic treatment in targeted searches to acknowledge the high proportion of women who have additional needs such as physical disability, as discussed in intersectional theory; (iii) the inclusion of drug or alcohol misuse in eligibility criteria for interventions, given the linkage between intersectionality and marginalisation theories and literature on co-morbidity of conditions. Second, the coding framework for the realist evaluation (presented in full in 6.3) incorporated the structuring of codes related to the following theoretical concepts: power in relationships, organisational relations and intersectionality.

The theoretical framework originally presented in Figure 3 is expanded upon in Figure 9 to depict how each of the theoretical considerations described above were incorporated in my research design.

Figure 9: application of theoretical framework



4.7 Chapter summary

In this chapter, I began by discussing the relevance of realist approaches, where the methodology emerged from and how it could be applied as an epistemology, specifically through realist syntheses and realist evaluations. I discussed its compatibility with intersectionality and related methods, including case study models

and thematic network analyses. I then discussed the specific approaches being applied in the project in the context of my theoretical framework.

Chapter 5 Understanding diversion programmes as an intervention for women with mental health conditions: a realist review

5.1 Introduction to chapter

In Chapter 2 we saw that diversion programmes are initiatives designed to divert people with pre-existing mental illness from the criminal justice system into mental health services. We saw that these programmes vary in their structure and procedures and operate at various points in the criminal justice process, which can be categorised as pre- or post-booking, and the current literature suggests that they are effective for some, but not all. Furthermore, there is limited understanding of the drivers of this variation (Lange, Rehm et al. 2011, Bonkiewicz, Green et al. 2014). The variability in effectiveness makes realist approaches particularly appropriate for understanding the nature of diversion programmes, and as such becomes the wider framing for the research questions in this thesis, as detailed below.

This chapter presents and discusses the results of the realist review of diversion programmes. Although some evaluations and a small number of systematic reviews have been undertaken in recent years focusing on specific types of alternative sentencing (Lange, Rehm et al. 2011, Bird and Shemilt 2019), this work presents the first realist review exploring the breadth of the topic. This review was published in the journal Social Science and Medicine – Mental Health, in 2022.

5.2 Research questions

In undertaking the review, I responded to Research Question 1: How do the key mechanisms associated with the delivery of interventions that include diversion as a component interact with contextual influences and with one another to explain the successes, failures and partial successes of diversion programmes as an intervention to improve the outcomes of women offenders with mental health conditions?

5.3 Approach

The approach to a realist review is different to that of a systematic review and we saw earlier that some key differentiators of realist reviews are that they: i) are theory driven; ii) are iterative (i.e. made up of multiple searches of the literature that build on

each other); and iii) incorporate stakeholder engagement (e.g. interviews and / or focus groups).

The review followed a five-phase process. It was grounded in the realist approach defined by Pawson (2004) (Pawson, Greenhalgh et al. 2004) and adapted by Rycroft Malone et Al (2012) (Rycroft-Malone, Fontela et al. 2010). I built on this framework to include additional interviews in Phase 3, an approach taken by Rivas et al (2019) (Rivas, Vigurs et al. 2019).

5.3.1 Phase 1: Formulating initial programme theories

In line with the realist methodology (Pawson, Greenhalgh et al. 2004, Rycroft-Malone, Fontela et al. 2010), I developed initial programme theories in context-mechanism-outcome configurations in August 2020, by running a broad literature search to describe how diversion services and diversion programmes might impact incarceration and outcomes through described mechanisms.

I began by conducting searches of electronic databases for academic literature related to the initial theories. Throughout the review, searches were run using the following databases: MEDLINE, EMBASE, PsycINFO, PscyARTICLES, Social policy and practice, ASSIA and IBSS. Searches were performed iteratively, as defined by the realist review methodology (Pawson, Greenhalgh et al. 2004, Pawson 2006), and supplemented with citation chaining and hand-searching. The Phase 1 search used the following key search terms, combined with Boolean Operators: alternative sentenc*, anxiety, arrest, community, service, crim*, deferred, adjudication, diversion, service*, female*, incarcerat*, mental health, mental competency, disorders, health, well-being, wellbeing, parole, police, pre-arrest, prearrest, prison*, probation, psychology, applied, suspended, wom?n

This initial search strategy is included in Appendix B. These search terms were iterated in subsequent searches to achieve more targeted searching.

Eligibility criteria included interventions focused on adults with mental health issues, including substance use disorders, at any juncture in the criminal pathway. The criteria notably excluded juvenile programmes, interventions that did not target individuals with mental health issues and studies based solely on men.

A data extraction table was developed in Microsoft Excel (see Appendix C) to use in search #1 and the subsequent targeted searches, to capture information on contexts, mechanisms and outcome combinations discussed in the papers, as well as assessments of relevance, rigour and potential bias.

5.3.2 Phase 2: Applying programme theories

The purpose of this stage was to strengthen understanding of the evidence base, focusing on the initial theories in order to refine them. Evidence identified during searching, data extraction and synthesis was organised and understood through context-mechanism-outcome configurations (CMOCs). To do this, I used the extracted data to create CMOCs that were explicitly linked in the literature. Patterns were identified, with possible explanations alongside other data extracted from other papers and against the emerging theories. I analysed data according to intervention and study type; for example, separating Mental Health Courts from alternative programmes such as boot camps. From these smaller datasets, I then clustered emerging themes across interventions and studies to ensure that the evolving programme theory was underpinned by mechanisms across the range of interventions and contexts.

At this point, I ran a number of targeted searches based on the initial CMOCs. I used these searches to support, refute and develop the initial theories and underpin explanations of refined programme theories for use at the conclusion of the review. In the spirit of the structure used by Rivas et Al (Rivas, Vigurs et al. 2019), emerging themes were developed into Essential Principles, with hypotheses developed through the review underlying each.

5.3.3 Phase 3: Testing programme theories through interviews

Incorporating stakeholder engagement is a key component of the realist review methodology (Pawson, Greenhalgh et al. 2004, Rycroft-Malone, Fontela et al. 2010). Doing so at an early stage has been argued to be a meaningful route to identifying gaps for further literature searching (see Rivas et Al (Rivas, Vigurs et al. 2019)). I conducted expert interviews to refine the initial programme theories and to test the logic of the data extraction table, with an emphasis on identifying gaps.

Six academics were consulted in the first round of interviews. Two were based in the United States, two in the United Kingdom and two in Australia, as countries with

greater adoption of diversion programmes and therefore where the majority of evidence originated. Two individuals had experience in developing and operating post-booking diversion programmes, one in operating pre-booking diversion programmes and all had experience in evaluating diversion programmes. They brought in interdisciplinary views as the group included three psychiatrists, two implementers of diversion programmes, one criminologist with experience in working with police officers both in training and practice and in court, one drug and alcohol abuse expert, and one expert in public service development and public policy. Some had more than one specialism and all had experience of working with women involved in criminal justice, which was an area of specialisation for two experts.

5.3.4 Phase 4: Incorporating feedback and further targeted searching

Once programme theories were refined and future search strategies developed based on expert input, I supplemented previously collected data through searches targeting candidate programme theories through the methodology applied in Phase 1, citation chaining (through backward citation tracking of reference lists and forward citation tracking through Google Scholar) of papers considered most relevant to the review, pragmatic searches of policy databases to identify relevant grey literature and hand-searching for relevant evaluations.

As stated in Table 1, the types of evidence acceptable for inclusion in realist reviews is broader than for systematic reviews, and may include research and non-research information including opinion pieces from subject matter experts and policy papers. This is because from a realist perspective, all document types, and study designs have the potential to contribute useful data for programme theory development and testing, regardless of quality (Pawson 2006). To balance this approach to drawing upon diverse literature with the risk of potential bias this creates, the source of data was considered in estimating risk of bias of each finding, which in turn helped to inform the level of confidence reported in the write-up of the review.

I continued to refine programme theories for these subsequent searches until I was satisfied that I had reached saturation, which was the point at which no new information was emerging.

5.3.5 Phase 5: Narrative development

The purpose of this stage was to test the refined programme theories and to develop iteratively a narrative around the findings of the review. A final data synthesis that drew upon the realist review methodology (Pawson, Greenhalgh et al. 2004, Pearson, Chilton et al. 2015) was completed in the following steps:

- Juxtaposition of sources in ways that might have provided further insights;
- Consolidation of sources when evidence about mechanisms and outcomes was complementary;
- Reconciliation of sources where outcomes differed in comparable contexts;
- Situation of sources where outcomes differed in different contexts;
- Adjudication of sources according to methodological strengths or weaknesses (Gough 2007, Pearson, Chilton et al. 2015).

An example of my approach was the review of evidence related to legal leverage, which was discussed in 10 publications. Five of these found that legal leverage was effective in reducing reoffending, two found that it was not, and three offered explanations for variation in effectiveness. When authors came to differing conclusions, I considered whether study context could explain the variation in observed outcomes. I examined publications whose authors offered explanations for this variation to determine whether the findings were consistent. In the example of legal leverage, preservation of autonomy and reduced feelings of coercion were hypothesised to be factors in the variation in effectiveness, as there was evidence that diversion might not be effective unless people were sincerely motivated to change their lifestyle (Deci, Vallerand et al. 1991, Koestner and Losier 1996, Sheldon, Ryan et al. 1997, Wild, Enzle et al. 1997). The outcome of the analysis is reflected in the table of CMOCs (Appendix D), and a narrative description of the tensions in 5.8.3.

A second set of interviews with the experts engaged in Phase 3 was completed in December 2020, to test the context-mechanism-outcome configurations that the search had uncovered and to assist in refining the narrative around the programme theories. Tensions in the data were raised through these interviews to garner feedback from the group on how they were articulated and managed. When these discussions identified a potential gap, I undertook a further specific data search to be comprehensive in its articulation in the literature.

To articulate the role of gender, my approach was to highlight where specific comparisons were made within a study and collate the information on gender into a single discussion section to give an overarching view of observed differences. There was consensus in the stakeholder group that this was appropriate.

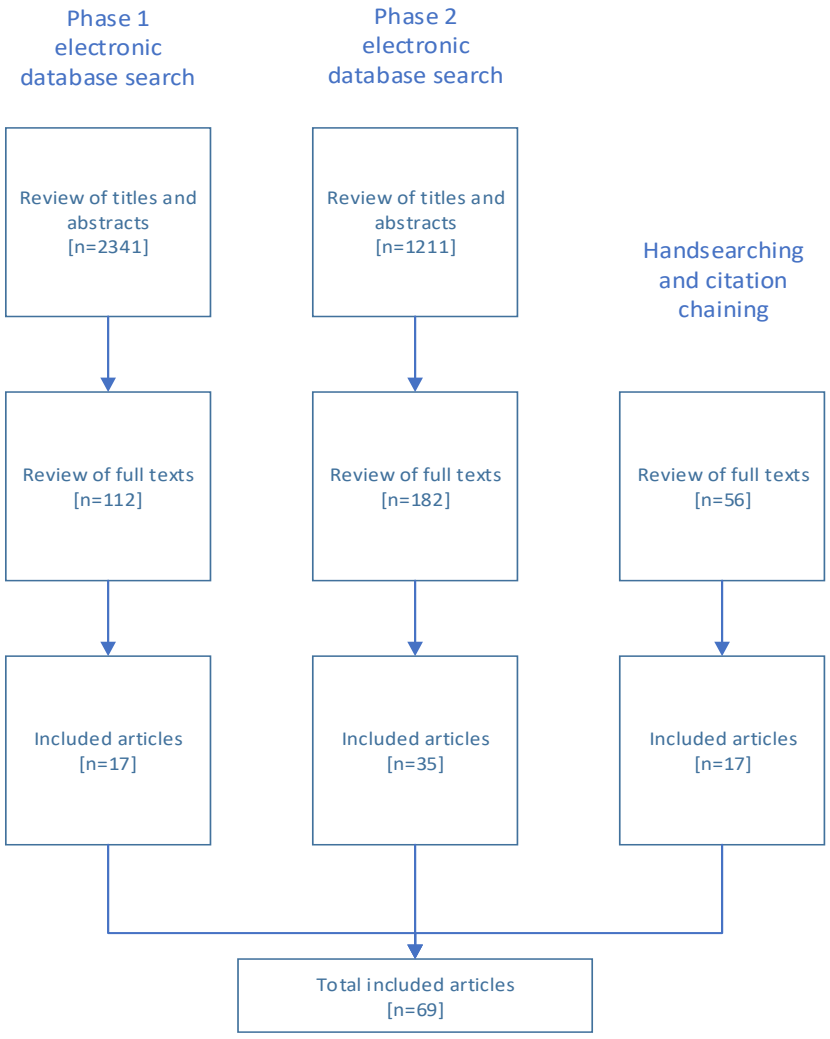
5.3.6 Publication and dissemination of findings

The project was undertaken over a period from August 2020 to March 2021, when a paper was published in Social Science and Medicine mental health (Brady, Burgess et al. 2022). The findings of the review are presented in 5.8.

5.4 Results of the search

Papers were entered into EPPI-4 review management software (Thomas 2010). Figure 10 shows the number of papers included at each stage of the process.

Figure 10: Articles included



Most excluded studies focused on juvenile diversion programmes or only included male participants, both beyond the scope of the review. Despite a desire to explore the specific approaches designed for women, the review identified only eight articles that focused only on women and four additional articles that meaningfully compared needs and experiences between genders. What follows is a discussion of the full sample, which highlights where specific comparisons were made within a study and collates the information on gender into a single discussion section to give an overarching view of observed differences from the literature, which was agreed as an appropriate approach in the stakeholder group.

5.5 Description of studies

Table 3 provides an overview of three types of study—qualitative, experimental, or cross-sectional—against a categorisation of interventions.

Table 3: Overview of studies

	Qualitative studies	**Experimental studies**	**Cross-sectional studies**
Mental Health Courts	4	2	2
Drug Courts	5	4	0
Suspended Sentencing	0	2	0
Crime-specific Programme	1	0	0
Community Service	0	0	0
Probation	1	1	1
Police-based	4	2	1
Community-based treatment	6	1	3
A combination of interventions	14	1	1
None	7	0	1
Other[4]	4	1	0
Totals	**46**	**14**	**9**

Studies categorised as ‘none’ had a specific focus on the participants or practitioners of diversion programmes rather than a specific intervention.

5.6 Quality of studies and risk of bias

Three separate risk of bias checklists were used. To assess risk of bias in experimental studies, the 2011 Cochrane 'Risk of bias' criteria (Higgins, Altman et al. 2011) were used to assess the extent to which each study attempted to control for six potential types of bias and assigned ratings of 'low risk of bias', 'high risk of bias', or 'unclear risk of bias'. To assess risk of bias in cross-sectional (survey) studies, I used criteria from a methods paper (Agarwal, Guyatt et al. 2017). To assess risk of bias in qualitative studies, I used the Critical Appraisal Skills Programme (CASP) (Critical Appraisal Skills Programme) to inform the 'risk of bias' rating insofar as it could be

[4] “Other” interventions: a sober living house, a Dual Treatment Track Program, a court-based coordination function, a peer support group and a parenting programme

applied to qualitative research (Lincoln 1985). Table 4 summarises overall judgements of bias.

Table 4: Bias in included studies

Type of study	High risk of bias	Unclear risk of bias	Low risk of bias
Experimental	0	4	10
Qualitative	2	14	30
Cross-sectional	0	1	8

5.7 Confidence in findings

I used the GRADE-CERQual (confidence in the evidence from reviews of qualitative research) approach to summarise confidence in the evidence (Lewin 2015). After assessing each of the four components, I judged confidence in the evidence supporting each review finding as high, moderate or low as indicated in Appendix D and summarised confidence in each Essential Principle in 5.12. In line with realist review principles I focused on the relevance of the data rather than study quality, and drew upon a diverse range of sources of evidence to construct a comprehensive understanding of the subject matter (Pawson 2006). In this review, I included academic publications, reports and government publications. Given some of these data sources are not peer-reviewed and therefore likely to be less robust, the type of evidence source fed into risk of bias assessments. This is not reported on in detail and the risk of bias assessment was not used to exclude studies. Instead, it helped to inform the overall level of confidence in the findings.

5.8 Essential Principles

Through the literature review, several hypotheses were developed by thematically grouping CMOCs as they were identified. When analysing these hypotheses, four essential principles were identified. These essential principles and hypotheses are summarised in Table 5.

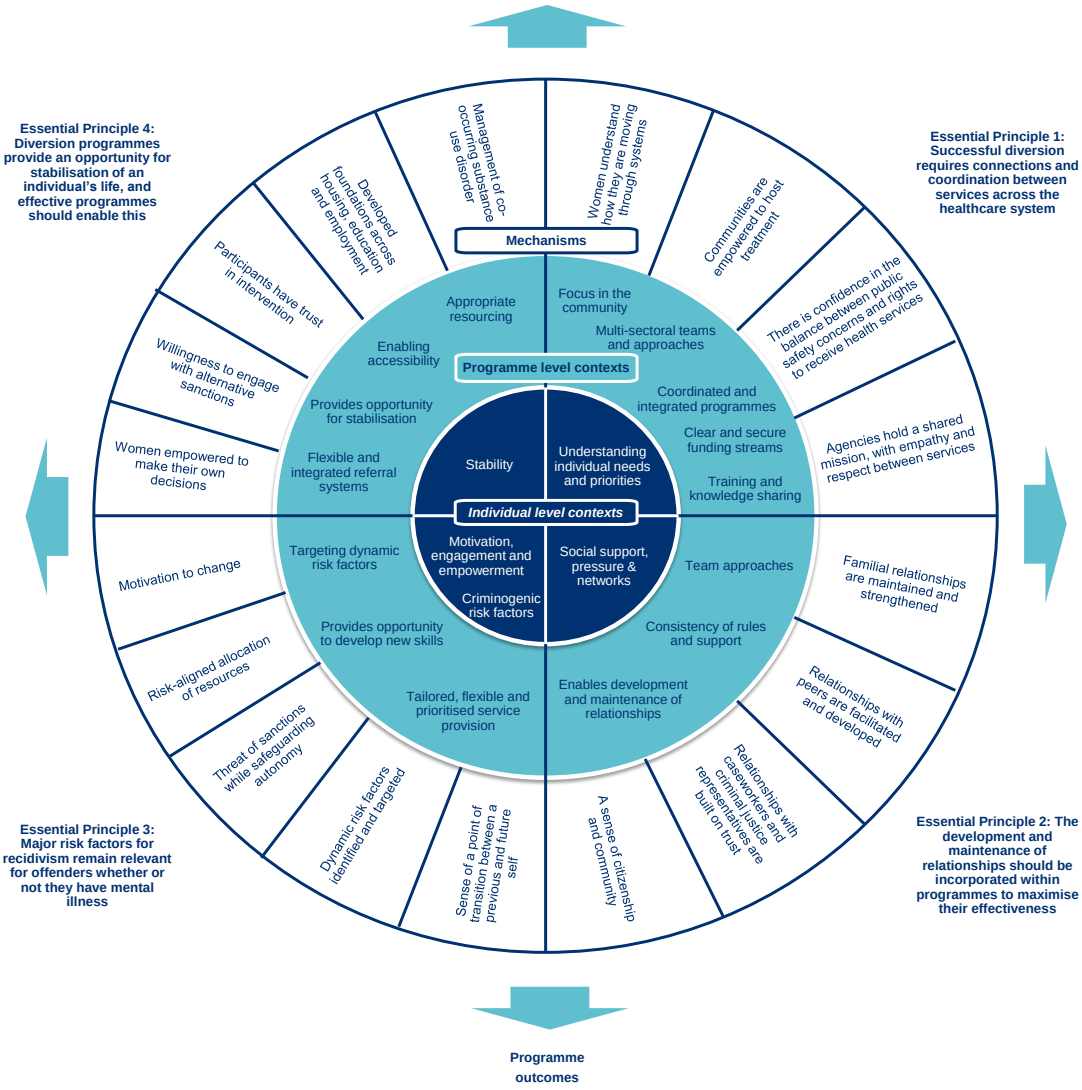
Table 5: Summary of Essential Principles, hypotheses and underpinning mechanisms

Essential principles	Essential Principle 1: Successful diversion requires connections and coordination between services across the healthcare system	Essential Principle 2: The development and maintenance of relationships should be incorporated within programmes to maximise their effectiveness	Essential Principle 3: Major risk factors for recidivism remain relevant for offenders whether or not they have mental illness	Essential Principle 4: Diversion programmes provide an opportunity for stabilisation of an individual's life, and effective programmes should enable this
Hypotheses	*Hypothesis 1:* Coordinated and integrated collaboration between healthcare and criminal justice systems, allows for flexible, prioritised and adaptable access to relevant services, particularly for complex case management *Hypothesis 2:* Having a focal point in the community can enable continuity of care and appropriate identification of follow-on services, and provides additional benefits to the community within which a programme is based *Hypothesis 3*: Multi-sectoral teams, training and knowledge sharing can enable teams to work together towards a common goal of health improvement, which supports the identification and facilitation of effective treatment	*Hypothesis 4:* Social support and pressure can motivate people to change *Hypothesis 5*: Diversion programmes that are designed to enable the development and maintenance of relationships can result in greater treatment and programme adherence	*Hypothesis 6*: If a diversion programme is designed to address criminogenic risk factors as well as mental health treatment, there is a greater opportunity to reduce the risk of offending *Hypothesis 7*: Tailoring service provision to account for immediate and urgent needs, the type of crime committed and history of criminal justice involvement can maximise the effectiveness of diversion programmes by targeting specific risk factors and needs *Hypothesis 8*: Diversion programmes can create an opportunity for participants to develop new skills, making space for behaviour change and an overall change in outlook	*Hypothesis 9*: Diversion programmes are only as effective as the services they link to, which requires flexible and integrated referral systems to enable engagement with relevant services *Hypothesis 10*: Diversion programmes can motivate, facilitate and enable individuals to engage with relevant services through increasing accessibility to participants *Hypothesis 11*: Sufficient levels of resourcing with knowledgeable staff are required for successful assessment and identification of needs that are robust and not limited to one primary issue

Underpinning mechanisms	Women understand how they are moving through systems Communities are empowered to host treatment There is confidence in the balance between public safety concerns and rights to receive health services Agencies hold a shared mission, with empathy and mutual respect	Familial relationships are maintained and strengthened Relationships with peers are facilitated and developed Relationships with caseworkers and criminal justice representatives are built on trust A sense of citizenship and community	Motivation to change Risk-aligned allocation of resources Threat of sanctions while safeguarding autonomy Dynamic risk factors identified and targeted Sense of a point of transition between a previous and future self	Management of co-occurring substance use disorder Developed foundations across housing, education and employment Participants have trust in intervention Willingness to engage with alternative sanctions Women empowered to make their own decisions

Although structured in four categories, the essential principles are in reality interconnected and the mechanisms within each strand interact with each other to achieve change, as shown in Figure 11. The interconnections between mechanisms make up the Essential Principles and demonstrate the related mechanisms that work together to achieve outcomes.

Figure 11. Summary of how levels of contexts interact with mechanisms within each Essential Principle



5.8.1 Essential Principle 1: Successful diversion requires connections and coordination between services across the healthcare, social support and criminal justice systems

Diversion programmes cannot focus solely on 'diversion from the criminal justice system,' but also have to focus on 'diversion into the mental health system' (Weisman 2004). To achieve this, a diversion programme must build and maintain connections across services. Research has shown the cost-effectiveness of this approach (English and Mande 1991, Allen 1995, Hser 1995, Ryder, Kraszlan et al. 2001), and that it increases service use (Hartford, Carey et al. 2006, Prins and Draper 2009). Criminal justice goals must be recognised as discrete from improved mental health outcomes (Case, Steadman et al. 2009), but programmes should be structured such that these

interests are not mutually exclusive (Draine and Solomon 1999, Alarid and Rubin 2018).

Hypothesis 1: Coordinated and integrated collaboration between healthcare and criminal justice systems allows for flexible, prioritised and adaptable access to relevant services, particularly for complex case management.

Diversion should be viewed as a system made up of various programmes, with a filtering system to prioritise access to the most urgent services (Bond, Drake et al. 2001, Clayfield, Fisher et al. 2005, Cosden, Ellens et al. 2005, Gordon, Barnes et al. 2006, Davis, Fallon et al. 2008, Erickson, Lamberti et al. 2009, Lange, Rehm et al. 2011), facilitated by a coordinating layer (James 2000, O'Callaghan, Sonderegger et al. 2004, Herinckx, Swart et al. 2005, Gordon, Barnes et al. 2006, Hartford, Carey et al. 2006, Hean, Heaslip et al. 2010, Bonfine and Nadler 2019, Forrester, Hopkin et al. 2020). Justice and mental health professionals are able to cross boundaries within the system to provide appropriate treatment (Draine and Solomon 1999, Wertheimer 2000, Fight Crime 2004, Hean, Willumsen et al. 2015). Because offenders with mental health conditions present with complex needs, assessment, management and support should not focus on a single diagnosis or stage on a pathway. Regardless of the point of intervention, a case-centred approach should provide an individualised support package to improve overall health and wellbeing (National Association for the Care and Resettlement of Offenders 2005, Confederation of British Industry 2009, Revolving Doors Agency 2010, Winstone and Pakes 2010, Dyer 2012).

Balance between ensuring public safety and respecting the rights of individual offenders can be achieved through assessment of risk and the resulting extent of need for monitoring (Marlowe 2003). This provides ongoing comfort that public safety is protected, as enforcement capability can allow for diversion of a wide-range of cases, and there is no indication that diverted individuals who have non-violent or low-level violent offenses pose any greater public safety risk than those not diverted (Broner, Lattimore et al. 2004, Naples and Steadman 2004, Coffman, Shivale et al. 2017).

Hypothesis 2: Having a focal point in the community can enable continuity of care and appropriate identification of follow-on services, and provides additional benefits to the community within which a programme is based.

Treatment hosted within the community has been found to reduce the risk of reconviction (Prins and Draper 2009, Aarten, Denkers et al. 2014), whilst being more cost effective (Cloud and Davis 2013) and providing broader benefits through improving 'treatment as usual' services (Cosden, Ellens et al. 2005). Screening and assessment are often more accurate in the community and home visits can facilitate medication delivery, crisis intervention and networking (Bond, Drake et al. 2001). Placing community partnerships at the centre of diversion programmes can facilitate the provision of individualised services and maximise available options (Bond, Drake et al. 2001). Programmes should engage with the public, as this leads to a more symbiotic and efficient criminal justice-community relationship, enables consensus around goals and allows partnerships to be forged (Steadman, Deane et al. 2000, Wertheimer 2000, Acquaviva 2006).

Unclear funding creates a challenge for diversion programmes that rely on community involvement. Planners must recognise their permanence and implement strategies to provide specific resources for their long-term support, to prevent and mitigate funding issues, legitimise their objectives and enable long-term, infrastructure, professional staffing and succession planning (Acquaviva 2006, Winstone and Pakes 2009).

Hypothesis 3: Multi-sectoral teams, training and knowledge sharing can enable teams to work together towards a common goal of health improvement, which supports the identification and facilitation of effective treatment.

Effective treatment requires a multidisciplinary team with capacity to access a range of services related to housing, addiction, vocational rehabilitation and social services, in addition to formal mental health care (Hean, Heaslip et al. 2010, Scott, McGilloway et al. 2013). This can be improved through cross-systems education and training, which raises awareness of available services, shares resources, builds empathy and creates a community of respect between services (Hean, Willumsen et al. 2015, Bonfine and Nadler 2019), and enables a clear focus on health improvement (Dooris, McArt et al. 2013). Information sharing is critical to support service provision and should be covered by policy (Nacro 2004, Winstone and Pakes 2009, Coffman, Shivale et al. 2017), with shared agreements around confidentiality, roles, responsibilities and resourcing (Winstone and Pakes 2009).

5.8.2 Essential Principle 2: The development and maintenance of relationships should be incorporated within diversion programmes to maximise their effectiveness

High social capital has been shown to be associated with lower crime rates (Edwards and Foley 1997, Halpern 1999, Halpern 2001, ONS 2002, Chamlin and Cochran 2006), and family/marriage disturbance is identified as one of the eight central criminogenic needs relevant for reducing recidivism (Lamberti 2007, Andrews and Bonta 2010a). The literature shows that developing social links and increasing social capital through community connectedness (Dooris, McArt et al. 2013) provides the potential to increase self-efficacy for persons with mental illness (Davidson and Strauss 1995, Frese and Davis 1997).

Hypothesis 4: Social support and pressure can motivate people to change.

A stable family base can increase willingness of individuals to engage with diversion programmes, as long as they allow for continued contact with family (May and Wood 2005). Drug court participation can lead to less family conflict and an increase in emotional support received from family members (Green and Rempel 2012). This can be supported by providing psychoeducation, support to families and involving them in treatment planning (Bond, Drake et al. 2001). Family dysfunction is a risk factor for substance abuse (Nurco and Lerner 1996), so an intervention reducing drug use may assist participants in reconnecting with family (Green and Rempel 2012).

The relationship between participants and case workers or clinicians is an important determinant of outcomes, including treatment attitudes and adherence (Day, Bentall et al. 2005). A relationship enabling participants to feel 'believed in' and supported correlates with positive outcomes (Dooris, McArt et al. 2013), including increased service use (Canada and Epperson 2014), and relationships characterised by care, fairness and trust (Peterson, Skeem et al. 2010) reduce risk of recidivism (Prins and Draper 2009). Participants find consistency in rule enforcement reassuring and can be destabilised and demoralised when enforcement is seen to be inconsistent (Guzman, Korcha et al. 2020).

Multidisciplinary staffing and shared caseloads improve effectiveness (Bond, Drake et al. 2001), with the consistency of experiences with personnel being important (Sarteschi, Vaughn et al. 2011). Where required by programmes, the role of a judge

and the frequency, quality and length of interactions can improve outcomes and enhance motivation to change (Gallagher, Nordberg et al. 2019).

Hypothesis 5: Diversion programmes that are designed to enable the development and maintenance of relationships can result in greater treatment and programme adherence.

In general, women wish to be 'good' mothers, even if using illicit drugs (Banwell and Bammer 2006, Brown and Hohman 2006, Huxley and Folger 2008, Kalivas and O'Brien 2008, Vandermause, Severtsen et al. 2013). The stigma experienced by non-custodial mothers is an added assault to their self-worth as they try to build healthy relationships with their children (Vandermause, Severtsen et al. 2013). Possibilities for building these relationships need to be central, whether or not this is disclosed as a prime concern or a relationship is desired (Henderson, Schaeffer et al. 1998, Vandermause, Severtsen et al. 2013). In addition to therapeutic elements, the structure of a diversion programme should enable a schedule which allows a woman to meet the needs of her family (Aguiar and Leavell 2017, Gallagher, Nordberg et al. 2019).

Groups are a primary method of treatment used in diversion programmes for people with mental illness (Panas, Caspi et al. 2003, Taxman and Bouffard 2003, Bellamy, Bledsoe et al. 2006) and their effectiveness comes from the development of social coping and skills (Fram 1990, Garvin 1992, Vannicelli 1992, Flores 1997, Garvin 1997, Kurtz 1997, Henderson, Schaeffer et al. 1998). Treatment methods should be skills-oriented, active and designed to improve problem solving in social interaction, based on cognitive behavioural techniques (Harper and Chitty 2004). Effectiveness can also be improved by identifying role models, for example by employing ex-offenders to offer hope for the possibility of change (Dooris, McArt et al. 2013). Where possible, groups should be gender-specific to allow women to feel safe and to enable greater focus on their individualised needs (Gallagher, Nordberg et al. 2019), and tailored to disorders, addictions and offence to encourage sharing (Allam, Middleton et al. 1997) in a place of openness, flexibility and support (Harper and Chitty 2004).

Citizenship is a measure of the strength of people's connections to the rights, responsibilities, roles and resources available to them through public and social institutions (Rowe 1999, Rowe, Kloos et al. 2001, Rowe, Bellamy et al. 2007, Rowe, Benedict et al. 2009). Civic participation is a measure of an individual's involvement

in society (Ilah, Madsen et al. 1996), and opportunities to participate should be created for members of marginalised groups (Werbner and Yuval-Davis 1999). This is enhanced through social networks (Bourdieu 1983, Coleman 1990), with an emphasis on supporting clients' access to housing, work, friends and public and social activities (Carling 1993). It can in turn help individuals to feel entitled and empowered to engage with services (May and Wood 2005).

5.8.3 Essential Principle 3: Major risk factors for recidivism remain relevant for offenders whether or not they have mental illness

The literature shows that eight central criminogenic needs[5] are relevant for reducing recidivism: antisocial associates, antisocial cognitions, antisocial personality, history of antisocial behaviour, substance use, family or marriage disturbances, school or work disturbances and lack of prosocial leisure or recreation (Andrews and Bonta 2010a). Criminogenic risk factors have been found to be the strongest predictors of recidivism, whereas clinical variables were the weakest (Bonta, Law et al. 1998, Bonta, Blais et al. 2013). Focusing on criminogenic need has been shown to produce better outcomes, even when an individual has a mental health condition, across a range of severity of needs and risk levels (Gendreau, Little et al. 1996, Taxman, Thanner et al. 2006, Vieira, Skilling et al. 2009, Hean, Heaslip et al. 2010, Gill and Wilson 2016, Long, Sullivan et al. 2018). Diversion programmes should therefore include components focusing on addressing criminogenic risk factors as well as any underlying mental health conditions.

Hypothesis 6: If a diversion programme is designed to address criminogenic risk factors as well as mental health treatment, there is a greater opportunity to reduce the risk of offending.

Dynamic risk factors such as education, employment and substance misuse (Bonta 1996, Benda, Corwyn et al. 2001) are criminogenic risk factors that are amenable to change (Bonta and Andrews 2007, Hanson, Bourgon et al. 2009, Andrews and Bonta 2010a, Skeem, Manchak et al. 2011, Hean, Willumsen et al. 2015), and interventions that aim to reduce re-offending should target them directly (Hanson and Harris 2000, Hoge 2002, Peterson, Skeem et al. 2010). Criminal thinking and antisocial attitudes,

[5] Criminogenic needs are characteristics, traits, problems, or issues for an individual that directly relate to their likelihood of re-offending.

values and beliefs related to crime are common among justice-involved people with mental illness (Morgan, Fisher et al. 2010, Wolff, Morgan et al. 2011, Wolff, Morgan et al. 2013, Wilson, Kathleen et al. 2014, Bartholomew, Morgan et al. 2018). This contributes to engagement in criminal behaviour and prolonged involvement in criminal activity by supporting a criminal lifestyle (Walters 2006, Bartholomew, Morgan et al. 2018). Interventions targeting these needs should be incorporated into traditional mental health services to help individuals avoid criminal justice involvement (Draine, Salzar et al. 2002, Hodgins, Müller-Isberner et al. 2007, Vieira, Skilling et al. 2009, Morgan, Fisher et al. 2010, Wolff, Morgan et al. 2011, Wolff, Morgan et al. 2013, Wilson, Kathleen et al. 2014, Bartholomew, Morgan et al. 2018).

Legal leverage can require individuals with mental health conditions to choose between treatment and supervision or legal consequences (Lamberti 2007). The benefits are avoiding a criminal record and incarceration (Marlowe 2003) and associations with improved adherence (Steadman, Barbera et al. 1994, Brown 1997, Swartz, Swanson et al. 2001, Elbogen, Swanson et al. 2003, Appelbaum 2005), although not with reduced recidivism or programme completion (Hepburn and Harvey 2007, Cid 2009, Aarten, Denkers et al. 2014). Legal leverage has been found to be less effective when associated with perceived coercion (Rain, Steadman et al. 2003, Farabee, Shen et al. 2004), as this can reduce an individual's sense of autonomy (Wild, Newton-Taylor et al. 1998) and in turn motivation for treatment or compliance (O'Callaghan, Sonderegger et al. 2004) and lasting behaviour change (as seen in other conditions associated with treatment adherence problems (Deci, Vallerand et al. 1991, Ryan, Plant et al. 1995, Koestner and Losier 1996, Williams, Grow et al. 1996, Sheldon, Ryan et al. 1997, Wild, Enzle et al. 1997, Zeldman, Ryan et al. 2004, Williams, McGregor et al. 2006, Lamberti 2007), though evidence is mixed (Cusack, Steadman et al. 2010). Key to establishing effective legal leverage are partnerships between mental health and criminal justice staff (Lamb, Weinberger et al. 1999, Draine and Solomon 2001, Council of State Governments 2002, Lamberti 2007), but their structure is important. Perceptions of coercion are increased when probation officers are incorporated within mental health treatment (Solomon and Draine 1995, Draine and Solomon 2001) and there is an enforcement approach to collaboration (Draine and Solomon 2001) rather than a shared belief in treatment as an alternative to incarceration (Solomon, Draine et al. 2002).

Hypothesis 7: Tailoring service provision to account for immediate and urgent needs, the type of crime committed and history of criminal justice involvement can maximise

the effectiveness of diversion programmes by targeting specific risk factors and needs.

As offenders often have multiple needs, interventions need to tackle a wide range of problems (Andrews, Bonta et al. 1990, McGuire 2002a, Latessa, Lowenkamp et al. 2006, Vieira, Skilling et al. 2009, Andrews and Bonta 2010a, Peterson-Badali, Skilling et al. 2014). Behavioural interventions are most effective when tailored to characteristics (Andrews and Dowden 2006, Andrews and Dowden 2010), and when offenders' own goals and needs are incorporated, with practical, achievable targets to show progress (Miller 2002, Dooris, McArt et al. 2013, Bosker and Witteman 2016).

The Risk-Needs-Responsivity model is a set of principles that seek to maximise the effectiveness of community corrections interventions (Prins and Draper 2009). These principles state that recidivism can be reduced when programmes match intensity of supervision and treatment services to the level of risk for recidivism, match modes of service to participants' abilities and styles, and target a greater number of their changeable risk factors for recidivism or criminogenic needs (Cullen and Gendreau 2001, Festinger, Marlowe et al. 2002, Marlowe 2002, Marlowe 2003, Bonta and Andrews 2007, Skeem, Manchak et al. 2011, Balyakina, Mann et al. 2014).

Hypothesis 8: Diversion programmes can create an opportunity for participants to develop new skills, making space for behaviour change and an overall change in outlook.

There is a strong link between graduation status and reduced subsequent arrest rates (Herinckx, Swart et al. 2005, McNiel and Binder 2007). Heightened motivation to change attitudes and behaviours is a factor in predicting programme completion (Herinckx, Swart et al. 2005), which in turn reduces likelihood of reoffending (O'Callaghan, Sonderegger et al. 2004, Herinckx, Swart et al. 2005). This can allow for higher levels of supervision and compliance (Herinckx, Swart et al. 2005), lifestyle and outlook changes (Dooris, McArt et al. 2013), programme and treatment adherence (Prochaska, DiClements et al. 1992, Miller and Rollnick 2002, Zygmunt, Olfson et al. 2002, Polcin and Korcha 2015, Guzman, Korcha et al. 2020), and establishing a positive therapeutic alliance between the participant and diversion team (Frank and Gunderson 1990, Martin, Garske et al. 2000). Motivational and behaviour change elements such as motivational interviewing and cognitive behavioural or social learning strategies can be embedded (Prochaska, DiClements et al. 1992,

Miller and Rollnick 2002, Zygmunt, Olfson et al. 2002, Allam, Middleton et al. 2006, Andrews and Dowden 2006, Andrews and Dowden 2010, Hean, Willumsen et al. 2015). Increased likelihood of graduation can also be achieved through the application of evidence-based, trauma-informed and gender-responsive interventions (Gallagher, Nordberg et al. 2019).

Nordberg (2015) concluded that graduation parallels the graduation that occurs to mark passage out of liminality into a new status of reintegration (Nordberg 2015), and can act as a point of transition for offenders. However, continuity of care should be preserved and there should be a transition plan for programme completers to allow continued access to services where required (Lamb 1988, Davis, Fallon et al. 2008).

5.8.4 Essential Principle 4: Diversion programmes provide an opportunity for stabilisation of an individual's life, and effective programmes should enable this

Unemployment (Peters and Murrin 2000, Harrell and Roman 2001), poverty (Lamberti 2007), lower educational attainment (Draine, Salzer et al. 2002), and history of trauma (Green, Miranda et al. 2005) are associated with increased risk of incarceration. All are more likely to be experienced by persons with severe mental illness (Draine, Salzer et al. 2002). Diversion programmes can increase retention in mental health services (Bond, Drake et al. 2001) and help people avoid hospitalisation, increase housing stability and moderately improve symptoms and subjective quality of life (Bond, Drake et al. 2001), through providing access to social services, educational and vocational training, health and housing provision and ongoing counselling (Makkai and McAllister 1997), to rebuild networks and nurture stability. Increasing availability of services increases an individual's chances of graduating from a programme (Fetros 1998, Peters, Haas et al. 1999, Hartley and Phillips 2001, Mateyoke-Scrivner, Webster et al. 2004, Roll, Prendergast et al. 2005, Hepburn and Harvey 2007, Butzin, Saum et al. 2009, Shannon, Jackson et al. 2014, Smith 2017).

Hypothesis 9: Diversion programmes are only as effective as the services they link to, which requires flexible and integrated referral systems to enable engagement with relevant services.

Homelessness is an agreed risk factor for recidivism (Stephen 2001, Ford 2005, Case, Steadman et al. 2009) and is associated with other problems such as

substance use, HIV risk and psychiatric symptoms. Appropriate housing is an essential need among adults with psychotic disorders (Swanson, Swartz et al. 2002, Swanson, Swartz et al. 2006, Swartz and Tabahi 2017) and the incorporation of a residential treatment component may be critical to promoting safety and stability (Erickson, Lamberti et al. 2009, Coffman, Shivale et al. 2017), while increasing service use and reducing incarceration rates (Case, Steadman et al. 2009, Prins and Draper 2009). However, housing providers are often reluctant to serve high-risk individuals (Guzman, Korcha et al. 2020), so diversion programmes should enable this and develop a realistic plan for residence following programme completion (Case, Steadman et al. 2009, Coffman, Shivale et al. 2017).

Stable employment has been shown to correlate with programme completion (English and Mande 1991, Smith 2017), and finding work or job training is an essential component of a diversion programme (Shannon, Jackson et al. 2014, Polcin, Korcha et al. 2017). Supported employment is effective at increasing chances of obtaining and keeping employment for people with mental illnesses (Prins and Draper 2009) and promoting career growth can strengthen family and career associations (Smith 2017).

Trauma interventions can reduce associated symptoms (Prins and Draper 2009) and trauma should be assessed and treated concurrently with any substance use disorders (Gallagher, Nordberg et al. 2019). This is particularly relevant given the high rate of trauma among people with mental illnesses, particularly women involved in the criminal justice system (Gallagher, Nordberg et al. 2019). Illness self-management and recovery focuses on providing individuals with mental illnesses the skills to monitor and control their own well-being (Prins and Draper 2009), and strategies such as psychoeducation and relapse prevention programmes can improve clinical outcomes (Prins and Draper 2009). Psychopharmacology is established as a treatment for people with serious mental illnesses (Prins and Draper 2009) and can be made more effective within a diversion programme through family psychoeducation to build relationships and collaborations (Prins and Draper 2009).

Hypothesis 10: Diversion programmes can motivate, facilitate and enable individuals to engage with relevant services through increasing accessibility to participants.

Diversion programmes should be accessible to all, including those with family commitments (May and Wood 2005, Hartford, Carey et al. 2006, Swartz and Tabahi

2017) and individuals with conditions that can make it difficult to engage, such as learning difficulties (Howard, Phipps et al. 2015). Women may be more hesitant to enter treatment due to their roles as primary caregivers and additional concerns around having children removed from their care (Gallagher, Nordberg et al. 2019). Strategies to facilitate attendance should be established, to quickly respond to patient emergencies, provide personalised feedback and positive reinforcement and facilitate self-selected modes of delivery (Harvey, Shakeshaft et al. 2007). Information should be accessible with appropriately trained staff to increase understanding and trust for those with communication difficulties (Howard, Phipps et al. 2015).

Programmes should be persistent in engaging reluctant clients, both during initial contacts and after they have enrolled, and should not automatically terminate contact with clients who miss appointments. Outreach should focus on relationship-building and provide tangible help, especially with regard to finances and housing, with an ability to fund emergency expenses (Bond, Drake et al. 2001). Following the programme, services should remain accessible in some form to allow for the development of long-term, trusting therapeutic relationships and to avoid participants regressing (Bond, Drake et al. 2001).

Hypothesis 11: Sufficient levels of resourcing with knowledgeable staff are required for successful assessment and identification of needs that are robust and not limited to one primary issue.

Diversion programmes should include robust mental health screening and open referral mechanisms (Hartford, Carey et al. 2006, Scott, McGilloway et al. 2013) to enhance accessibility and increase the likelihood that needs are properly addressed (Winstone and Pakes 2009). Programmes should be tailored to needs (Harvey, Shakeshaft et al. 2007) and avoid a focus on recording one 'primary issue', which hinders the ability to capture multi-layered problems (Dooris, McArt et al. 2013). This can be facilitated through multidisciplinary staffing (Bond, Drake et al. 2001, Prins and Draper 2009) and requires adequate training (Bond, Drake et al. 2001, Kane, Evans et al. 2018), resourcing and capacity to provide ongoing support and appropriate treatment services for referral (O'Callaghan, Sonderegger et al. 2004).

Treatment should be intensive and of sufficient duration to have lasting effect, as this time ensures medication adherence and stabilises participants, while ensuring individuals attend any court-related commitments (Alarid and Rubin 2018). This can

be particularly effective as diversion programmes often come in contact with an individual when they are most susceptible to entering a treatment plan, with court-supervised treatment individual monitoring and the potential threat of sanctions (Brown 1997).

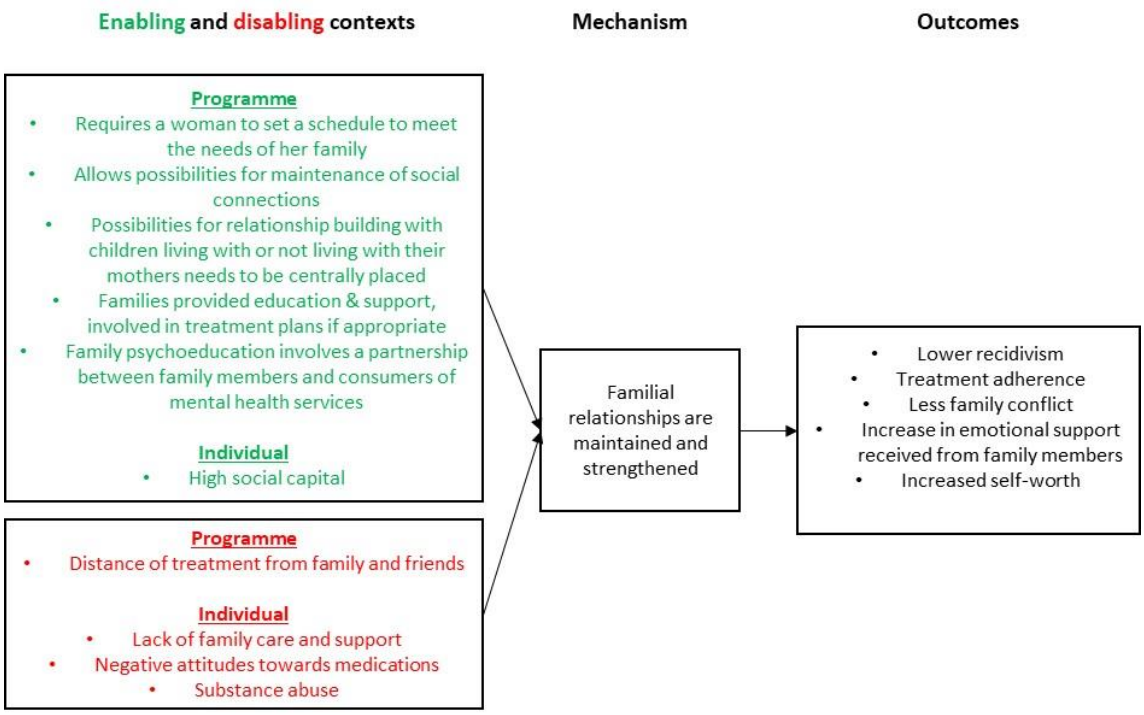
5.9 What does this mean for the design of diversion programmes?

The essential principles and hypotheses distil what works, by describing clusters of CMOCs identified through the review. As discussed earlier, mechanisms are enabled or disabled by contexts, which may be related to programme design, for example the structures implemented by an intervention; or may be individual in nature, for example the strength of an individual's support network. There is a clear disparity in the leverage that intervention designers have between these types of context, as intervention design can account for programme contextual factors, but does not have this level of influence over individual contexts. In these cases, what an intervention can do is aim to create an enabling environment for mechanisms of action.

An example is Hypothesis 5: "Diversion programmes that are designed to enable the development and maintenance of relationships can result in greater treatment and programme adherence." A mechanism identified through the review is "Familial relationships are maintained and strengthened." This mechanism facilitates the formation of social bonds, which is a central criminogenic need relevant for reducing recidivism. It is particularly relevant in the context where women have children, as most women intend or wish to be 'good' mothers and the stigma experienced by non-custodial mothers can be an added assault to the self-worth of recovering mothers (Banwell and Bammer 2006, Brown and Hohman 2006, Huxley and Folger 2008, Kalivas and O'Brien 2008, Vandermause, Severtsen et al. 2013).

Figure 12 shows a worked example of the identified enabling and disabling CMOCs related to this mechanism, utilising the structure introduced in Figure 4. The complete set of CMOCs across all Essential Principles and Hypotheses can be found in Appendix D.

Figure 12. Worked example of a CMOC from the review



Here we see that the relevant programme-specific contexts identified are theoretically (with limitations around funding, capacity, etc.) within the control of an intervention. For example, a programme can be designed with the flexibility to allow women to maintain contact with their family, by putting in place practical structures to allow this (such as building in social time, facilitating meetings or phone calls). On the other hand, there are contexts that are not within the control of an intervention, an example of this being the disabling individual context of “Lack of family care and support.” A diversion programme is not able to directly eliminate this disabling context through intervention design but can create an environment that may encourage it or allow for it to be possible; for example, by addressing logistical issues by facilitating contact and addressing underlying relational issues through access to talking therapy, education and support. Of course, there may be more permanent barriers to enabling this mechanism, particularly when it comes to mother-child relationships for which there may be legal restrictions on contact or where a programme participant does not have a family of her own. This is an area that demonstrates the limitations to diversion programmes and where the combination of mechanisms becomes important to achieving positive change.

5.10 Gender differences in the literature

A key difference in treatment needs identified in the literature is unsurprisingly around a woman's role as a mother. Women who have offended or engaged in substance abuse can feel a huge amount of shame and confusion around their children, as they generally want to be 'good' mothers (Banwell and Bammer 2006, Brown and Hohman 2006, Huxley and Folger 2008, Kalivas and O'Brien 2008, Vandermause, Severtsen et al. 2013). The resulting suffering, as well as the relationship with children more broadly, should be a focus of mental health treatment (Vandermause, Severtsen et al. 2013), which can be positive for mothers, families and society (Snyder 2009, Vandermause, Severtsen et al. 2013).

Beyond therapeutic approaches, supporting mothers through diversion programmes can include the practical management of participation in a woman's familial commitments. This can also increase the accessibility of programmes to women, who have been found to be more willing than men to serve more time in diversion programmes to avoid imprisonment: the idea being that women are able to meet the needs of their family and retain custody or contact with their children (May and Wood 2005).

Mental health treatment should itself be gender-responsive. Where cognitive-behavioural approaches with a focus on the development of a community support network have shown promise in reducing male recidivism, it is suggested that for women the emphasis should be on connections and disconnections, and trauma and recovery within a relational framework (Nelson 2004). This has a basis in relational theory, established through research in the context of women from childhood to young adulthood, and black women, within the tradition of close ties to family and community (Miller 1986, Bloom, Owen et al. 2003, Nelson 2004). While a physiological development goal for men is typically to become self-sufficient and autonomous, women develop a sense of self and self-worth when their actions arise out of, and lead back into, connections with others, and therefore connection is the guiding principle of growth for women. Women have identified feeling they were not receiving effective gender-responsive interventions as a barrier to graduating, for example, in a treatment group setting (Gallagher, Nordberg et al. 2019).

5.11 Completeness and applicability of evidence

The review drew on diverse literature, including both grey literature and peer-reviewed papers. There were gaps in the literature, the most significant being the lack of gender-focused or gender-specific studies. Although this is a limitation, expert consultations provided some assurance by suggesting that the differences identified were the critical differences they had experienced in practice. There was also a lack of evidence published in the last few years, so more recent evaluations of diversion programmes would support the further development of the literature base.

The literature base would particularly benefit from further research on three of the topics discussed in the review in the context of diversion programmes. Firstly, how to foster positive peer relationships. Group sessions are highlighted in the literature as a primary way of promoting the development of peer relationships and learning. However, knowledge of ways of applying these principles outside group settings and for different types of offenders is limited, despite an understanding that the model may not be appropriate for everyone. For example, in the use of offence-specific groups, dealing with clients' own experiences of being sexually abused may be inappropriate in the context of sex offender treatment (Allam, Middleton et al. 1997). Secondly, how to develop feelings of citizenship and belonging. Although the literature describes the benefits, it is less clear on how feelings of citizenship can be encouraged for individuals who have little or no previous experience of it. Finally, how to effectively integrate mental health treatment and management in this context. The literature points to a clear need to incorporate a range of services for diversion programmes to be effective, as described in Essential Principle 3 and Essential Principle 4. It remains the case, however, that mental health conditions and underlying trauma must be addressed to enable recovery. There was limited evidence on achieving the effective integration of these services and how they should be prioritised.

Outside the topics explicitly discussed here, another area of research which would be valuable is in defining and measuring the benefits of effective diversion programmes to wider communities. The literature focuses largely on economic benefits, with a small amount of evidence on the “bleeding” of new treatment practices into other services and, as a result, improving treatment as usual. Understanding and empirically demonstrating the societal benefits of diversion programmes would enable decision makers to consider the longer-term funding commitments suggested above.

Finally, the perspectives of service-users could provide useful insight in testing and refining the programme theories generated through the review.

5.12 Overall confidence in findings: strength of the literature and stakeholder reflections on relevance of essential principles

Despite these limitations, the review provides clear indications of mechanisms and contexts for effectiveness in diversion programmes. I made a judgement about the overall confidence in the evidence supporting individual review findings, based on the volume of evidence, consistency of findings, and expert stakeholder feedback, which I report in Appendix D.

Overall, I have a moderate-to-high level of confidence in Essential Principle 1, an area of focus in 47 studies. There is a clear need for boundary-spanning approaches and inter-agency collaboration, but a lack of evidence on how to achieve it in resource-limited settings. The stakeholder group were in complete agreement with this principle, with one participant reflecting that:

> *"You have sometimes just one single health professional or somebody in the criminal justice system who really gets it, and they make all this stuff happen. You know they will ring the housing and they will contact their welfare rights people and they will do all this other stuff which is not strictly speaking within their role. But they take it on because they understand what's needed"*
> *– UK Professor, interviewed January 2021*

I have a moderate level of confidence in Essential Principle 2, which was the focus in 20 studies. This is mostly driven by a lack of evidence around the mechanisms for achieving change as they relate to increased feelings of citizenship, as well as how best to foster relationships with peers. I have a moderate-to-high level of confidence in Essential Principle 3, an area of focus in 32 studies. I have particularly high confidence in findings around the need for diversion programmes to target dynamic, criminogenic risk factors, but have less confidence around the most effective use of sanctions, due to the mixed evidence base. The stakeholder group agreed with this principle, with one participant saying:

> *"It's the criminogenic needs. It's the social needs the family needs. Whether a person has mental illness or not, that is. The basis for*

how they behave, and if you want to change the behaviour, if you want to enhance their level of function, you have to understand these needs" – USA Professor interviewed December 2020

A note of caution was expressed about how Essential Principle 3 is articulated, discussed below. I have a high level of confidence in Essential Principle 4, an area of focus in 35 studies. There is a strong evidence base for the need to consider a woman's practical needs as part of any diversion programme and there are established and tested ways of achieving this.

The expert group overall had confidence in the findings but had two points of concern which diverged from themes emerging from the review. First, that there was limited evidence that explicitly discussed the role of a treatment focused on trauma. One participant said that there was a need for:

"... Much more of a life course approach to supporting people who've experienced adverse childhood experiences and trauma because we know that the likelihood is that they will end up with mental health difficulties or in the criminal justice system." – UK Professor interviewed September 2020

This resulted in further searching around this topic specifically, although it remained light on evidence associated specifically with diversion programmes. Second, related to Essential Principle 3, experts were concerned that this could underplay the role of mental health treatment for those with mental health needs. This feedback was helpful in developing narrative around this principle, to clarify that women with mental health needs do require specialist treatment and are at greater risk of incarceration as a result of these needs and how they interact with other risk factors. Nevertheless, what this principle is aiming to articulate is that criminogenic risk factors seen in the wider criminal-justice-involved population remain relevant for those with mental health issues and, as such, should be targeted in addition to any specific mental health treatment.

5.13 Chapter conclusions

If an overarching objective of diversion programmes is to change behaviour, an individual's needs have to be understood, including those which are not directly

related to mental illness. This includes, but should not be limited to, mental health needs, particularly through addressing trauma.

The findings confirm that care to promote mental health requires individual rather than agency-based plans. Programmes require flexibility to be able to prioritise services and interventions based on need, building connections with other resources in the community where they are based. Regardless of the way in which an individual comes into contact with a programme, they should be able to access the appropriate services, tailored to meet greatest and most urgent needs first.

The findings also suggest that quality of relationships can enhance, or even define, an individual's experience of a diversion programme. There are two aspects to this: the relationship an individual has with a programme, which should be based on trust, understanding and recovery; and the relationships an individual has outside the programme, which should be supported by diversion programmes, both through enabling ongoing contact with an individual's support network, and more broadly, through nurturing an individual's connection with the community they are part of.

Finally, the findings also suggest a role for specific gendered tailoring of interventions, linked to previously mentioned factors. However, there is more to understand about specific mechanisms of gender disadvantage and how they may feature in the design implications for programmes, and this is an area for future investigation.

5.14 Chapter summary

In this chapter I have presented the results of the realist review and the discussion of Essential Principles and underlying hypotheses identified.

The realist review was intended to provide a comprehensive view of what makes a diversion programme work, within which contexts and for whom. One of the key findings is around the criticality of operationalisation based upon the local service landscape and that a diversion programme is only as effective as the services into which an individual is diverted. Related to this, the review highlighted a gap in evidence related to how to achieve effective multi-agency working to support complex needs and co-morbidity.

My realist evaluation therefore discusses the operationalisation of an intervention to do this in a UK setting, aiming to draw some conclusions around what can make such interventions effective, how, for whom, and in what contexts.

Chapter 6 Putting methodology into action: a realist evaluation case study

6.1 Introduction

As previously mentioned, this thesis is rooted in an evaluation of an intervention, *It Takes A Village ("ITAV"*), which has been developed in a central London borough and represents an ambitious approach to working across systems to deliver integrated, interdisciplinary care for women with complex needs, some of whom have experiences of incarceration and most of whom have a high risk of contact with the criminal justice system in the future. The purpose of this work was to contribute evidence of what the drivers are for the programme working effectively or otherwise, and how it may be improved and replicated in other contexts. This evidence is particularly critical in an environment where funding for support services is being squeezed.

In this chapter I describe my approach to undertaking the evaluation. I discuss the application of the realist evaluation cycle, recruitment and participants, how an embedded case study model was applied to the evaluation, and how the findings of the evaluation are being disseminated.

6.2 Research questions

The research question I aimed to address through the evaluation was: How does the operationalisation and implementation of an intervention aiming to deliver integrated, interdisciplinary care for women in a London borough influence the outcomes of women with multiple disadvantage who are at risk of coming into contact with the criminal justice system, within which contexts and for whom?

Component questions which I used to address this research question are:

- How, if at all, does service use change as a result of ITAV?
- Who does service use change for?
- In which contexts does service use change?
- Through what mechanisms does this change happen?
- How, if at all, does practitioner confidence in treating complex cases change following the introduction of ITAV?

- Who does practitioner confidence change for?
- In which contexts does practitioner confidence change?
- Through what mechanisms does this change happen?

By focusing on the effectiveness of specific elements of the intervention and being clear about the contexts in which they work well or otherwise, inferences can also be applied to other programmes with similar aims, either to inform improvements to existing interventions designed to support women with complex disadvantage or to inform the future design of such programmes.

The evaluation was conducted across a borough in which multiple organisations come together to deliver services.

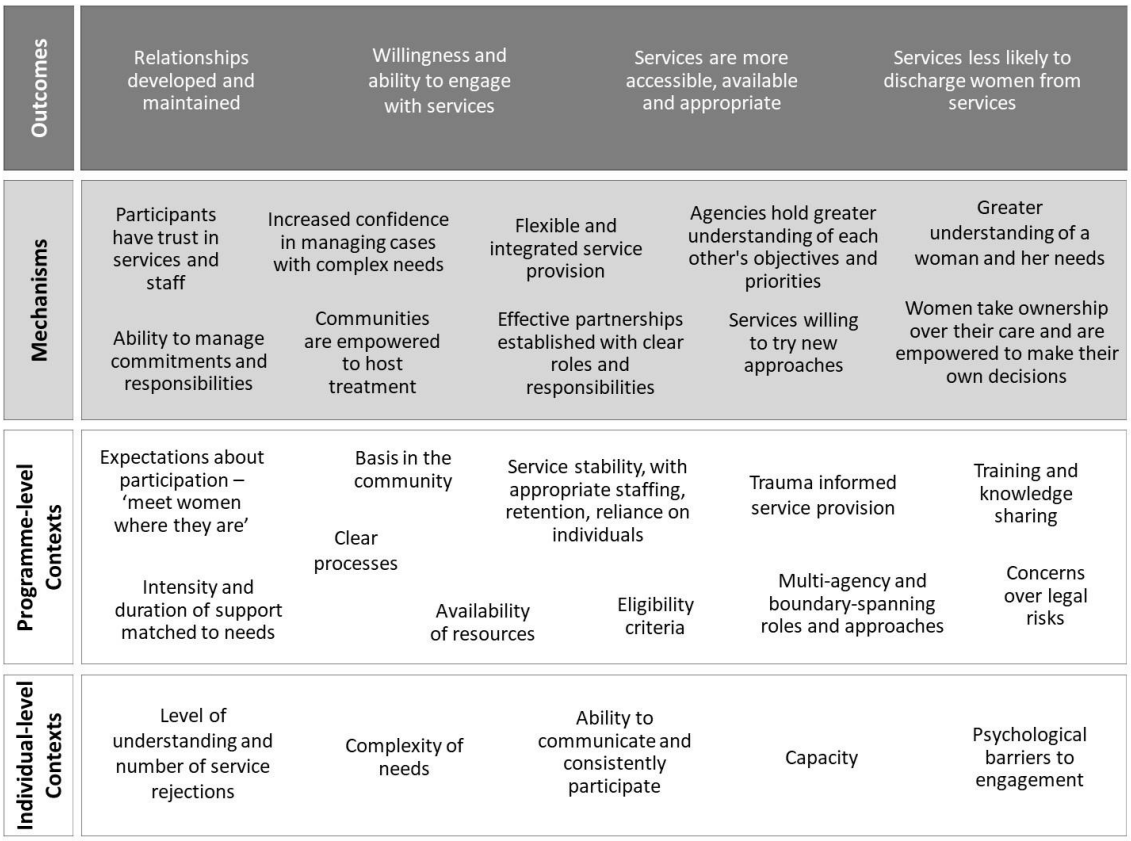
6.3 Approach to the evaluation: application of the realist evaluation cycle

As introduced in 4.3, the guiding framework for the evaluation was the realist evaluation cycle, which has four key steps: (i) Theory, (ii) Hypotheses, (iii) Observations, and (iv) Programme specification. I describe the approach I took at each of these steps.

Phase 1: Theory

A middle-range Theory of Change (Harries, Hodgson et al. 2014) was developed within a CMO framework to be used in the development of the study's coding framework and to guide the structure and content of interview questions. It was developed in partnership with those who designed the intervention, through interviews and workshops complemented by the theory guiding my work introduced in Chapter 3, to understand assumptions underpinning the relationships between the outputs and outcomes within the Theory of Change (presented in Figure 13).

Figure 13: Theory of change



In-depth interviews were undertaken with service users and providers who had been involved in services in the borough to understand the issues in accessing services experienced by women with complex needs. These interviews were semi-structured, and the interview guides can be found in Appendix E.

Phase 2: Hypotheses

The initial in-depth interviews were also used to formulate hypothetical CMOCs related to the intervention, to develop programme theories (or hypotheses) about why it could achieve its outcomes.

Questionnaires were administered to service users in person immediately in advance of each initial interview to collect information on:

- Demographic information
- Service use history (over the last 12 months)
- Criminal justice system involvement
- Perception of how service use did or did not meet their needs

Other than through the inclusion of demographic information, questionnaire responses were not analysed but instead provided prompts for discussion in interviews. The decision to do this was based on the experience of programme designers, that questionnaire responses for this group did not align to narratives described by the individuals completing the questionnaire. For example, service designers shared a story of a woman who had recently attempted suicide, and was open when discussing her experience and her current state of mental ill-health, however when completing a survey she had indicated that she was extremely happy and healthy across all measures presented in the survey.

The interview then allowed for a detailed discussion of the rationale for selecting their answers in the questionnaire and to understand from their perspective what they felt had been the key drivers of differences between the service they would have liked, and the service they had received.

Service providers who came into contact with ITAV also completed a questionnaire in advance of the initial round of interviews (issued by email a week before the meeting), to collect information on:

- Their training and experience to date
- Their current confidence in managing complex cases
- How they would score their confidence and training as meeting their requirements to undertake their job effectively

The interview again provided a forum to understand the rationale for selecting their answers in the questionnaire and understand from their point of view what they felt the challenges were in managing cases for women with complex disadvantage.

Nvivo (Ltd. 2020) was used to analyse interview data. Interviews were analysed using a CMO heuristic (Pawson and Tilley 1997) and through a Thematic Network Analysis (Attride-Stirling 2001), whereby contexts, mechanisms and outcomes were articulated through basic, organising and global themes, respectively, as outlined in 4.2.

Figure 14 shows the initial coding framework used for this analysis, whereby data were entered against each code and against a CMO framework, to ensure that CMOCs were appropriately captured.

Figure 14: coding framework

Codes	Contexts	Mechanisms	Outcomes
Ability to engage			
Accessibility			
Basis in community			
Capacity of woman			
Complexity of needs			
Confidence of provider			
Criminal justice			
Duration of support			
Gender			
Health			
Intersectionality			
Multi-agency approach			
Navigation			
New approaches			
Organisational relations			
Power in relationships			
Practical needs			
Processes			
Provider culture			
Race			
Relationships			
Resources			
Risk			
Covid-19			
Safety			
Self-belief			
Sexuality			
Socio-economic status			
Trauma informed			
Understanding of women			

All consent forms and information sheets can be found in Appendix F.

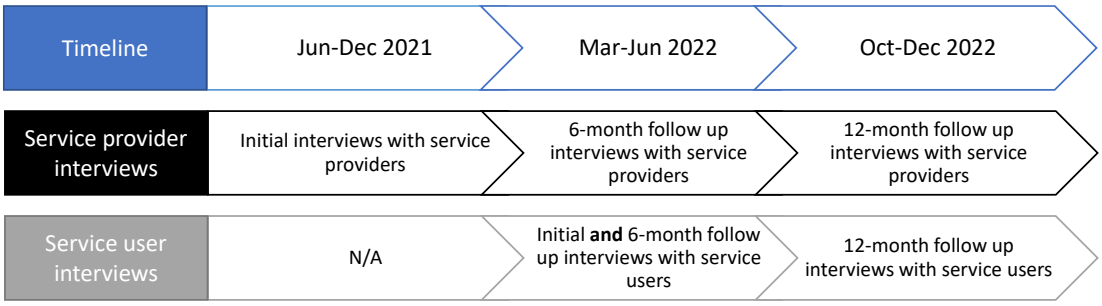
Phase 3: Observations

The observation phase of a realist evaluation involves gathering insights through further data collection to affirm, dispute or refine initial hypotheses. Researchers are encouraged to collect data through a variety of methods, and I approached this through a combination of questionnaires, in-depth realist interviews and observations of the intervention working in practice.

Interviews: As described above, I held interviews with service providers and service users in the borough. For service providers, I held initial interviews in June-December 2021, followed by six-monthly follow up interviews over a period of 12 months to

identify any changes in responses to the questionnaire and interviews. My original intention was to hold a parallel process for service users, but the Covid-19 pandemic prevented the initial round of interviews happening with service users at the time I had planned, as I could not physically visit the service users in person and engaging with them over a video or telephone call was not a viable or realistic option. I therefore adapted my approach to service user interviews, such that I combined the initial interview and the six-month interview, to focus on both their previous experience of service use, and any changes in service use they had seen over the previous six months. I have outlined this schedule in Figure 15.

Figure 15: interview schedule and timeline



Questionnaires and interviews for follow-up interviews were adapted to understand whether interviewees perceived any differences in service use or confidence since the introduction of the intervention, and the reasons they suggested for it. Questionnaires were administered and used in the same way as the previous interviews. Again, questionnaires and interview guides for subsequent interviews are in Appendix E.

I analysed all interviews using a CMO heuristic (Pawson and Tilley 1997) and through a Thematic Network Analysis (Attride-Stirling 2001) using Nvivo (Ltd. 2020) to capture and code data as they were collected. I first analysed each embedded unit of analysis, before analysing and summarising similar and opposing evidence across the units of analysis through data triangulation and pattern matching (Yin 2003). Cross-comparisons were made to determine how the same causal mechanisms played out in different contexts and produced the same or different outcomes, and I then looked across units of analysis to see whether CMO patterns could be identified both within and across units of analysis.

Other observations: I attended “supergroup” meetings which brought together representatives from different specialisms to discuss systemic issues being observed

and how they might be addressed. I attended the training sessions put on through the intervention, including shorter “mic-drop” videos. I observed complex case panels where pathways were created and navigated for specific cases. I also attended “champions” meetings where training was delivered and knowledge was shared. Observations were captured in field notes, then coded and analysed using Nvivo. Observations were analysed to develop the sections describing life at the hostel, develop an understanding of issues in the borough, build an initial programme theory for ITAV, and to test and develop the refined programme theory. Although observations were analysed in the same way as interview data, where I have shown evidence in the text, I have prioritised the voices of interview participants by including their quotes.

Analysis was iterative, going ‘back-and-forth’ between the programme theories and the CMOCs from the Hypotheses phase and the data gathered in the Observations phase.

Phase 4: Programme specification

I finally developed a visual model to show the patterns of CMOCs and denote the causal pathways leading to program outcomes, which I present in 8.3.

6.4 Recruitment process and eligibility

Realist evaluation standards on sampling focus on depth and diversity across contexts, with an emphasis on engaging hard to reach groups (Wong, Westhorp et al. 2016). My approach to sampling was therefore to aim to engage with all women at the hostel who were working with the ITAV intervention. To ensure breadth and depth of the sample, I aimed to engage at least two people across each area of expertise (elaborated on below), with an even split of service providers between those in the voluntary and statutory services (i.e. across embedded units of analysis).

Service providers were recruited to take part in interviews through their engagement with the intervention and were eligible to participate if they had worked with women with complex disadvantage and with the intervention being evaluated. Service users were recruited to take part in interviews through their engagement with the intervention and were eligible to participate if they were an adult (>18 years old), woman, user of the relevant services (nb. one study participant was gender non-

binary). The ITAV intervention had recruited service users through a hostel in the borough, so all service users who were eligible at the hostel were invited to participate in the study. I talked through the accessible format information sheet and consent form with potential participants to ensure there was a clear understanding of what was involved and how their contributions would be used, and participants were given the opportunity to ask questions before signing consent forms.

6.5 Participants in the ITAV evaluation

The ITAV evaluation consisted of 33 in-depth interviews with 15 service providers and 13 in-depth interviews with 8 service users. The evaluation focused on service users identifying as women (with one gender non-binary person): people identifying as men were not included. Table 6 and Table 7 summarise characteristics the interviewees and their specialisms. For service providers, these specialisms represent the services they worked in (an individual could have more than one specialism); for service users, they refer to the types of services that they had accessed or attempted to access. Given concerns related to anonymity, which are heightened as I use the real name of the ITAV intervention, I have provided aggregate figures across these categories rather than breaking this down into individual cases.

Table 6: Summary of interviewees – service users

Age	**Number of service users**
18 – 29	*2*
30 – 39	*4*
40 – 49	*2*
50 +	*-*
Data unavailable / left blank	*-*
Gender	**Number of service users**
Female	*7*
Male	*-*
Prefer to self-describe	*1*
Data unavailable / left blank	*-*
Ethnicity	**Number of service users**
White	*2*
Mixed / Multiple ethnic groups	*3*
Asian / Asian British	*1*
Black / African / Caribbean / Black British	*2*
Other ethnic group	*-*
Data unavailable / left blank	*-*

Category of service use / provision[6]	Number of service users with lived experience of this service category
Mental health	*8*
Probation or criminal justice	*4*
Housing	*8*
Drug and alcohol misuse	*6*
Adult social care	*2*
Financial benefits	*2*

Table 7: Summary of interviewees – service providers

Age	Number of service providers
18 – 29	*2*
30 – 39	*5*
40 – 49	*7*
50 +	*-*
Data unavailable / left blank	*1*
Gender	**Number of service providers**
Female	*9*
Male	*5*
Prefer to self-describe	*-*
Data unavailable / left blank	*1*
Ethnicity	**Number of service providers**
White	*-*
Mixed / Multiple ethnic groups	*-*
Asian / Asian British	*-*
Black / African / Caribbean / Black British	*-*
Other ethnic group	*-*
Data unavailable / left blank	*15*
Category of service use / provision[7]	**Number of service providers with this perspective**
Mental health	*9*
Probation or criminal justice	*8*
Housing	*8*
Drug and alcohol misuse	*7*
Adult social care	*15*
Financial benefits	*2*

[6] Nb these categories are not mutually exclusive, and most participants had experience across multiple areas of service use.

[7] Nb these categories are not mutually exclusive, and most participants had experience across multiple areas of service provision.

Although when discussing participants throughout this thesis I articulate the categories of disadvantage that each woman who participated had, each has her own individual story - thoughts, feelings, relationships and personal goals - which were not defined by these categorisations. Of the eight service users interviewed, all had multiple areas of lived experience across the categories listed above. Two had lived experience of two service categories, two of three categories, one across four categories, one across five categories, and one service user had lived experience of services across all six categories listed. I did not ask service providers to classify their ethnicity, as I wanted to avoid collecting sensitive information which was not required to achieve the research objectives set at the beginning of this study, though some chose to discuss this in interviews.

6.6 Specific application of the embedded case study model

The case study model was applied in four ways.

Firstly, in developing my research questions to be explored in the evaluation. In 'Case Study Research: Design and Methods', Yin's case study model describes (i) research questions compatible with a case study methodology, and (ii) how compatible research questions should then be developed to make them as effective as possible. I followed this process to finalise both my primary and secondary component research questions.

Secondly, in assessing the quality of research design, the same source provides a detailed guide to assessing the overall quality of a proposed design through the use of four tests: (i) Construct validity, (ii) Internal validity, (iii) External validity, and (iv) Reliability. I reviewed the quality of my research design against these criteria in both initial planning and assessment of quality upon completion of the study. This is reported in the discussion of findings.

Thirdly, in adhering to the case study models process of defining the logic linking data to propositions. Specifically, through active linking of the collection of observations to the programme theories developed in the Theory and Hypotheses stages of the realist evaluation cycle. I achieved this by using a coding framework that incorporated the theoretical propositions identified through these stages, as well as the CMO categorisations. This allowed me to collect data against specific codes, and therefore identify where data collected aligned with or contradicted programme theories.

Finally, through applying embedded units of analysis within the thematic network analysis, such that interviews were first analysed as embedded units. This approach also had the benefit of allowing for exploration of intersectionality through analysing groups of individuals with multiple intersecting characteristics to understand whether or how their experiences – or perceptions of experiences – differed from those of women with differing characteristics.

6.7 Reflexivity

Reflecting on reflexivity and positionality was important in conducting this qualitative research to examine my own potential influence on the study. Reflexivity in research is required to ensure accountability and transparency, especially in fostering non-oppressive relationships with research participants (Rodriguez & Ridgway, 2023). Rodriguez and Ridgeway argue for a nuanced examination of the researcher-participant dynamic, to consider how researcher self-accountability is approached and communicated, particularly as relates to the potential for oversight of oppressive dynamics linked to intersectional positioning. This is particularly relevant to this work given the intersectional nature of reflexivity, which I aimed to explore through considering, recognising and articulating my potential biases and preconceptions, taking in to account my own social and cultural context, and how my own identity and background could have an impact on my interactions with study participants.

The three key challenges I identified related to reflexivity were : i) as a woman, I have my own experiences of engaging with systems and individuals, which could bias findings; ii) women with complex needs face many challenges which I have not experienced in my own life, such as deep trauma and adverse childhood experiences, and this may make it difficult to truly understand their experiences; and iii) I had not previously spent much time with women with complex needs, which might have made engagement more challenging. I mitigated these challenges by testing emerging findings on an ongoing basis with both my supervisors and programme designers who had more experience, taking the advice of service providers on how best to engage with participants, keeping my interviews as open as possible to ensure that women were given the opportunity to share their feelings and experiences, and through the UCL training I undertook on interview methods and ethics in research.

The third challenge was particularly relevant during my very first interview with a service user, who became distressed while discussing their experiences but did not

want to close the meeting. This was challenging to manage as I was aware that they were distressed and we should end the interview, but they were clearly keen to tell their story and I wanted to provide the space for this and avoid being dismissive. I discussed this experience with the programme designer and my supervisors after the meeting, which resulted in me setting clearer boundaries up front around timings and then sticking to them firmly. This was not an issue I experienced in other service user interviews.

6.8 Publication and dissemination of findings

The project was undertaken over a period from September 2020 to February 2023. I plan to submit three publications: the first, a write up of the issues experienced by women with complex needs in accessing appropriate services; the second, the full results of the realist evaluation; and the third, a methods paper to discuss the application of realist evaluation methods to a live evaluation.

I developed a version of the programme theory to be shared with programme designers to aid the ongoing evaluation of ITAV over the longer-term, and summary report to share with management and service providers who participated in the ITAV study, accompanied by a lay summary for the service users who contributed.

The findings of the study are presented in Chapter 7 and Chapter 8.

Chapter 7 It Takes A Village: a case study

7.1 Introduction

In this chapter I describe It Takes A Village ('ITAV'), a boundary-spanning intervention aiming to establish a new way of working with women with complex needs, building on existing systems in the borough to help those who fall out of service provision or circulate between services without improving outcomes. I describe the context that the intervention is operating in, starting with discussion of the women the intervention seeks to support, the issues and gaps in the current support system, and the features of the intervention that have been designed to address them.

This is the first results chapter from the realist evaluation and the data contained within it are sourced from interviews, field notes I took while observing meetings, spending time in the hostel where the participants were residents, and participating in training sessions, following the approach to data collection and analysis detailed in 6.3. Pseudonyms are used throughout this work and some details have been changed in quotes where required to ensure anonymity.

To briefly recap on the need for a boundary-spanning intervention, we saw in Chapter 2 that mental health conditions correlate with other types of disadvantage, and that individuals often face significant challenges in accessing treatment, with mainstream services unable to effectively engage them or address their long-term recovery. This means that people with complex needs often go without the help they require, and services can even have the effect of reinforcing earlier traumatic experiences and causing further harm (Revolving Doors Agency 2015). Women with complex disadvantage rarely receive the treatment they need and 'fall through the cracks', missing help from specialist services such as mental health or drug and alcohol services (Dobson 2019, Lamb, Moreton et al. 2019). As articulated in Chapter 5, the realist review found that to effectively support women to improve outcomes related to criminal justice, health and wellbeing, effective multi-agency collaboration is required, supported by boundary-spanning systems, roles and approaches.

ITAV was therefore developed as an intervention aiming to improve service provision and use in a central London borough. The intervention proposes a new way of working with people with complex vulnerabilities, building on the current systems in the borough to help those who have not had access to the support that they need.

7.2 A boundary spanning intervention ("It Takes A Village") in a central borough of London

The ITAV intervention was established to address challenges in appropriate service access for women with complex needs by bringing together a variety of statutory and voluntary services across specialisms - including mental health, criminal justice, drug and alcohol, housing, domestic violence and physical health – through a combination of structured interactions, pathway development, knowledge sharing and training. ITAV is the real name of the intervention, which I have used to support clarity and transparency and to provide additional contextual understanding of the intervention's underlying concept of bringing together a wide range of support. Table 8 shows the principles underpinning the intervention**.**

Table 8: **It takes a Village principles**

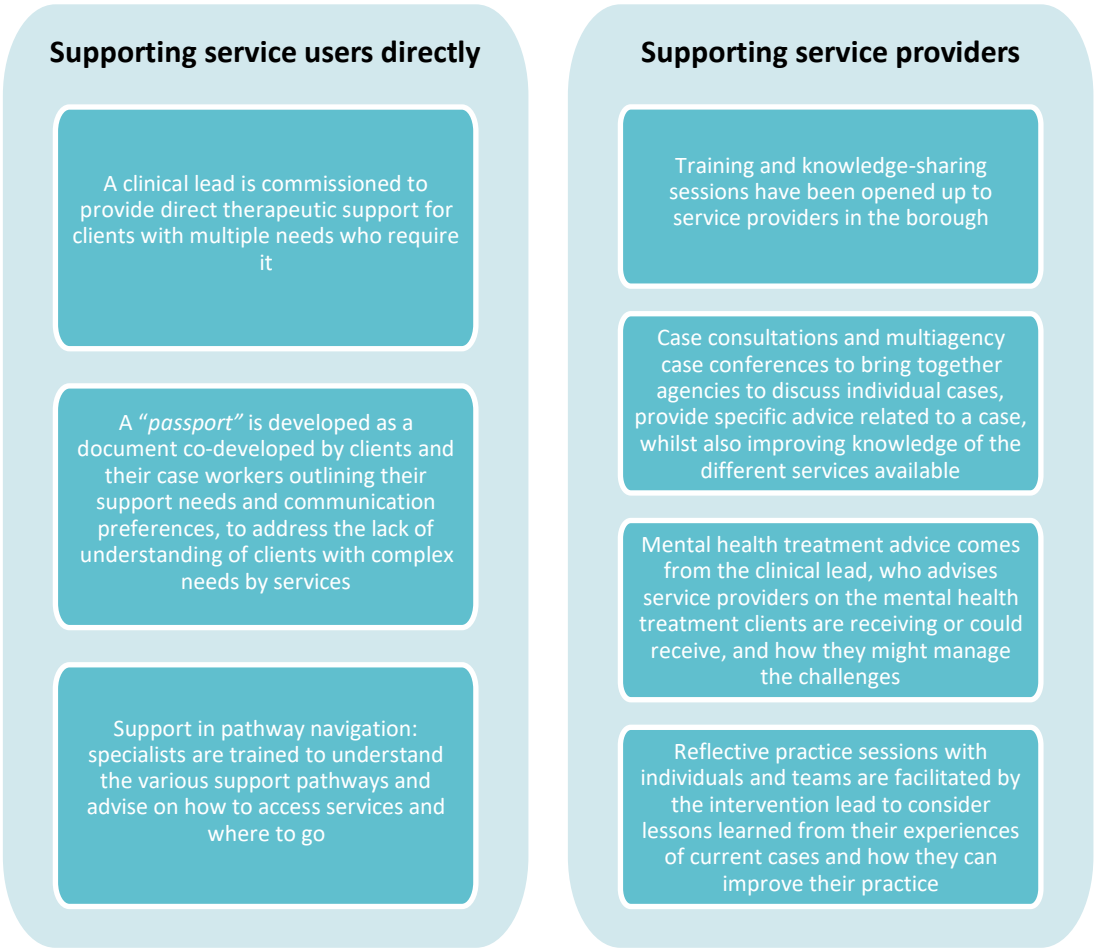
1. People facing complex problems will be met by a more personalised, psychologically informed and bespoke response across the whole system.
2. This is ‘reasonable adjustment' for people who, for psychological and socio-economic reasons, find it harder to access preventive support.
3. It recognises that services have systemically disadvantaged certain groups.
4. Healing 'takes a village' – expertise does not lie solely with a particular role, paygrade or sector, paid or unpaid: all voices and ideas are valuable and everyone’s effort, and wisdom, is needed. We need to get better at recognising and redressing unequal conversations.
5. To develop knowledge of how to heal, services need to get better at involving and learning from communities.
6. People with complex needs who have faced inequality can access a passport. This will provide fast-track access to support and health services across the borough that are holistic, thoughtful and creative.
7. Services and departments across the borough – Housing, Health, Social Care, the Voluntary Sector, and grassroots organisations and groups - will sign up to taking a creative energetic and ‘learning’ approach to ensure people facing the greatest complexity do not ‘fall out’ of community services.
8. Services will nominate Multiple Disadvantage Champions. Champions will be able to access clinical and community informed input through the Clinical Lead for Multiple Vulnerabilities, through regular Continuing Professional Development events, and through liaison and linkage with Champions in other services across the borough.
9. Work will be undertaken to rigorously embed the voices of people with lived experiences of complex needs and exclusion at all levels and stages of service delivery and evaluation, and community planning.
10. Services will work to ‘meet people where they are at’ in non-institutional, comfortable and local spaces, as well as using digital and online media.

ITAV was established in 2021, developed through a project funded by Guys and St Thomas’s Charity, the London Borough, and Pembroke House. ITAV is not an institution or a commissioned service, but is instead an approach, run by a small team employed by existing organisations and services to establish and implement a new way of working across teams.

The intervention is made up of several components which link to create a holistic approach to improving services in the borough. This can be split into two categories:

components aimed at supporting service users directly, and components aimed at supporting service providers (Figure 16).

Figure 16: key components of the ITAV intervention



The combination of these components is intended to create an interlocking and holistic package of support to improve the outcomes of individuals with complex disadvantage.

In 2.4 we discussed the sequential intercept model as a framework for understanding the ways in which the criminal justice system can identify individuals to divert them towards healthcare pathways. This model introduced the concept of the '*ultimate intercept*' as being a comprehensive, effective mental health treatment system focused on the needs of individuals with serious and persistent mental disorders, with an effective base of services and adoption of evidence-based treatments which are integrated and used consistently (Munetz and Griffin 2006). ITAV is an example of an

intervention aiming to work in this ultimate intercept, providing support and treatment to women with complex needs before they come into contact with the criminal justice system.

7.3 Support structures and socio-demographic contexts in the borough

The ITAV intervention is based in a deprived borough in London (Leeser 2011) with a population of over 315,000. It is ethnically diverse, with a greater number of Black-Caribbean residents but fewer South Asian residents than other areas of London (ONS 2021). This diversity in ethnicity is reflected in the service users who participated in the study. Interviewees identified that the lack of specific and aggregated data makes it hard to fully identify the number of individuals with multiple disadvantage in the borough, but the Hard Edges report produced in 2015 by the LankellyChase Foundation looked at people with overlapping needs who had engaged with a number of statutory services, and estimated that the borough had a multiple disadvantage rate of 8.33 per 1,000 working age residents (Lankelly Chase Foundation 2015). Based on population estimates at the time, this equated to 1,911 people over the year.

Some of the key systemic structures in the borough relevant to women with multiple disadvantage are mental health support, probation and criminal justice, housing, drug and alcohol misuse, adult social care and financial benefits services.

Adult mental health services in the borough include community mental health teams, some carrying out assessments and some providing ongoing treatment. There are complex case management teams for people in supported housing and residential and nursing homes. Psychological therapies for common conditions such as anxiety and depression and therapy for more serious mental health issues are provided by an integrated psychology and psychotherapy service along with a personality disorder service.

Probation services are provided by a rehabilitation company that works across all London boroughs. Women who are on probation may have a variety of arrangements in place for keeping in touch with probation officers, but they usually include regularly scheduled meetings. As well as providing services from within council buildings, before the pandemic there was also a representative who would be based in a women's community hub run by a local charity, to make services more accessible to

women. Covid-19 made this more challenging, but charities in the borough are working to bring back this more accessible service provision.

The borough housing strategy includes increasing the supply of available, good-quality homes, explicitly linking this to improvements in wellbeing and empowerment for residents. Government initiatives are complemented by the voluntary sector to deliver a range of pathways, including routes for those with specific needs and those transitioning from prison. These pathways can be accessed via either self-referral or referral by a service practitioner. However, over the last few years the demand for housing in the borough has increased and affordable housing is harder to come by, reducing the overall supply of properties. The reality of this is that those seeking housing often do not have options available and the borough is not always able to meet specific requirements, resulting in long wait times and people being relocated outside the borough, away from any existing support networks that they may have.

Drug and alcohol misuse services are available in the borough and can be accessed through either self-referral or referral by a service practitioner. The drug and alcohol service is delivered by a non-profit organisation funded by councils and local authorities. Many of the staff members are individuals who have previously used the services, and as part of their offering they include a mentoring service. The service partners with a charity supporting those in contact with the criminal justice system and preparing them for release if they have been imprisoned. This allows services to work together to provide more holistic support. Funding available to the service has not increased in line with required expenditure, which has meant that service cuts have had to be made.

The borough has an adult social care provision for those who are eligible under the Care Act 2014. The service undertakes a needs assessment for those with care and support needs. The timeliness of this assessment is driven by urgency and limited resources mean that only those in crisis are likely to be seen. Adult social care aims to review how it can support individuals to remain independent for as long as possible and prevent, reduce or delay the need for long-term care.

The borough also has a general advice service where individuals can gain independent advice, information and guidance on their legal rights and responsibilities. This advice includes help with issues such as welfare benefits,

housing, employment, consumer rights, money and debt. There are also specialist legal services that provide more in-depth advice, support and advocacy.

Pathways for working between these services are not well defined for clients with multiple needs, though some referrals and signposting between services does happen. Where an individual is ineligible for treatment from a statutory service, they may be signposted to the voluntary sector, but the landscape for services is ever evolving and as such it is difficult for specialist practitioners to make referrals outside their own service or the defined pathways. Staff at the hostel where the women I interviewed were in residence helped them to coordinate their treatment and navigate the variety of services that were on offer.

7.4 Life in the hostel

All interviews with service users took place inside a women's hostel described to me by a service provider as being *"the place that will accept people when nowhere else will."* The following description of the hostel environment draws on both interviews and field notes from personal observations.

The hostel describes itself as catering for single homeless women (though it should be noted that one of the residents - who also participated in the study - was gender non-binary) with medium-to-high level support needs, including women with mental health, alcohol or drug use concerns and women escaping domestic violence. Eligibility criteria state that they must have a local connection to the borough and basic life skills. The hostel has a capacity of 34 women and the maximum length of stay is formally two years, though some residents have been there far longer.

The hostel felt old with stained furnishings, flickering lights and paint flaking from the walls. Mice were a common problem described by both staff and residents and on more than one of my visits the hostel staff were doing what they could to track down and catch them. On one occasion, a member of staff felt she could smell a mouse that might have died nearby but was struggling to locate it. Residents commented on this problem as well as disruptions caused by some of the hostel's infrastructure being old and not functioning as it was supposed to.

"They have school bells instead of fire alarms. But the fire alarms are all connected, that needs to change. Someone burns

something. Everyone gets it and it shocks us, and at night. That's bad." – 'Nadia', service user.

Despite these environmental challenges, on one of my visits I witnessed a woman, 'Charlie', who had been homeless and living on the streets, sobbing with joy and disbelief when she was told that there was a room available for her and she could move in right away. For a long while she kept checking that the staff were serious and asking questions like *"Is the room really mine? For real?"* The first thing that Charlie did when this was confirmed was request extra food from the hostel's donated supply for that day so that she could cook a big dinner for some of the other residents. The next few hours were spent rushing around the hostel, moving in her small number of belongings and trying to locate spices for that evening's group dinner.

The first time I arrived I was welcomed by the staff and invited to sit with them in the front office, to get a more complete view of what life was like inside the hostel. Around 20 minutes after arriving, a member of staff received a call from the police to say that one of the residents had absconded from the hospital in which she was being held while undergoing treatment. The member of staff was instructed to give them a call if she arrived back at the hostel, which they did later that afternoon when the resident was spotted upstairs.

Several women had come to the front desk throughout the day, and many had expressed an interest in being interviewed by me. Many returned to the desk several times, always saying that they would be "down soon", although I sensed there was a feeling of unease at having someone new sitting in the office. The time passed into the evening and I headed home, having interviewed no-one. It took another two visits before someone was willing to come down and talk to me, and from that point onwards engagement was much easier as the women seemed to have discussed their experience of the interviews with each other and encouraged one another to participate. This emphasises the importance of building trust between researchers and research participants, particularly in the case of vulnerable women, who may be particularly concerned about why they are being studied (Wilson and Neville 2009, Marsh, Browne et al. 2017), may be suspicious as to the motives of the researchers due to past discrimination, and may be unwilling to put themselves in situations that could leave them feeling discriminated against, shamed, ostracised, exposed or incriminated (Liamputtong 2007).

There was almost constant disruption at the hostel. One of my interviews had to be paused as someone in an upstairs flat was throwing their items out of their window and they were smashing on the ground outside the room I was interviewing in. Another was delayed due to a verbal confrontation between the residents that was going on in a common area, leaving the staff at the hostel on high alert in case this became physical and they required support from the police, but unable to intervene themselves. On one occasion, a member of staff came into the interview room to let me know that the interview was unlikely to go ahead as the interviewee was *"the woman who has been yelling outside for the last 20 minutes."* Incidents like these create a highly charged and slightly frantic atmosphere in which staff are literally running around the building to attempt to manage issues as they arise and it is never clear what the next incident will be.

The residents I met in the hostel had all lived through traumatic experiences. Some of their experiences would come out in interviews, but women would also come to the front office to share stories with staff members. During one of my visits, one of the residents, 'Georgia', who had high needs, came to the front desk and shared some of her adverse child experiences. This was something that she hadn't shared with the hostel team previously, but she had wanted to explain to them why she had been upset that morning, resulting in her snapping at the staff, and apologise for her behaviour. More than one member of staff cried after she had left, while comforting each other and agreeing that it was unsurprising she was in her current situation given her experiences. It is common for people to cope with trauma by sharing their trauma with others (Caplan, Haslett et al. 2005, Jones and Wirtz 2006), however this can have a detrimental impact on those listening to these stories of trauma (Omdahl and O'Donnell 1999, Ludick and Figley 2017), putting staff in a challenging position (Michelson and Kluger 2021).

The staff at the hostel were all incredibly resilient and the genuine care they had for the residents was clear to see, despite staff turnover being high. One member of staff reflected that the best part of the job was *"getting to spend time with such amazing women"* and a departing member of the team in their early 20s described themself as being *"in it [the profession] for life now."* Staff members would help the people staying at the hostel to organise appointments with various services, remind them to attend, and follow up as necessary. This could be a frustrating role as the residents would not always wish to engage and often missed appointments, but they would persevere and rearrange them.

It was not uncommon for men to be trying to get into the hostel to visit the residents, which often made them feel unsafe. Residents described men trying to get into their rooms, but also described men shouting to them from outside the hostel. This is particularly challenging given feelings of safety and privacy are key characteristics of a perceived 'home' environment (Walsh and Rutherford 2009), and the importance of women-only spaces to increase women's sense of safety (Walsh, Beamer et al. 2010). Nadia described in an interview being hyper-aware of which parts of their room they could not be seen in, which limited where they felt able to spend time safely.

> *"And people knock on my neighbour's door all the time and those guys who's jumped the fence down outside my window and stare at me in the middle of the night. And I had some like stand on the wall and look through my bedroom window … people lining up every day and looking at me through the window. It's very like a zoo exhibit … I'm a person literally in a glass cage … I know the angles that people can't see me from windows. So whenever I get changed, I get changed there." - 'Nadia', service user*

The presence of drugs was an issue at the hostel. One resident described her recovery from the misuse of drugs and alcohol, only to then be surrounded by the temptation to use substances again due to their proximity inside the hostel. She described a feeling of being torn between appreciating the support and sense of community, whilst also feeling it was an unsafe place for her to be. Although I didn't confirm this, in one of my interviews the participant appeared to show signs of either being under the influence of drugs or alcohol or suffering from symptoms of withdrawal. Throughout the interview her speech was slurred, she was physically shaking and kept scratching at each of her arms in turn.

Towards the end of my work, I happened to be at the hostel interviewing on one of the days that the council were visiting following the announcement that they were purchasing the hostel from the organisation that had previously owned the building. The council representatives were coming in to speak to the staff and residents about what this would mean for them. The staff knew this could mean a restructuring with potential redundancies, despite members of staff feeling constantly rushed off their feet. For residents, there was a nervousness around the potential for even less funding to be available and potential evictions.

A highly challenging point in my research project came when I arrived at the hostel for a follow-up interview with one of the participants to learn that she had recently passed away. She was a caring resident of the hostel who was described as *"motherly and loving"* by the staff and was extremely welcoming to me while working together. In our first interview together she had described to me the ways in which she had been trying to get her life back on track for the sake of her children. For other residents of the hostel as well as members of staff, this can also be a sad reminder of the outcomes experienced by some of the residents, and links to some limited wider literature which shows the positive and negative impacts of social comparison in relation to health outcomes, and specifically participants' estimates of their own risk being influenced by the health outcomes of those with similar health issues (Buunk, Collins et al. 1990, VanderZee and Buunk 1993, Suls, Martin et al. 2002, French, Sutton et al. 2010, Brakel, Dijkstra et al. 2012).

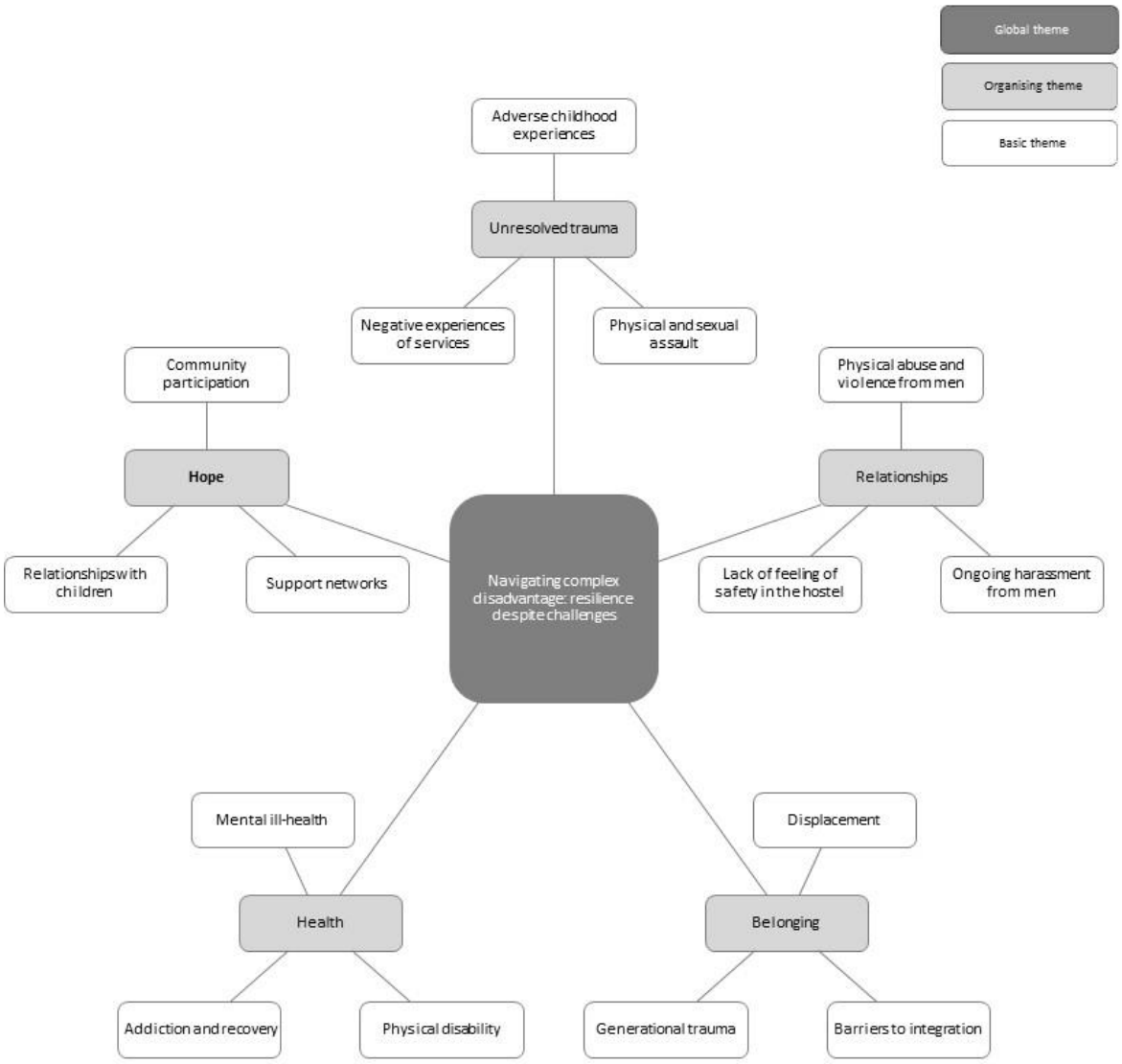
7.5 The hostel residents

This section describes the realities for the hostel residents who are eligible to access the ITAV intervention. Data were generated through interviews with service users and providers then analysed through the thematic network approach described in section 6.3, though this section uses data gathered through interviews with service users only, as I wanted to ensure that the description came from the residents' own perspectives. I have supplemented this with evidence from relevant literature, which is highlighted in the text when included. The findings have been grouped by organising theme and presented to depict what life was like for the study participants.

As mentioned above, service users participating in this study were all women other than one participant who is non-binary. In this section, I will refer to the service users who participated in this study as "the residents". When I come to discuss the issues in service access and present the results of the realist evaluation, I will refer to "women" as that is the focus of this study. The participant who is gender non-binary was aware that this study was focused on women and that their contributions would be analysed in this way.

The global theme is informed by five organising themes, as shown in Figure 17.

Figure 17: Summary of thematic network analysis – the hostel residents



7.5.1 Unresolved Trauma – adverse childhood experiences, physical and sexual assault, and negative experiences of services

Each of the residents I interviewed had experienced trauma which largely remained unresolved. Some participants reflected on trauma having roots in adverse childhood events, of which some explicitly described sexual assault, with more still describing physical assault in terms of violence, either to themselves or family members.

> *"I've seen my dad throttle my sister and smack her head against the wall a bunch… So when I say like I'm scared of my dad hitting me, it's because if my dad hit me once, I'd be dead." - 'Greta', service user*

Others had experiences of trauma that continued into adulthood, particularly in relation to the immediate and ongoing impact of their children being taken away, which the literature shows can often be the case for women who have experienced domestic violence, resulting in complex feelings of loss (Nixon, Radtke, & Tutty, 2013). Trauma can affect a mother's ability to understand and interpret relationships, which in turn can diminish their ability to keep themselves and their children safe (Carolan, Burns-Jager, Bozek, & Chew, 2010). As noted by Sasi:

"I lost the kids and then I went a bit nutty. Being on the streets for a long time, in and out, in and out." - 'Sasi', service user

Jess described her experience of certain approaches that were intended to be therapeutic, but instead reinforced trauma. This is supported by the literature which shows that many people with trauma who access mental healthcare experience re-traumatisation in acute mental health inpatient settings (Chambers, et al., 2014; Duckworth & Follette, 2012) and that despite this, patients and staff either do not draw connections between their trauma histories and their presenting problems, or they avoid the topic altogether (Sweeney, Clement, Filson, & Kennedy, 2016; Sweeney, Filson, Kennedy, Collinson, & Gillard, 2018; Hennessy, Hunter, & Grealish, 2023). For example, with Jess:

"Don't tell people to do fucking mindfulness exercises when they have CPTSD 'cause what you're doing is making their physical bodily trauma and their flashback trauma turn up and trying to make them tune into it. So you're re-traumatizing them regularly." - 'Jess', service user

7.5.2 Relationships – ongoing harassment from men, physical abuse and violence from men, lack of feeling of safety in the hostel

Despite the efforts of the hostel staff, residents continued to be harassed and assaulted by men. Some had partners, or ex-partners, who abused them but would still appear in their lives, either at their place of residence or in the surrounding area, which, as discussed in 7.4, is challenging given the importance of women-only spaces to increase women's sense of safety (Walsh, Beamer et al. 2010). An example of this was provided by Sabah:

"He came in through the back entrance and he was doing so, please. I just wanna speak to 'Sabah', one time and [staff member] was like I'll give you 5 minutes. I asked why are you giving them 5 minutes, as he comes to my room to attack me? I mean he's very abusive. The police are aware and then there's another time, within my room, I called downstairs to say he's in my room so can you call the police, but they refused to believe me." – 'Sabah', service user

This issue seemed to be common – for example, one service provider told me about a woman (not a participant in the study) who had to be evicted from the mixed-sex hostel where she was living due to the danger she faced after repeated rape. The hostel staff were unable to guarantee her safety and so it was the woman who had to be relocated. The service provider shared their perspective that this had a negative impact on both her wellbeing and the wellbeing of others in the mixed-sex hostel, given the feeling that women were not safe there, as well as creating the practical challenge of needing to find a new place to live.

7.5.3 Belonging – displacement, barriers to integration, and generational trauma

Immigration is documented as having an impact on health during both pre- and post-migration periods (Lien, Nafstad, & Rosvold, 2008; Kumar, Meyer, Grøtvedt, Søgaard, & Strand, 2008.; Naess, 1992; Hoye & Severinsson, 2008), which can be further impacted by inequalities in health and socioeconomic status (Varvin, 2009). Many of the residents I met were born outside the UK and had to adapt to life in a new country, which came with challenges such as differences in customs, accents and ethnicity. There is evidence of mental health status being influenced by a mix of "culture shock", language difficulty, homesickness, job insecurity, powerlessness and the fear of deportation in the case of asylum seekers (Lien, Nafstad, & Rosvold, 2008; Kumar, Meyer, Grøtvedt, Søgaard, & Strand, 2008.), which Nadia reflected on in her interview:

"I got school counselling at one point. They said, is it hard being mixed race, I said, no shit, it's hard being mixed race … People are like, your nose represents a culture which I don't like according to my culture … And that makes me make assumptions about you

as a person because of like your nose or like your ear or some bullshit ... And I'm like, yeah, it's hella hard." - 'Nadia', service user

This was described by some as a significant barrier to integration within UK society and to forming constructive relationships and social support networks, including by Greta:

"I grew up through 9/11 times as a Muslim. So people didn't want me. Because it's a safety hazard." - 'Greta', service user

Nadia referenced the impact of being an immigrant on their parents and the associated generational trauma, which the literature suggests should be addressed through awareness and education (Chokshi, Pukatch, Ramsey, Dzienny, & Smiley, 2023). Generational trauma is also documented as being relevant to those who have been victims of abuse, making it further relevant to this group of participants (Walker, 2007). Nadia reflected on her experience of generational trauma:

"Generational trauma is a bitch. I've got it on both sides. Like my mom's side caused my dad's side's generational trauma and our whole family deal is all traced back to partition … And it's really funny because fundamentally their belief systems were completely incompatible. And they made it work but it wasn't great." – 'Nadia', service user

7.5.4 Health – mental ill-health, physical disability, addiction and recovery

All residents had mental health conditions, and a consistent theme identified was a perceived lack of understanding of their mental health conditions among service providers.

"People are just so fucking blind to all and do not understand anything about depression, like it's insane how little people understand about, like any complex mental health stuff, it's like consistently shocking to me and has been my entire life. But now it's just… I'm not surprised." – 'Jess', service user

Almost all participants also had experiences of drug or alcohol addiction and were at various stages of use and recovery. 'Lauren' describes the challenges she experienced in trying to abstain from drugs whilst residing at the hostel, which creates complexity given the literature shows that residing in a hostel can increase social

capital, which can be beneficial in supporting reduced drug and alcohol use (Stevenson, 2013).

> *"I was in rehab and when I came out I lived here [at the hostel] again. There were too many drugs. I could get them if I wanted and eventually I started on them again. Next time I go to rehab I won't come back here. Not if I want my kids back." – 'Lauren', service user*

Some participants also had chronic physical health issues in addition to other needs, which made it difficult for services to offer them appropriate support. The challenges associated with service access and co-morbidity are covered further in 7.6. Jess described her experience of seeking appropriate housing:

> *"Then the things [housing] they showed me were not suitable for my care. They were like here's all these [options] upstairs. And I was like, I can do one step. I could maybe do two steps. But they are painful for me and difficult. Um, like the reason I didn't use my electric wheelchair's 'cause like it's actually harder for me to use my electric wheelchair than not because the access is so bad" – 'Jess', service user*

7.5.5 Hope – support networks, community participation and relationships with children

Despite these disadvantages, residents were resilient, and would often participate in the local community and in activities aiming to support others. Peer support is documented in the literature to "promote hope and belief in the possibility of recovery; empowerment and increased self-esteem, self-efficacy and self-management of difficulties and social inclusion, engagement and increased social networks… these are outcomes that "people with lived experience have associated with their own recovery" (Repper & Carter, 2011, p. 17). Nadia described some workshops they had led for men with similar experiences to their own.

> *"I also run workshops for the men's hostel version of here 'cause. They didn't know that I lived here. So according to them I'm a professional you know. And I can do this. I can talk. That's what I'm good at. You don't need to know that I self-harm and don't eat.*

But I can fucking teach about art and some creative writing – I'm really good at it and it helped." – 'Nadia', service user

Social capital is documented in the literature as being a key driver of recovery (Best & Laudet, 2010; Carballo, et al., 2008; VanDeMark, 2007), and Greta described how their survival, even at their lowest points, was driven by a desire to support their family members.

"Because I knew that if I died, she would be gone, 'cause I'm the only thing that's carrying this house." - 'Greta', service user

Relatedly, Sasi described their motivation for recovery being driven by attempts to rebuild their relationship with their children, who had been removed from their care.

"Like years ago I went to rehab, and also they took my kids just before I was leaving. I offered to go. And I learned I've got to do things for myself. Not for the kids. I was getting ready to get my kids back, and then I realised I had to learn to do it for my love myself and do myself first. Before I come to help anybody else and me and my kids." - 'Sasi', service user

7.6 Issues in service access for women with complex needs

As illuminated in the accounts of residents, there are a multitude of issues that the people in this study are grappling with in an environment that is not always conducive to recovery. The challenges articulated above have an impact on the ability and willingness of women to engage with services, which is then compounded by failures in the system to offer appropriate support for women with complex needs.

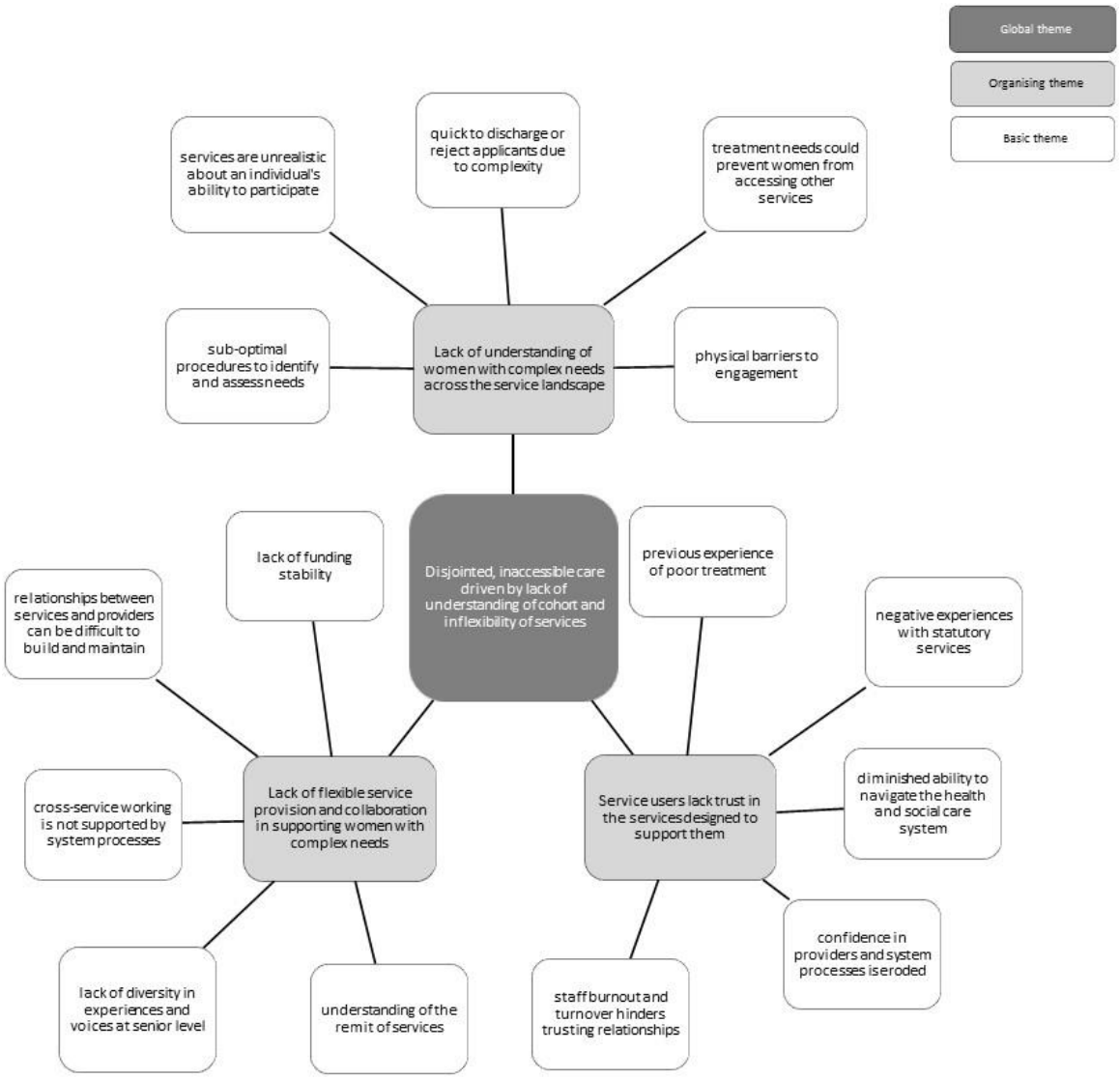
This section engages with the global theme from this work, ***Disjointed inaccessible care driven by a lack of understanding of the cohort and inflexible service provision,*** which articulates the primary barriers to women in accessing quality services, according to study participants.

Data for this section were generated through interviews with service users and providers and supplemented by field notes from observations, then analysed through the thematic network approach described in section 6.3. I examined each embedded unit of analysis (service users, statutory service providers and voluntary service providers) separately, before looking across units of analysis to see whether CMO

patterns could be identified. The analysis of issues is presented across units of analysis in line with the principle in realist evaluation methodology of generating and combining several partial understandings to build a clearer picture of how contexts interact with mechanisms to generate outcomes.

The global theme is informed by three organising themes. Figure 18 provides an overview of issues identified across the three organising themes.

Figure 18: Summary of thematic network analysis – current issues in accessing services



7.6.1 Lack of understanding of women with complex needs across the service landscape

A major issue identified through the analysis was a fundamental lack of understanding by service providers of women with complex needs. This was observed at a system level, for example in the design of assessment and eligibility criteria; and at an individual provider level, for example in approaches to engagement. The combined result was that the design and delivery of systems and care were inappropriate to support women with multiple disadvantage.

We saw in Chapter 5 that diversion programmes are only as effective as the system that women are diverted to and that if an overarching objective of diversion programmes is to change behaviour, an individual's needs have to be understood, including those which extend beyond mental health needs. If all needs are not effectively understood and addressed, conditions can worsen and the risk of contact with the criminal justice system can increase. This is supported by economic and social marginalisation theory, as described in 3.3, and further supported by the existing literature base, which shows that to effectively support women with complex needs, service provision needs to be tailored to individual needs, without this being restricted to mental health support (Swanson, Swartz et al. 2002, Swanson, Swartz et al. 2006, Swartz and Tabahi 2017) to be able to increase service use and reduce rates of incarceration (Case, Steadman et al. 2009, Prins and Draper 2009).

Five basic themes were identified through the analysis as contexts that exacerbate a lack of understanding of women with complex needs.

First, participants suggested that **sub-optimal procedures to identify and assess needs** are driven by a lack of training in understanding women with multiple disadvantage. Needs assessments are often structured to narrowly focus on a single issue, meaning that a woman's needs are not viewed holistically in the context of her wider experience and she can therefore fall through gaps in service provision.

> *"So you tick a box to say what their primary need is and … it actually is really important to get it right, because what it means is that someone's pathway, any funding, is determined by that box that's been ticked. So what I mean by that, if the mental health box has been ticked, it means that the funding streams and the options*

available are defined. So when you're trying to joint-work, that that becomes an issue." – Service provider specialising in adult social care in the statutory sector

Strict eligibility criteria are established, with long waiting lists and time-limited support limiting proactivity and collaboration, resulting in a continuous decline in wellbeing until services can be made accessible, with an increased risk of criminal justice involvement.

"Very reactive … until someone is in crisis or has like done the thing we've been trying to prevent. That's when the help is offered, and obviously a much more beneficial and for everybody would be to work in a much more preventative way." – Service provider specialising in mental health in the statutory sector

This decline in wellbeing may continue until the situation becomes critical, at which point there may be an intervention through services (e.g. through hospital admission or via the criminal justice system). As well as resulting in poorer healthcare outcomes, this can be more costly for the broader system.

"It would be more beneficial and for everybody to work in a much more preventative way and getting women support before they relapse again, or before they try and hurt themselves or before they commit a crime. But more often than not, that isn't the case. It's wait until this woman is in hospital or wait until this woman is in prison, then then we'll hear you." – Service provider specialising in mental health in the statutory sector

Both practitioners and service users said that there was a need for additional training for practitioners on women with complex needs, but service providers were time-poor and individual caseloads were very high.

"Here the problem is that the staff are underpaid, undertrained… the people have complex needs… staff are not trained to [manage service provision for women with] complex needs" – 'Nadia', service user

Second, the analysis identified that women with complex needs found it challenging to engage with services, particularly where **services were unrealistic about their ability to participate** consistently.

Individuals with multiple disadvantage often have unpredictable and unstructured lifestyles which mean that arranging and attending appointments can be challenging. There are many reasons for this, both from a practical perspective (e.g. losing devices that hold appointment reminders, not being able to finance travel to appointments), and for reasons related to their treatment needs (e.g. anxiety, the impact of drug or alcohol misuse, physical challenges). This is particularly disadvantageous for people from lower socio-economic backgrounds who may not have finances available to travel to services.

"They used to give us bus tickets to get there because sometimes we can't afford from where we are" – 'Sasi', service user

Instead of services being flexible and 'meeting women where they are' through outreach activities which encourage engagement, limited resources in the health and social care system and a lack of understanding of engagement challenges mean that services are not designed with this in mind. This can make them inflexible and unrealistic about participation, ultimately causing frustration both on the part of the woman being refused treatment and on the part of service providers who do not understand why an individual is unable to keep appointments that have been made for her. This is particularly challenging in relation to appointments with probation officers, as failure to attend them can result in penalties including additional time in prison.

"You have to be incredibly patient with them. You're very skilled to get them to engage as a lot of skill in that engagement. You have to understand attachment and trauma. Other services don't. They're not there to do that in some way, so they just see them as a problem." – Service provider specialising in women and trauma in the voluntary sector

Similarly to assessments and gaining initial access to treatment, the power to make decisions about subsequent treatment pathways lies with the service provider, who can determine whether or not an individual can continue to receive care, or whether they receive penalties related to violating the rules of their probation, serving as a

further barrier to continued engagement. This dynamic can make women reluctant to engage and they may not specifically continue to seek support.

"I had medical neglect 'cause nobody listens to little girls at the doctors." – 'Nadia', service user

Third, limited understanding of complex needs results in services being **quick to discharge or reject applicants due to complexity**, particularly those who are unable to engage or communicate effectively.

Participants noted that most providers lack training in trauma-informed service provision, despite a belief held by several interviewees that incorporating a trauma-informed approach is required for service users to fully engage, particularly given women serving prison sentences are known to suffer trauma both before and during incarceration as discussed in Chapter 2. In practice this can mean that a woman may be rejected or discharged from a service with little or no follow-up due to a lack of understanding.

[They perceive these clients to be] "this one big mess walking into their office and they do not want it on their caseload, so that's a lot of it, and they get overwhelmed by them. 'Cause they're very complicated women." – Service provider specialising in women and trauma

Even once a woman with complex needs gains to access initial treatment if her capacity is limited, her ability to communicate and engage with services consistently can also be compromised. Without an appreciation of challenges related to attendance, if a service user misses appointments, they may end up being discharged from follow-up or penalised for missing probation-mandated appointments. Without having the capacity or means to consistently communicate with services, and in the absence of understanding on the part of the service, this can mean another gap in treatment.

"Clients would not end up engaging with these services so their case basically just gets closed. But due to just the nature of the environment that clients find themselves in where they would be dependent on drugs and alcohol and the circumstances coming from a DV [domestic violence] background or having experienced

lots of trauma and stress and anxiety on a day to day basis, they find it incredibly difficult to just even engage with myself as their advocate, let alone make sure that they attend every appointment or pick up a phone call for an assessment" – service provider specialising in trauma

This can be heightened by service providers' perceptions of service users' attitudes and behaviours, which may be linked to socio-demographic and cultural differences. An example given by an interviewee was that working class individuals were seen as aggressive. This could lead to inappropriate treatment provision as service users can be branded as difficult to work with and are therefore more likely to be passed on to another service.

"[The service providers] don't understand them and you know [service users] don't always present themselves very well. You know they can come in and be emotional and seem aggressive 'cause they've got short fuses 'cause of the trauma and if you don't know how to handle that or take it the wrong way. I say some people aren't skilled up to do it." – Service provider specialising in mental health in the voluntary sector

Fourth, some **treatment needs could prevent women from accessing other services** for additional needs, particularly if they have drug or alcohol issues.

Participants reflected that co-morbidities are often not treated in parallel. Instead, eligibility criteria can result in services rejecting applicants based on complexity. This is particularly common if an individual has co-morbidities related to drug and alcohol misuse. They may be advised to 'resolve' one issue before treatment for another can begin.

"[Mental health services] can say to you that we can't assess this person's mental health whilst they are actively using substances… and whilst that does make some kind of sense, it's just not a very realistic proposition for many of the people that we work with" – Service provider specialising in co-morbidity in the voluntary sector

Although some dual-treatment specialists are being appointed or considered, consistent system pathways do not currently exist and instead the system relies on a

handful of individuals to help navigate the service landscape, despite the commonality of co-morbidity among the group of women who participated in the study and with those who come into contact with the criminal justice system more broadly.

> *"Somebody with a dual diagnosis is not kind of given any support because they fall between two spaces. It is ridiculous and actually what this person needs is somebody who is actually knowledgeable in both mental health and substance misuse, because the thing is, it's so complex it's difficult to see where one ends and one begins" – Service provider specialising in social care in the statutory sector*

This can also limit the ability of services to collaborate and be proactive, as women often need to wait for the outcome of their first application before starting a second to another service, or risk becoming ineligible for the first.

Finally, **physical barriers to engagement** such as distance from service users and spaces that feel unwelcoming and cold can act as barriers to accessing support, particularly for women who have experienced trauma.

The distance that women have to travel to attend appointments can create financial and logistical challenges, particularly for those of lower socio-economic position who may not have sufficient finances to afford travel, as we saw earlier. The buildings in London where appointments take place are often intimidating and cold in their appearance, which makes visiting them daunting and reduces the will to engage with appointments.

> *"I always think probation is very uninformed about trauma … they're always in these buildings that are incredibly hard to find. You have to press those buzzers and you have to walk up all the stairs and for a lot of women it's a male area they have to walk through and for probation to change that it's a big piece of work, and so I think people are really put off, but they maybe don't see all the small things you could just implement." – Service provider specialising in trauma in the voluntary sector*

This has worsened in the context of budget cuts that has meant services are no longer able to focus on increasing accessibility, despite the apparent advantages of doing so.

> *"And plus they used to do them painting … classes and things like that and everybody used to be there really… people wanted to go … Sweet everything, coffee and everything. And people used to come there for that, for their breakfast and everything and come there and stay there. Stay down and do some classes and then all leave together and find something to do. It was brilliant. Now we would just go different districts and still miserable and they fight." – 'Sasi', service user*

Service practitioners did provide some examples of services aiming to mitigate this and provide care in a more accessible way, through: i) coming to community spaces such as women's hubs to deliver treatment or hold probationary meetings in more comfortable and accessible surroundings; and ii) creating a more friendly environment in the council buildings where appointments happen. However, this relies entirely on individual service providers being willing to travel to these spaces and has also been deeply impacted by Covid-19, as many spaces were unable to operate and have not fully recovered or regained attendance following re-opening.

7.6.2 Service users lack trust in the services designed to support them

Another organising theme was a lack of trust and understanding in services on the part of women with complex needs. Lack of trust is a critical component when engaging with services as it is beneficial for women to set their own treatment goals and identify their own needs. This requires a level of openness and honesty which will only come with having trust in both the system and the practitioners that women are working with. However, this trust is difficult to build, particularly in a context where women with complex needs may have had negative experiences through involuntary hospitalisation or incarceration.

This is supported by literature showing the importance of trusting relationships between service users and both individual providers and systems (Peterson, Skeem et al. 2010), which can enable participants to feel 'believed in' and is correlated with positive outcomes (Dooris, McArt et al. 2013), including increased service use

(Canada and Epperson 2014) and a reduced risk of recidivism (Prins and Draper 2009).

Five basic themes were identified as contexts that exacerbate women's lack of trust in - and understanding of - services.

First, women may have **previous experience of poor treatment** from services, making them untrusting that the providers who are there to support them will take their concerns seriously. One result of poor treatment can be that women do not feel heard, but instead find that they are repeatedly told what is wrong with them. Similarly, if a service user has attempted to seek support for a long time without success, this can reduce her feeling of agency and control as there may be a perception that the person running the assessment has the ability to accept or reject her as a patient and will do so without her views being taken into account.

> *"I'm ADHD and nobody picked it up because why am I here? I fell through all of the nets of everything and ADHD frankly was the least of my worries…If you have high anxiety and trauma, that has a high overlap with my ADHD. But what if you have trauma and high anxiety and ADHD because there are extremely common comorbidity? Maybe just ends up being hidden, does it? Yeah. And ADHD, like, creates anxiety because you're neurodivergent and that's got nothing to do with all the other trauma that I'm sure it gives you plenty of anxiety. I didn't know anxiety existed until I was 16 'cause it was just like breathing." – 'Nadia', service user*

This can pose a significant issue for treatment and can also highlight the decision-making power imbalances between service users and providers, as service users can feel that they don't have any influence over their own care and disengage with services in the future.

> *"I just kind of feel by the time people get to us, a lot of the time people are just very, you know, really stuck … They don't feel like they will get anywhere because they haven't before. They don't feel listened to because they haven't been before." – Service provider specialising in mental health in the voluntary sector*

Second, women may have had previous **negative experiences with statutory services,** which reduces trust. All women interviewed had had previous negative experiences with formal services. A common interaction with statutory services was related to the removal of their children.

> *"What hasn't been [good is] through social services and I'm supposed to get myself an adult one and I'm scared. Because social services don't help me too much, they took my kids from me when I was being honest. Yeah, I hate them." – 'Sasi', service user*

Three of the interviewees referred to having their children removed from their care, at least four were removed from their own parents at a young age, and four had been in contact with the criminal justice system through incarceration, probation, or both.

> *"They've got a negative view of statutory services, they may have been put in prison you know, or maybe be on probation. So their experience of statutory services may not be that pos*itive." – *service provider specialising in mental health*

Services are not always cognisant of the trauma individuals have experienced in their past encounters with statutory systems, but these encounters understandably reduce appetite to engage, as they may be seen as a threat rather than a system designed to support them. It can also prevent women being honest about their own treatment needs. An example given by a service practitioner in a training session I attended was related to a mother who was aiming to regain custody of her children but was reluctant to raise any mental health concerns or admit to drug or alcohol misuse as it could damage her chances of bringing her family back into her care and she was worried about being arrested.

Third, **diminished ability to navigate the health and social care system** is a significant barrier to attaining support.

Analysis identified several different services available for a variety of treatment needs available to women. Variations in the application processes and eligibility criteria between services can make navigating these services both overwhelming and confusing. Service rejections are often vague about reasons for rejection and lack signposting or practical advice on what the next steps should be.

"How these services could improve is if they provided more information [when issuing a rejection] or referring to another place that could help … it would be useful for myself and for my clients, definitely, rather than just saying 'oh, it's just she got rejected on this basis blah blah' but going a little bit beyond that" - Service provider specialising in community based care in the voluntary sector

Even once a seemingly appropriate service has been identified, the application process often requires a certain level of information technology literacy and access to the internet, which can be a barrier for many people with complex needs, particularly for those with low levels of literacy, learning disabilities, or without a fixed address.

So it's the simple things that can cause huge barriers and challenges for us. Sometimes it feels like an obvious issue so I can see why that would be really frustrating, 'cause it almost makes it seem like it's an excuse, doesn't it? That you know, we've sent one letter and that's it, that's kind of job done. Well, they should understand that literacy is really poor. So you've already lost a lot of the people you're sending letters to" – Service provider specialising in community based care in the voluntary sector

Fourth, where a woman has not been able to access services, her **confidence in providers and system processes is eroded**, making her less likely to engage in the future. Unclear processes and a lack of signposting can reduce service provider confidence in being able to advise potential service users, resulting in confusion and frustration on both sides and eroding the service providers' confidence in being able to help women.

"it affects their relationship with their advocate [case worker] because their advocate is looking like they're not doing stuff when they really are, and but it massively affects your how they view services in general and how willingly, how willing they are to then go and look for help because their kind of attitude, even more so is that well, no one's gonna help me. No one wants to help me. I can't speak to anybody." - Service provider specialising in community based care in the voluntary sector

This rejection erodes women's confidence in the process and, as experiences of rejection or premature discharge increase, they become less likely to engage in the future as they may perceive it to be a waste of time.

> *"Inability to trust… suspicious of the support that they can receive from these services… clients would not end up engaging with these services [so] their case basically just gets closed" – Service provider specialising in trauma in the voluntary sector*

This has an additional impact on engagement as a lack of involvement in decisions related to women's own care highlights the power imbalance between support services and the women they are looking to support and can make a woman feel powerless, undermining her agency.

> *"[Service providers] seem a bit jaded and fed up and seen it all before … it impacts on how you perceive the services, you might not even want to engage, you know, because you feel judged" – 'Lizzie', service user*

Service navigation was also negatively affected by the impact of Covid-19. Throughout the pandemic there was a move to run services online rather than in person, without the provision of phone numbers. This created a 'faceless' front to a service which was difficult to engage with, and broke down relationships both between different providers, and between providers and the people they were trying to support. Service users and providers would often receive communications on behalf of a service rather than an individual who they could connect with. Ultimately, the result of this was frustration and unclear direction for both service providers and users.

> *"We have definitely seen a fallout from Covid … more of a distrust of services. Where services weren't around, you know, some literally just couldn't stay open, some moved completely online and became really hard to kind of reach. We have found it incredibly hard to speak to actual people that work in those organizations, and so like the impact on that on the women is that" – Service provider specialising in community based care in the voluntary sector*

Finally, **staff burnout and turnover hinders trusting relationships** between service providers and users. Providers want to deliver a good service but are constrained by

the resources available to them and the related pressures that come with their role. The resulting frustration in not always being able to help, on top of long working hours in a high-pressure environment, means that staff burnout is common, even for resilient members of a team.

> *"You come across a lot of burnout professional today, you can tell it they're cynical, they're overworked and they become cynical and hard. So it's really about educating people and collaborating and being grateful to them for what they do, even if it's a bit shoddy." – Service provider specialising in women and trauma*

One consequence of high turnover is that relationships between service providers and service users constantly need to be rebuilt. A cycle develops of service users introducing themselves and their needs, building a relationship with someone they hope can help them, then being passed to another individual or service who does not understand the context and needs to go back to square one. This creates an environment where women need to continuously explain themselves – their history, service needs, preferred ways of engaging – which is exhausting, particularly when it means revisiting past trauma.

> *"She has no contact with anybody apart from myself and recently one other person. Briefly, she had no contact with anyone. So if I was to stop supporting her, that could be pretty bad news" – Service provider specialising in housing in the voluntary sector*

Another consequence of high staff turnover is the challenges in building and maintaining relationships between services. Having strong relationships between services is critical to providing joined-up care for women with multiple treatment needs, but service providers struggle to maintain it due to staff moving on. This means that more time needs to be put into building relationships on an ongoing basis to be able to deliver effectively, but staff do not have sufficient bandwidth to dedicate to this.

> *"incredibly high staff turnover and so again, it becomes really hard to get plans in place for the women that we work with, because you formed a relationship and then that person's left and they seem to leave very quickly with very little handover. So it's like they're here today and next week they're gone" – Service provider specialising in community-based care in the voluntary sector*

Burnout is unevenly distributed. Women of colour working as service providers often recognise issues related to racism in the system and have been victims of racism themselves. This can make them feel obligated to bear additional responsibilities focused on addressing these issues as they see them, resulting in even greater pressure. This is due to both the emotional strain of being subjected to this treatment and the extra labour that comes with these responsibilities.

> *"I've been in [the profession] for over 20 years, so I get it from both sides. I get it completely why they don't trust systems, but I understand what the problem with the system is. So I'd rather be a part of the change and help both sides get the system, fight the system and say you're doing it wrong. I fight this battle every single day." – Service provider specialising in social care in the statutory sector*

7.6.3 Lack of flexible service provision and collaboration in supporting women with complex needs

Service providers can be rigid in both the types of support that they provide and the way in which they are able to provide it (e.g. through the processes that they follow or the amount of time they spend on each case). This makes collaboration between services – particularly in the context of working in parallel or moving a woman from one service to another and back again – challenging. It can be further hampered by hierarchies between services and the resultant dynamics between and within systems. Experiences of working with individuals on the ground are overlooked and disregarded. We saw in Chapter 5 that care to promote mental health and provide effective diversion from prison requires individual rather than agency-based plans. Women with complex needs require services to be coordinated to ensure that their requirements are appropriately assessed, prioritised and addressed through collaboration between services.

The importance of this theme is supported by literature which shows that a case-centred approach should be adopted to provide an individualised support package to improve overall health and wellbeing (National Association for the Care and Resettlement of Offenders 2005, Confederation of British Industry 2009, Revolving Doors Agency 2010, Winstone and Pakes 2010, Dyer 2012). The literature also shows that effective treatment requires multidisciplinary approaches with capacity to access a range of services related to housing, addiction, vocational rehabilitation and

social services, in addition to formal mental health care (Hean, Heaslip et al. 2010, Scott, McGilloway et al. 2013), with a system to prioritise access to the most urgent services (Bond, Drake et al. 2001, Clayfield, Fisher et al. 2005, Cosden, Ellens et al. 2005, Gordon, Barnes et al. 2006, Davis, Fallon et al. 2008, Erickson, Lamberti et al. 2009, Lange, Rehm et al. 2011).

Five basic themes were identified through the analysis as contexts that exacerbate the lack of flexibility and collaboration demonstrated by services.

First, a **lack of understanding of the remit of services** can hamper collaboration. To achieve it necessitates mutual understanding between services of their respective roles, priorities and procedures, and this is currently lacking.

The service provision landscape is complex, made up of statutory services with specialisms (e.g. mental health treatment provision, housing provision, drug and alcohol support) and voluntary sector organisations who work both within and across these areas of specialism. The system is continuously changing, with services reprioritising, scaling up or down, teams merging and processes evolving. This makes it particularly difficult for services to understand how best to interact with each other and the types of support that can be provided, particularly in the context of limited available time.

> *"It's a complicated world signposting because the system changes over time with landscape changes. So today you think it's working then next week you find out a service has shut down and so there's a lot of kind of going back to the drawing board, so it's not the easiest" – Service provider specialising in women with complex needs in the voluntary sector*

There is often a misalignment between services in their expectations of each other, resulting in inappropriate case referrals; or, when aiming to collaborate, work may not be completed or progressed as intended due to unclear roles and responsibilities.

> *"Even if you know how to navigate the system, you can still have women get bounced back for various reasons" – Service provider specialising in social care in the statutory sector*

Case managers can experience similar challenges to service users in getting clarity on why a rejection or discharge has happened and which alternative services can be made available. Services often do not 'talk to each other' when it comes to coordinating complex cases, and individuals trying to support women to navigate services are required to spend considerable time trying to figure this out, so that they can provide appropriate advice to their clients.

"I would say, more often than not, our clients are rejected with very little explanation and no onward. No kind of onward to help." – Service provider specialising in women with complex needs in the voluntary sector

Second, **lack of diversity in experiences and voices at senior level** to enable the dismantling of systemic discrimination. There are fewer people from minoritised backgrounds at more senior levels within services, meaning that decision-makers need to actively seek out viewpoints from people with lived experience if they want to gain a greater understanding of the challenges surrounding service access and engagement. There is a perception that this does not happen, and that a lack of diversity of views at senior level can act as a barrier to taking on board the perspectives of others, with senior management being perceived to be *"out of touch"* with what is happening on the ground as a result.

"I've kind of noticed quite senior managers will walk into a room where there is a large majority of black staff, but they will walk up to the only white worker in the room and speak to them" – Service provider specialising in social care in the statutory sector

Staff may have personal lived experience of discrimination on the basis of race, gender, disability, class, or a combination of these factors. This can prevent the sharing of relevant views and hinder progress in dismantling oppressive structures and behaviours, particularly when working within a hierarchy in which a junior member of staff may want to escalate an issue to decision-makers. The associated power dynamics can stop these issues and concerns being escalated by those working in frontline services. The systems remain unfit for purpose, even once an issue has been identified.

"The other professionals will address the answer [to a question I asked] to my white colleague … particularly if that's a man … they

then lose someone's experience" – Service provider specialising in social care in the statutory sector

Staff members may feel excluded from conversations, or they may not feel comfortable engaging and remove themselves from similar situations in future. This can reduce the confidence of providers with relevant lived experience to speak up when they see problematic behaviours or issues with the broader system as it relates to a specific group or community.

"Obviously like women of colour struggle far, far more. And if you look at like I've never met that many women of colour that high up in the NHS, it's a very, the whole medical, like system is patriarchally built, isn't it?" – Service provider specialising in women with complex needs in the voluntary sector

Third, **cross-service working is not supported by system processes** for complex cases and is rigid in the care it provides (particularly in statutory services). The level of care often depends on the creativity of individuals and their willingness to 'go above and beyond'. Examples of this include structured solutions (e.g. practitioners setting up peer networks between services; establishing working groups related to a specific case to identify a pathway) which are a lot of work to implement and disband with each case, and less formally structured solutions (e.g. a service provider physically visiting a hostel to ensure there is contact with one of their clients and to verify they are safe); which are often time consuming and mostly short-term in nature.

We have seen that clear processes do not always exist for complex cases. Where they do they can be rigid in the support that they are able to provide as a standard offer, particularly in statutory services.

"But there seems to be a lot of the time a one size fits all approach that doesn't fit any of our women at all, and so they are kind of often dismissed from services. They are told they are too complex and so they can't get access in the first place because of their trauma." – Service provider specialising in co-morbidity in women in the voluntary sector

Restrictions in service provision can also create a challenging landscape for case managers who recognise multiple care needs and want to seek access to services for their clients but find themselves hampered by the complexity of the service landscape.

This leaves service providers feeling helpless as they struggle to find the right pathways for the women they are trying to support.

> *"We're also very conscious of basically gatekeeping [parallel service access] and feel that maybe people who are in in need of help are not getting the help they need and that's really frustrating but we understand there's a limit to what can be done." – Service provider specialising in social care in the statutory sector*

Concerns over legal risks (e.g. risks related to data sharing) are greater in managing complex cases – in part due to the scale of need and requirement to work across boundaries - which can increase the reluctance of services to engage with them. For statutory services in particular, this creates an even greater challenge in working flexibly across services which moves away from formal protocols.

> *"It can be really difficult sometimes to gather information from statutory services … hierarchy … risk" – Service provider specialising in women with complex needs in the voluntary sector*

These combined concerns may prevent services from wanting to engage with individuals with multiple disadvantage, or may at a minimum prevent effective and efficient cross-service working.

Fourth, **relationships between services and providers can be difficult to build and maintain**.

> *"I think most people in the team would say that by far the hardest part of the job is other professionals." - Service provider specialising in women and trauma in the voluntary sector*

Service practitioners reflected on the challenges in building relationships with other professionals. In part, this is due to frustrations caused by the factors already discussed, such as misunderstandings around the remit of other services, lack of clarity around referrals from other professionals and having to battle against structural barriers that prevent effective cross-service working. Professionals also found it difficult working with other service providers when under pressure. A feeling that they had given up on some complex cases was noted by a service provider specialising in trauma and criminal justice when describing her interactions with probation workers.

"You come across a lot of burnout professional today there … that's more challenging where they've got no time for these women and don't want to help them. It's hard not to get cross at that." – Service provider specialising in criminal justice, women and trauma in the voluntary sector

Service providers who had had previous negative experiences of other services carried this negative perception with them to other cases. Many participants reflected on specific services that they *"didn't trust"* or weren't perceived to have the right expertise, e.g. *"they don't really understand trauma"*.

Finally, a **lack of funding stability** for services prevents forward-planning and damages relationships between services and their ability to collaborate.

Unclear funding availability creates a challenge for programmes that are funded on a short-term basis and rely on collaboration with other services and establishing and maintaining community partnerships to do so. As their permanence is not guaranteed or recognised, and strategies are not in place to provide specific resources for long-term support, they experience challenges in continuously building and maintaining partnerships.

"It can feel like we're at the beginning again, like five years ago, where we were building up those relationships because there's less personal contacts, personal relationships obviously, in two years services come and go" Service provider specialising in community based care in the voluntary sector

This creates issues for the programmes themselves, as the short-term funding makes attracting and retaining staff more challenging. It also means that programme leads need to spend considerable time developing and submitting bids for future funding, rather than spending it on the delivery of care and support. It also restricts forward-planning as programmes cannot commit beyond the date they are currently funded to run until, making longer-term initiatives, support-commitments and collaborations impossible.

"I hate to think everything comes down to money, but ultimately I would think that being given proper funding and long-term funding would help with a lot of the services, 'cause another problem is

that funding is often for like 2-3 year contracts and sometimes, you know, like so for our project we are very established, but the funding that we currently have is all until next year, and so there's, you know, it's a constant job in itself to kind of make sure that you can keep on running and it doesn't always happen." – Service provider specialising in women with complex needs in the voluntary sector

This puts additional pressure on relationships between existing services and means that new partnerships need to be continuously established as some programmes close and others open in their place.

7.7 Chapter summary

In this chapter I have introduced the context that the ITAV intervention is operating in, the people that ITAV is aiming to support, the issues and gaps in the current support system, and the features of the intervention that have been designed to address these issues.

The analysis of the women in this study builds on literature related to trauma, particularly in relation to the complex feelings of loss connected to the removal of children and in those who have experienced domestic violence (Nixon, Radtke, & Tutty, 2013; Carolan, Burns-Jager, Bozek, & Chew, 2010), and the risk of reinforcing trauma through mental health service provision (Chambers, et al., 2014; Duckworth & Follette, 2012). The analysis also echoed the literature on immigration, and specifically in mental health status being influenced by a mixture of "culture shock", language difficulty, homesickness, job insecurity, powerlessness and the fear of deportation in the case of asylum seekers (Lien, Nafstad, & Rosvold, 2008; Kumar, Meyer, Grøtvedt, Søgaard, & Strand, 2008.). This was apparent in the accounts of women as they reflected on the challenges of having immigrated to the UK, either for themselves or their immediate family. The analysis of women in this study also builds on literature related to the benefits of increasing social capital in a residential space to support reduced drug and alcohol use (Best & Laudet, 2010; Carballo, et al., 2008; VanDeMark, 2007), while needing to balance this with the challenges experienced in trying to abstain from drugs whilst residing at the hostel where drugs were being used by other residents.

The challenges that women with complex needs can face in accessing appropriate treatment are complex and interlinked, particularly in a setting of restricted resources. However, despite gaps in understanding how to ensure that individuals with complex needs receive the care that they require, there is broad agreement on what the key issues are across specialties within the health and social care sectors, which provides a foundation for designing interventions to address them. Three key challenges were identified: i) a lack of understanding of women with complex needs across the service landscape; ii) service users lack trust in the services designed to support them; and iii) a lack of flexible service provision and collaboration in supporting women with complex needs.

The basis for how the ITAV intervention may address these issues and findings from the evaluation are presented in Chapter 8.

Chapter 8 It Takes A Village: a realist evaluation

8.1 Introduction to chapter

Through the realist evaluation I developed an overarching programme theory for the ITAV intervention, which describes how ITAV has achieved impact, for whom and within which contexts. Given that the ITAV intervention is primarily focused on achieving system change which takes time to gather evidence on material impact, I have synthesised the initial indications of the overall effectiveness of ITAV in relation to this programme theory, presented in 8.7. The latter assessment of effectiveness is based on the study data and framed as key indications of effectiveness based on early successes and emerging challenges that the intervention has experienced to date.

In this chapter I present the initial programme theory for ITAV as the rationale for the intervention and, specifically, study participants' explanations for how ITAV could be successful in addressing the issues that women with complex needs face in accessing services (discussed in 7.6). This is articulated as a set of initial hypotheses which underpin the intervention, which were then tested throughout the realist evaluation.

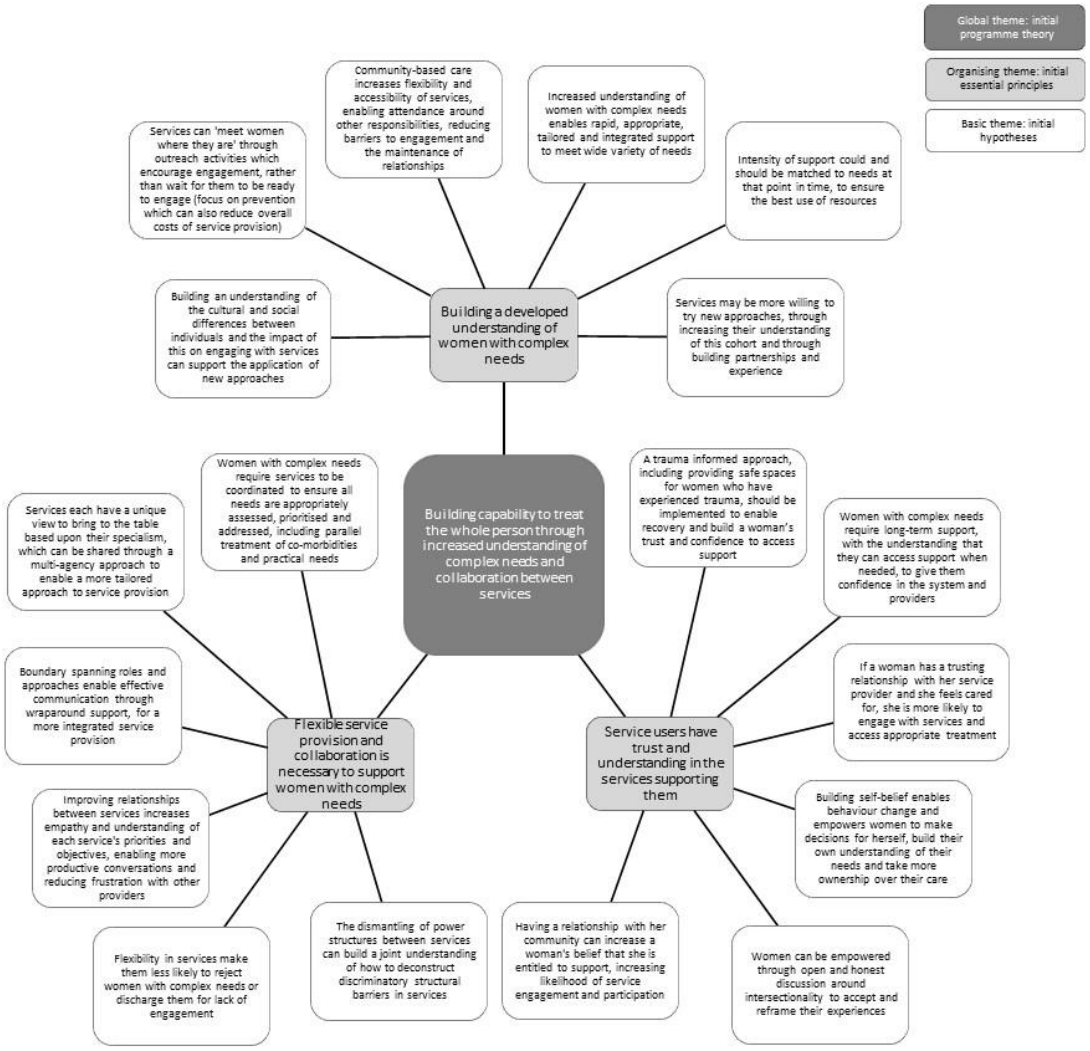
Second, I present the refined programme theory for the intervention in 8.3. This is an explanatory model for the drivers of - and barriers to - the effectiveness of ITAV that was developed by testing the initial hypotheses using realist evaluation methods (described in 6.3). The refined programme theory utilises a structure of Essential Principles and underlying Hypotheses (as applied in the realist review). The refined programme theory could be used going forwards as an initial programme theory for interventions with similar aims, to benefit women with complex needs. I discuss each of the findings in turn, a synthesis of early indications of success and challenges, the evolution of the programme theory throughout the evaluation and how perspectives differed across the three embedded units of analysis (service users, statutory service providers and voluntary service providers) and across select demographics.

Finally, I reflect on the impact of Covid-19 before presenting my conclusions.

8.2 Rationale for the ITAV intervention – the initial programme theory

Data for this analysis were generated through initial baseline interviews with programme designers, service providers and service users, complemented by a review of training materials provided by ITAV and my observations, to provide an understanding of the intended goals of the intervention and the resulting anticipated benefits for women with complex needs. Data were synthesised using a thematic network analysis to develop the overarching initial programme theory (Figure 19).

Figure 19: Summary of thematic network analysis – initial programme theory



The organising themes identified through the thematic network analysis are articulated below with the initial hypotheses. The detailed CMOCs which were grouped to form the initial hypotheses (with associated narrative) can be found in Appendix G. These initial hypotheses were subsequently tested through the

observation phase of the evaluation, to deliver the refined programme theory presented in 8.3.

8.2.1 Building an understanding of women with complex needs

As we saw in chapter 7, a major issue identified by the analysis was a fundamental lack of understanding of women with complex needs at systemic and individual provider levels. The result of this was that the design and delivery of systems and care was inappropriate to support this group of women.

ITAV aims to build a greater understanding of the individual women it is trying to support, and of women with complex needs more broadly, with a greater appreciation of intersectional considerations and culturally relevant approaches. It is aiming to do this through training, presentations and awareness sessions; case consultations and multiagency case conferences; mental health treatment advice; reflective practice; and Passport provision.

As we saw when considering issues in accessing services, women with complex needs can struggle to seek comprehensive treatment appropriate to their requirements, and the tailored prioritisation (and intensity) of support should be matched to needs at that point in time to ensure the best use of limited resources. This can be enabled by a more proactive approach to identifying appropriate services and pathways through outreach and active engagement with women who could benefit from support, rather than waiting for them to actively seek support or reach a point of crisis. As part of service provision, practical needs such as housing need to be addressed in addition to mental health support if outcomes are to improve, particularly when women have co-morbidities resulting in more specific requirements.

This can be facilitated by services working more closely to build a holistic understanding of the needs of the individual, to ensure appropriate support is identified to meet them. Women with complex needs are often known to local services through previous contacts, and services can increase their understanding of an individual by having a basis in the community, reducing barriers to engagement and facilitating the sharing of knowledge with other service providers. This could improve service user experience as there would be ‘no wrong door’ to access support, and a woman would have the option of support from someone she has an existing relationship with.

Building an understanding of the cultural and social differences between individuals and their impact on engaging with services can support the application of new approaches. This may be achieved by having service providers engage more frequently with practitioners and organisations who know an individual or community best (including faith- and community-based organisations), through knowledge sharing and training about effective working with different cultures, and through more reflective practice. To do this effectively requires service providers to feel comfortable having open discussions with each other about how best to support different individuals, being open to hearing different views and learning from others.

"It's about stepping outside the role of being an expert and into the role of a human being who is learning and trying to understand" – service provider in the borough

8.2.2 Service users have trust and understanding in the services supporting them

Another issue identified in the analysis was that service users did not trust the services that supported them and did not understand how to best navigate the system to access appropriate support. This may be heightened by experiences of discrimination or of ignorance around characteristics related to intersectionality and the related power dynamics. A consequence of this can be gaps in treatment and it acts as a major barrier to engagement.

ITAV aims to support the development of trust and understanding through pathway navigation support; clinical lead input; case consultations and multiagency case conferences. This combines the provision of direct support to service users, with encouraging further engagement by demonstrating the value of services through more effective service provision.

If a woman has a trusting relationship with her service provider(s) and feels cared for, she is more likely to engage with services and access appropriate treatment. Service providers can encourage trust by incorporating open and honest discussions around intersectionality in therapeutic settings. This can encourage empowerment and an acceptance of women's realities by directly addressing the inequalities they have experienced. Working relationships can also improve if service providers actively address power imbalances.

Improving service providers' understanding of the barriers faced by women with complex needs can help them to demonstrate their understanding of the women they are working with, giving service users more trust that they are being looked after. For example, women with complex needs often require long-term support, so demonstrating that they can access it when needed can give them confidence in their service provider and the health and support system more broadly.

Trust can also be built through a woman's relationship with her community. Basing an intervention in the community can reduce psychological barriers to engagement through increased familiarity to those seeking support, which can in turn encourage participation. Community-based care can enable women to meet their other responsibilities, particularly for those with familial responsibilities, which can enable the development and maintenance of relationships and support networks. Having a relationship with her community can also increase a woman's belief that she is worthy of - and entitled to - support and increase the likelihood of ongoing service engagement and participation.

A trauma-informed approach to service use should be implemented to enable recovery and build a woman's confidence to access support. As introduced in 2.3.1, a trauma-informed approach is a framework which emphasises creating a safe and supportive environment for healing and recovery. Providing a safe space for women who have experienced trauma helps them to regain confidence and provides an opportunity to address past trauma, while facilitating the building of relationships with others in the community to provide additional two-way support.

Women who have experienced trauma often lack self-confidence and self-worth, which ITAV designers believed that helping them to develop an understanding of their own needs and including them in decision-making can improve. To achieve this, services can be structured so that a woman makes her own choices about what her goals are and a plan to meet them can be co-developed, led by the individual. This can enable positive behaviour change and empower women to make decisions for themselves. Greater understanding of their needs and ownership of their care shifts the power to structure care towards the women seeking support and increases individual agency.

"So it's about providing choice [for the women], it's a collaboration." - service provider specialising in trauma informed approaches in the borough

8.2.3 Flexible service provision and collaboration is necessary to support women with complex needs

A third issue identified in enabling effective service provision relates to the working relationships between providers. Siloed working is common and there are barriers to engagement driven by both formal processes and informal relationships. Expanding to work across a variety of services and programmes can increase the diversity of views and experiences, bringing in associated expertise which could help service providers navigate challenging issues such as cultural and systemic barriers to accessing services.

ITAV is aiming to build these connections and increase the flexibility of service provision across services. It hopes to do this through case consultations and multiagency case conferences; training, presentations and awareness sessions; and reflective practice.

Services each have a view to bring to the table based upon their specialism, which can be shared through a multi-agency approach to enable more tailored service provision. Effective communication between services increases understanding of organisational objectives and priorities and supports partnerships with clear roles and responsibilities. This can be improved through boundary-spanning roles and approaches to facilitate more integrated service provision with wraparound support, to enable prioritisation and tailoring to individual needs.

Relationships between services can be improved by increasing engagement and knowledge sharing between agencies, and through the creation of specific forums for providers to share their expertise with each other. This can enable the implementation of a multi-agency approach to case management, through which decision-making power differentials between services can be reduced to ensure that diverse views are heard. It can increase empathy and understanding of each other's priorities and objectives, enabling more productive conversations and reducing frustration with other providers. It may also allow for more constructive conversations between providers around areas of discrimination, building the confidence of individual

providers in discussing sensitive issues in a compassionate way while sharing knowledge and experience.

"Good relationships between professionals ultimately benefit the women" – service provider, criminal justice

Increasing flexibility in the delivery of services can make providers less likely to reject women with complex needs or discharge them for lack of engagement, putting more decision-making power in the hands of the person with the greatest understanding of the individual. Increasing this flexibility can be facilitated through boundary-spanning roles which aim to maintain an understanding of the service landscape, hold relationships with professionals within services, and use this understanding to navigate appropriate treatment pathways. Boundary spanning roles can create space for more creative approaches in which service users can define their own care and service providers are supported to advise their clients on the available pathways.

8.3 The refined programme theory – an explanatory model for how ITAV has achieved impact, for whom and within which contexts

Once the initial programme theory was developed, I entered the Observation phase of the realist evaluation cycle, within which I tested and revised the initial hypotheses to produce the refined programme theory. Interviews with programme designers, service providers and service users, complemented by field notes from observations (including a review of training materials provided by ITAV and attendance at ITAV forums), provided an understanding of how the intervention was currently influencing the outcomes of women with complex needs in the borough.

Through the evaluation, 3 essential principles and 15 hypotheses were developed by thematically grouping CMOCs as they were identified. These essential principles and hypotheses are summarised in Table 9.

Table 9: Summary of Essential Principles and hypotheses

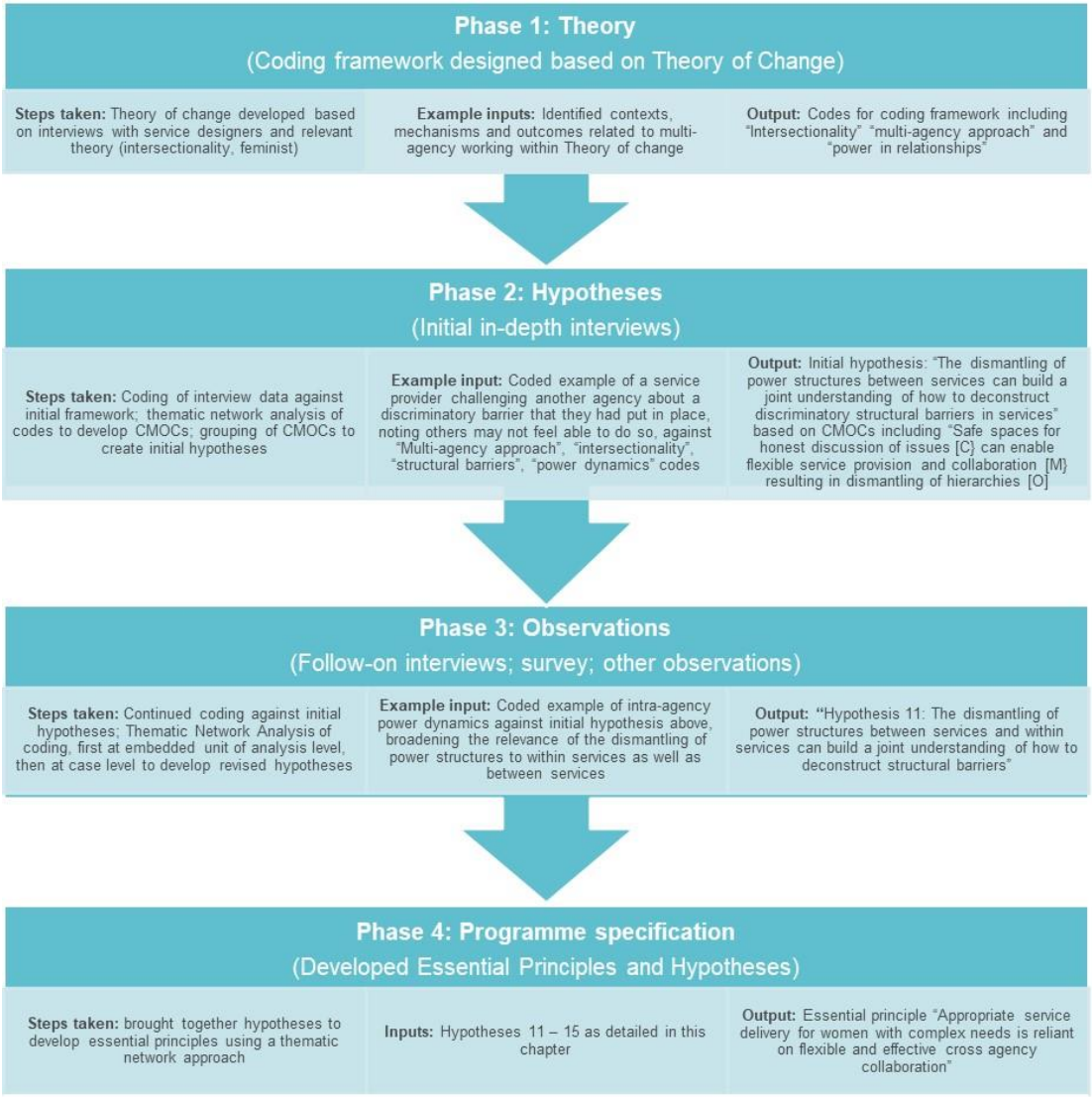
Essential principles	**Essential Principle 1: Effective service provision requires a developed understanding of women with complex needs**	**Essential Principle 2: Service users need to feel heard and supported by services to build trust in the system and foster engagement**	**Essential Principle 3: Appropriate service delivery for women with complex needs is reliant on flexible and effective cross-agency collaboration**

Hypotheses	*Hypothesis 1:* Having an understanding of cultural and social differences and expectations between individuals can increase engagement with services and support the application of new approaches *Hypothesis 2:* Services are designed on the understanding of the need to 'meet women where they are' to encourage engagement can do so through proactive outreach activities, rather than wait for them to be ready to engage or at a point of crisis *Hypothesis 3*: Care and support structures in the community based on an understanding of the needs and lifestyles of women with complex needs can increase the flexibility, availability and accessibility of services, reducing barriers to engagement and increasing choice *Hypothesis 4*: Flexible, needs-based assessments and eligibility criteria which are designed to facilitate engagement with complex needs can enable rapid, appropriate, tailored and integrated support *Hypothesis 5*: Services may be more willing to try new approaches, by increasing their understanding of women with multiple disadvantage through building partnerships and sharing experience	*Hypothesis 6:* A trauma informed approach should be implemented to build self-belief and trust in services to increase engagement from service users *Hypothesis 7:* Women with complex needs require tailored long-term support to give them confidence in the system and service providers and encourage ongoing engagement *Hypothesis 8*: If women have a trusting relationship with her service provider and feel cared for, they are more likely to engage with services and access appropriate treatment *Hypothesis 9*: Women can be empowered to build an understanding of their own needs and take ownership over their care which can support more appropriate assessment of needs *Hypothesis 10*: The development and maintenance of personal relationships can increase a woman's belief that she is worthy of support, increasing likelihood of service and appointment engagement	*Hypothesis 11:* The dismantling of imbalanced decision-making power structures between and within services can build a joint understanding of how to deconstruct structural barriers to the provision of multi-agency support and enable more flexible treatment delivery *Hypothesis 12:* Appropriate long-term funding, policies, processes and systems are required to enable flexible multi-agency service provision and facilitate support for women with complex needs which is focused on needs rather than rigidly defined pathways *Hypothesis 13*: Services each have a unique view to bring to the table based upon their specialism, which can be brought together through a multi-agency approach to enable more tailored service provision *Hypothesis 14*: Effective relationships between services increases empathy, trust and understanding of each service's priorities and objectives, enabling more productive multi-agency working to provide more integrated service provision *Hypothesis 15*: Boundary-spanning roles and approaches enable effective communication between services for more integrated service provision

Although structured as three separate essential principles, they are interconnected in reality and the mechanisms within each strand interact with each other to achieve change.

As described in 6.3, I applied the four-phase realist evaluation cycle. To illustrate how this process was applied in practice, Figure 20 shows the flow of data collection and analysis using a worked example (an approach that is iterative in practice, but shown here to be linear for simplicity).

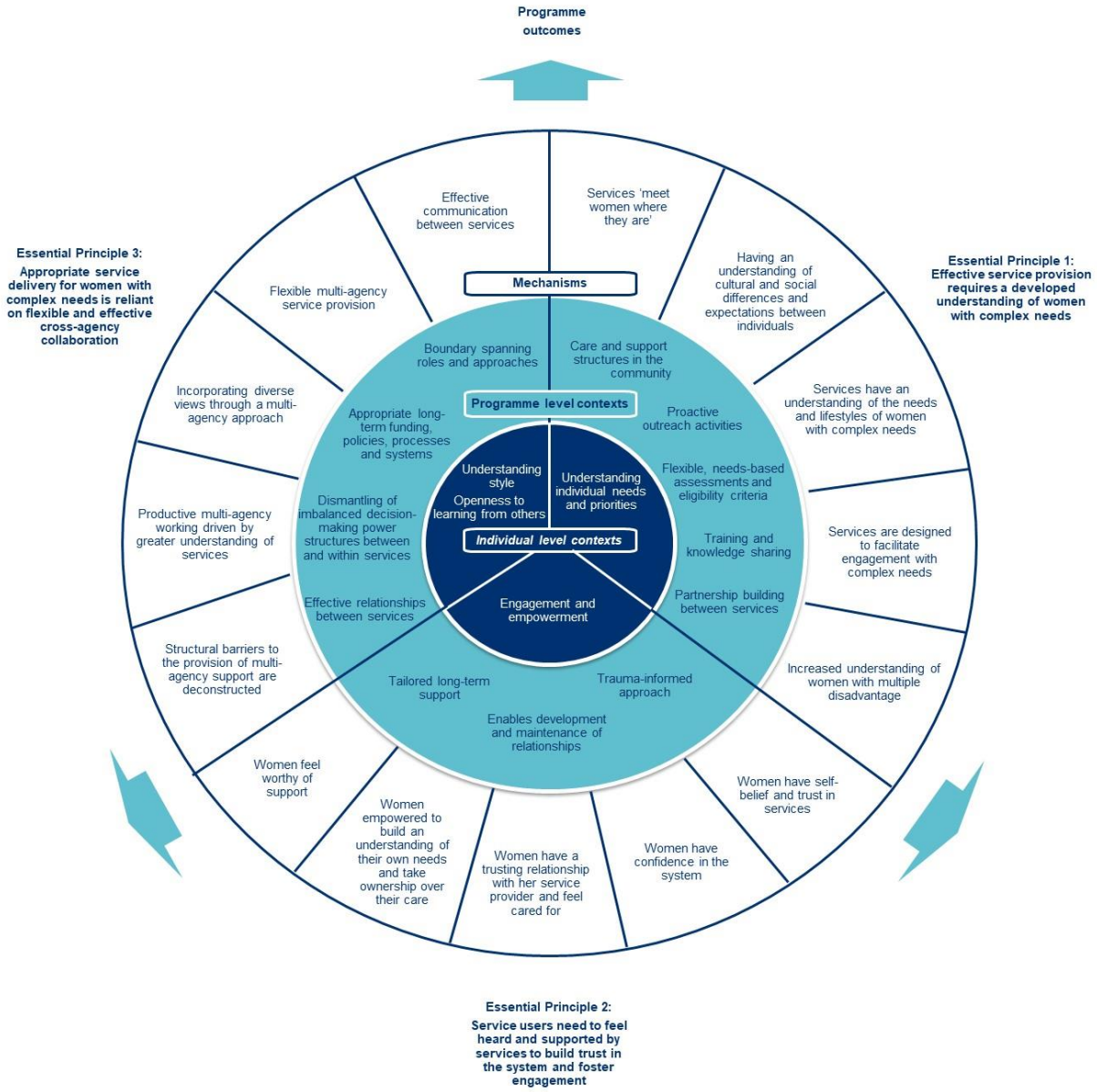
Figure 20: Flow diagram of approach to developing hypotheses and essential principles



In this example, during the data collection and analysis process it became clear that the initial hypothesis related to dismantling decision-making power dynamics between services was too focused on inter-agency dynamics and that it also needed to include the decision-making power dynamics within services. It also became clear that there should be a greater emphasis on the broader implications of deconstructing decision-making power dynamics as a way of creating a culture in which individuals are comfortable sharing opinions and challenging the status quo; providing a safe environment where the views of each member of the group are valued, as well as being able to have challenging discussions about discriminatory practice. The refined hypothesis reflects this.

The process was undertaken for each of the initial hypotheses to develop refined hypotheses, which were then brought together using a thematic network analysis approach to create the essential principles. Following through the same worked example, this led to the creation of “Essential Principle 3: Appropriate service delivery for women with complex needs relies on flexible, cross-agency collaboration”, as shown in Figure 21 which presents the refined programme theory.

Figure 21: The refined programme theory



In section 8.4 I present each essential principle and its underpinning hypotheses. For each, I highlight specific contexts, mechanisms and outcomes, with the following abbreviations. Enabling contexts: **[EnC]**, Disabling contexts **[DisC]**; Mechanisms **[M]**; and Outcomes **[O]**.

8.4 Essential principles and hypotheses

Essential Principle 1: Effective service provision requires a developed understanding of women with complex needs

Five hypotheses were identified and formed Essential Principle 1.

Hypothesis 1: Having an understanding of cultural and social differences and expectations between individuals **[M]** can increase engagement with services **[O]** and support the application of new approaches **[O].**

In 7.6 we saw that service providers' lack of confidence in navigating the complexities of treatment **[DisC]** can result in a real or perceived inability to provide appropriate support for women. Interviewees reflected that ITAV had developed service providers' understanding of women with complex needs, such that they could avoid pre-conceptions and instead provide more thoughtful care and support, seeing women for more than the problems that they face.

> *"[ITAV] is kind of … motivating staff to be a lot more patient and flexible and see women for all their good stuff rather than just all the problems that they face, and I think that kind of work is something that is super important." – Service provider specialising in trauma in the voluntary sector*

ITAV was able to improve service providers' understanding of women with complex needs by having service providers engage more frequently with community practitioners and organisations who know an individual or community best, including faith- and community-based organisations **[EnC]**. Pathways for engagement that allowed for this included knowledge sharing between services, training about effective working with different cultures and reflective practice **[EnC]**. Another way that services were able to build understanding within services was by hiring peer advisors and people with lived experience of complex needs (including but not limited to mental health conditions and the criminal justice system) and from different demographics, to share knowledge about the needs of different communities and engage directly with clients **[EnC]**.

> *"I hear the frustrations of the community and articulate it back to the power in a way that they get it. But it still resonates back with the community" – Service provider specialising in community based care in the statutory sector*

Building this understanding helped to dismantle barriers to engaging with service users **[EnC]** to make services more accessible **[O]**. An example provided by an interviewee was becoming aware of the need to consider challenges in internet access and use, particularly in relation to the class divide (limitations in digital literacy

as well as access to the internet) and the impact that it can have on not being able to discover what services are available to individuals. Appreciation of the challenges across socio-economic groups is a broader issue in being able to relate to the experience of service users, which ITAV helped to shine a light on through knowledge sharing sessions and training.

> *"Another barrier could be the class divide … The higher up you get in the NHS, people are not necessarily just financially privileged, but people have been in nice families who've loved them and cared for them. I think it's hard sometimes for people of that class to relate to the chaotic life that – just exactly what the women we work with are up against. People can't really understand unless you've experienced it just how difficult life can be for those that need the services the most." – Service provider specialising in community-based care in the voluntary sector*

Building a better understanding of the challenges experienced by service users helped to encourage greater consideration of cultural and demographic nuance in service provision **[EnC]**. The example of internet access and use was reflected on by an interviewee as being a way of empowering people, whilst also potentially closing doors to people who are not digitally literate, making a case for multiple channels for accessing information and additional support in doing so which they were exploring as a result **[EnC]**.

> *"A lot of stuff is on the Internet these days, isn't there? So we are actually in the process of setting up a social group, but around digital expertise, helping people navigate that kind of stuff on the Internet that don't have the ability or quite anxious about it, to signpost things 'cause that's one thing that there was definitely a need for" – service provider specialising in multiple disadvantage in the voluntary sector*

Developing an understanding of why women who have experienced trauma may respond in a certain way to services **[EnC]** can also avoid unhelpful labelling of them as "difficult", which can limit options and result in a lack of support **[O]**. In the context of ITAV, building this understanding between services allowed the intervention designers to advocate for moving away from punishing non-engagement by rejecting or dismissing people **[DisC]** to understanding and supporting ongoing engagement

[M] while continuing to offer an open door [EnC] which, during this study, prevented a service user from being discharged prematurely for disengagement.

> *"The person, when they behave badly rather than just constantly kind of reject them, throw them out, which is probably the pattern they've had from being a child. So they're constantly rejected and they're kind of pushing boundaries because that's the way they kind of communicate." – service provider specialising in complex needs of women*

Similarly, an openness to learn more about service users [EnC] can create positive change in perceptions of different cultures, with service providers commenting on having a greater appreciation of the differences following the "Mic drop" training sessions [EnC]. Service providers described instances of people from the Black community being seen by white service providers as aggressive when they were in a stressful or frustrating situation. They might inadvertently come across in a way that results in them being labelled as difficult, or even threatening, which can result in restrictions in treatment and penalties relating to terms of probation [O]. Interviewees felt this could be further combatted through service providers having an understanding style as well as being open to learning about different communities through initiatives such as ITAV's training offering [EnC].

> *" Like if you know anything about the culture they're from you would actually understand [the behaviour and mannerisms are] something they've been taught … if you understand the culture, understand the communities that use it and why it's being used, [you'd know] it's not a form of disrespect … you understand the cultures you're working with, and then interpret based on that rather than a perception that you have on someone" – service provider specialising in adult social care and mental health*

Several interviewees raised the point that some service users may be anxious about working with providers from different cultural backgrounds [DisC], but felt that this could be supported through a team approach, starting with people they may be more trusting of, but broadening the team to ensure appropriate expertise is brought in [EnC]. The ITAV model allowed for this across services, through creating forums for multi-disciplinary approaches [EnC], although there wasn't evidence of ITAV directly impacting team approaches within individual services beyond the provision of training

related to how this could be done. Team approaches were also thought by service providers to help with relationship building and support the development of understanding of different cultures more broadly to provide more culturally appropriate treatment **[O]**.

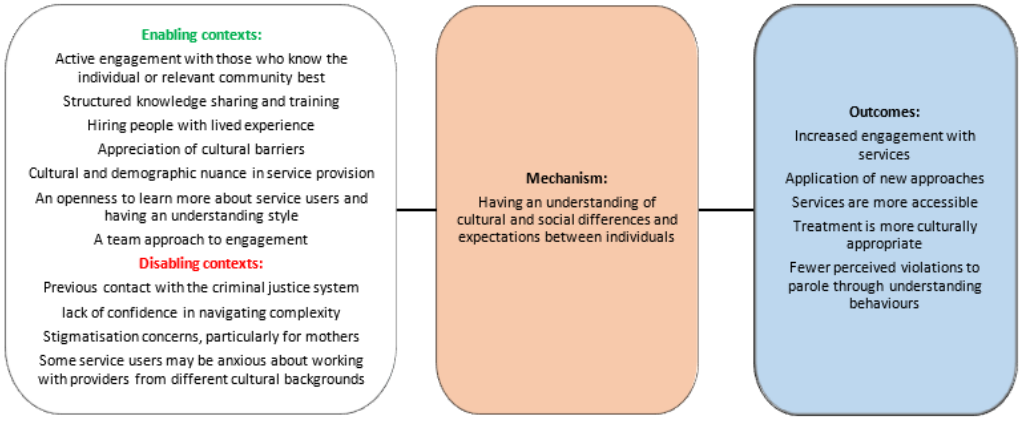
> *"It's that feeling of support that you understand what they're going through as part of their community. So you are there for understanding, availability and consistency, and then you bring in expertise from elsewhere when they are comfortable with you" – service provider specialising in community-based care*

Interviewees working in drug and alcohol services felt that women remained under-represented in their service, potentially due to stigmatisation concerns **[DisC]**, resulting in a hesitance to engage. This was particularly relevant for women who have previously been in contact with the criminal justice system due to nervousness around risk of re-arrest **[DisC]** or women who are mothers, given the expectation that often comes with being the responsible parent and potential implication of having their children removed from their care **[DisC]**.

> *"We used to get like, let's say, 25, between 25 and 33% of the referrals were for women, so they were probably under-represented. There were lots of ideas around why that would be the case. Stigmatisation, nervousness about seeking help because they have out might impact on them as parents and that sort of a thing." – Service provider specialising in drug and alcohol misuse in the statutory sector*

The complete CMOC for Hypothesis 1 is shown in Figure 22.

Figure 22: CMOC for Hypothesis 1



Hypothesis 2: Services are designed on the understanding of the need to 'meet women where they are' **[M]** to encourage engagement **[O]** and can do so through proactive outreach activities **[EnC]**, rather than wait for them to be ready to engage or at a point of crisis **[DisC]**.

In 7.6 we saw that women with multiple disadvantage may not actively seek out treatment **[DisC]** and may struggle to engage with services (particularly when it involves travel and attending council buildings **[DisC]**). The ITAV intervention takes a more proactive approach to identifying appropriate services and pathways through outreach and active engagement with women who could benefit from support **[EnC]**, rather than waiting for them to actively seek support or be in crisis **[DisC]**. Although there wasn't evidence of this happening to date in the context of ITAV, service providers felt that this approach would result in earlier intervention by support services and therefore more of a focus on prevention **[O]**.

> *"The first thing should be avoiding that [negative] outcome. Sometimes it can be that you have a hard conversation with the client. You go to them and [explain the problem that has come to your attention]. I've actually said you really do need to resolve this and I can help you if you want. Certainly a lot of it has to do with prevention" – Service provider specialising in housing in the voluntary sector*

Active engagement in this context included persevering and continuing to reach out and seek treatment for women who need support **[EnC]**. This was sometimes through local services and support centres, but could be through community or religious centres, bringing an additional understanding of cultural relevance, barriers and enablers, to improve the quality of – and trust in – outreach **[EnC]**.

"There was an African lady there [at an ITAV meeting] and she was doing this cooking using African foods and African herbs and, you know, kind of using food as kind of like a healing kind of thing. And there was this one quite difficult case I was working with and that's what she was specifically asking for. She didn't want the equivalent of Meals on Wheels, what she wanted was something that was like culturally appropriate and I don't think we would have known about it without ITAV" – Service provider specialising in adult social care in the statutory sector

Incorporating people with lived experience and peer advisors in services who are relatable and understanding in a way that sometimes traditional professionals are not helped to enable people to access services in a different way **[EnC]**. Service providers reflected on peer advisors in their service who are more representative of communities and could therefore act as credible role models, modelling behaviours both for other professionals and for service users who relate to them **[EnC]**.

"The peer advisors, the people with lived experience who are trained as professional advisors and guiders, can play a huge role in that in enabling somebody to come forward on the journey in ways they never thought imaginable… That you have to have somebody you can relate to. You know it's human." – Service provider specialising in criminal justice in the voluntary sector

As well as active outreach, services themselves need to be ready to provide support for women with complex needs **[EnC]** which one service provider reflected on, as she felt they were not always prepared to provide the required level of support when women felt ready to engage. If a woman has had negative previous experiences of services, for example due to interactions with the criminal justice system or child services, their willingness to engage might be limited **[DisC]**. If an opportunity to provide support is wasted (through service rejection or continuously signposting women elsewhere), there may not be an opportunity for engagement again for some time **[DisC]**. As well as further damaging perceptions of the system and reducing future engagement, this could result in a decline in wellbeing for the individual who was seeking support **[O]**.

"Because that's another step that's just too hard. Asking for help in the first place was really hard, so just being pointed somewhere

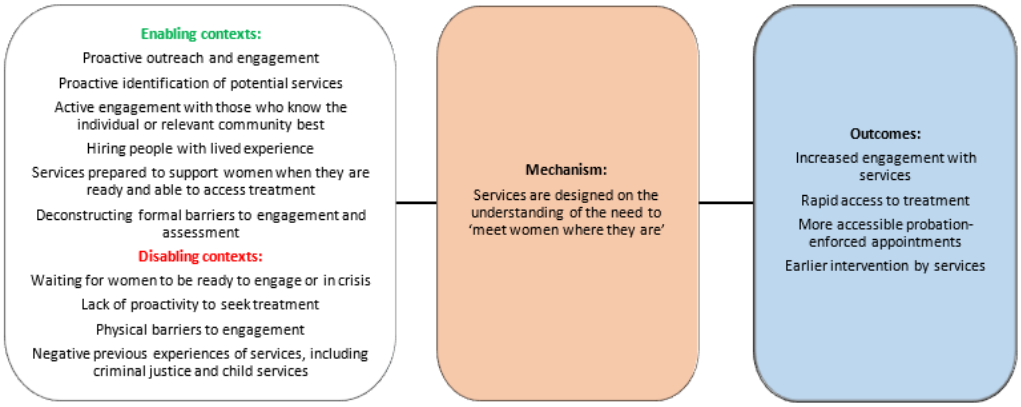
else is a barrier." – Service provider specialising in complex needs in the voluntary sector

'Meeting women where they are' was achieved through ITAV's efforts to deconstruct formal barriers to engagement and assessment where they may not be necessary or intuitive **[EnC]**, to facilitate more rapid access to treatment and ensure that women are able to attend probation-enforced sessions **[O]**. A representative of a housing charity gave the following example:

"You don't have to prove that you can cope with independent living because you have been doing that for many years… They kind of took the risk of saying, well, let's just give people with their own place. And we'll also given the wraparound support that they need in order to cope." – service provider specialising in housing

The complete CMOC for Hypothesis 2 is shown in Figure 23.

Figure 23: CMOC for Hypothesis 2



Hypothesis 3: Care and support structures in the community **[EnC]** based on an understanding of the needs and lifestyles of women with complex needs **[M]** can increase the flexibility, availability and accessibility of services **[O]**, reducing barriers to engagement and increasing choice **[O]**.

ITAV aimed to increase accessibility of services and appointments **[O]** by having individual treatment provision take place in comfortable surroundings such as residential spaces and community hubs **[EnC]**, and managed to organise this such that mental health, housing, financial welfare, and probation services were available in local spaces. Service designers identified that this may also mitigate some of the issues caused by perceived or real imbalanced decision-making power dynamics

[DisC] by providing treatment in a setting in which the service user is more comfortable, and by making services more flexible, allowing women to work in partnership with services to schedule appointments and giving them a better chance of being able to attend **[EnC]**. Although service users did not specifically refer to changes in decision-making power dynamics, they did reflect on utilising this approach through attending sessions in more accessible places. Service providers involved in these services also felt this way of working could provide a different perspective on the lives of service users, and that this could also improve service providers' understanding of the women they are trying to support **[O]**.

> *"We've come back to our hubs because we know that face to face working, especially with really vulnerable women is the most beneficial way to work with them. It's the best place for other professionals to meet the women as it gives them more insight in to them as people" – Service provider specialising in community based care in the voluntary sector*

Having a basis of care in the community increased the flexibility and accessibility of services by enabling attendance at appointments **[EnC]**. Service providers reflected on an advantage of having a basis in the community being that they felt more able to signpost relevant services and build relationships between teams to facilitate this with more effective communication **[EnC]**, as it gave them a stronger understanding of services available in the community **[EnC]**. Covid-19 has presented challenges in this respect, as it has impacted community relationships in all directions (between services, between service users, and between users and providers) **[DisC]**. The damaging impact of Covid-19 on smaller charities and local programmes means that some of the services that were previously offered no longer exist.

> *"I think another big one is that just there are services that just don't exist now [after Covid-19]. I cleared up the cupboard at the hub and went through all our old leaflets and was just like this doesn't exist. This doesn't exist. This doesn't exist." Service provider specialising in community based care in the voluntary sector*

Interviewees identified broad benefits gained through community engagement and participation, in helping women to see the bigger picture of what is available to them and the support systems that are in place, including more avenues of holistic support for wellbeing **[O]**. Service providers reflected on community care having enabled a

broader definition of health and well-being, to include things like local parks, community centres and social spaces that were utilised to support care and treatment plans **[EnC]**. Service providers reflected that this was also felt to ease some of the pressure on individual case workers **[O]**, through the awareness of other avenues of support and other individuals who are also working to help them **[EnC]**.

> *"A huge part of what we want to do at the hubs is have a place where, [women can] see that there's a whole team, there's other women accessing services. It takes the pressure off the relationship with the [case worker] a little bit because they realise that it's part of something much bigger rather than just one person that calls you when you're at home" – Service provider specialising in women's trauma in the voluntary sector*

There were challenges in the disparities in service availability between different boroughs and the impact on women of moving between boroughs while trying to build a feeling of community **[DisC]**. For example, housing shortages meant some service users needed to move to a new area which they may not feel comfortable or safe in.

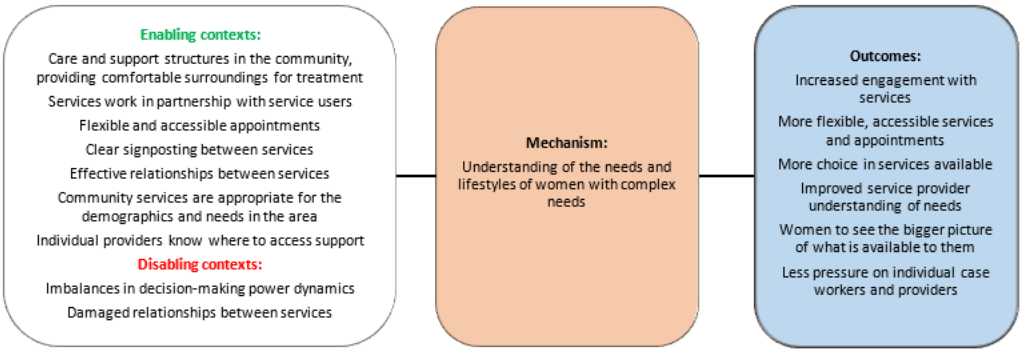
> *"They're going to send me somewhere where I know it's not really gonna benefit me. It's gonna help me get down, instead of helping me get up." – 'Lizzie', service user*

Linking with community-based resources was felt to be a priority for statutory service providers, but the timing of referrals was often a barrier to achieving it, as commonly by the time an individual fits within service eligibility criteria they are in crisis and the level of support may be insufficient **[DisC]**.

> *"Your role as a social worker is to try and keep someone out of hospital and try and link them in with community resources. But by the time that they get referred to us … I'd say 95, 90% [need to be] detained." – Service provider specialising in adult social care in the statutory sector*

The complete CMOC for Hypothesis 3 is shown in Figure 24.

Figure 24: CMOC for Hypothesis 3



Hypothesis 4: Flexible, needs-based assessments and eligibility criteria **[EnC]** which are designed to facilitate engagement with complex needs **[M]** can enable rapid, appropriate, tailored and integrated support **[O]**.

As we saw in 7.6 when considering issues in accessing services, women with multiple needs can struggle to find comprehensive treatment appropriate to their requirements **[DisC]**. As part of the ITAV approach, practical needs such as housing should be addressed in addition to mental health support, which is necessary if health and criminal justice outcomes are to improve **[EnC]**. This is particularly relevant when women have co-morbidities such as physical health concerns, or other characteristics that may result in more specific requirements or parallel treatment of co-morbidity which the system should enable **[EnC]**.

> *"Anyone can contact them with any issue and they will try to do their best to help to manage all those kind of really practical needs. Which is good as well, because it means that people get that kind of more creative approach and it's a lot more flexible to deal with the issues that are a priority to the woman instead of the service" – Service provider specialising in adult social care in the statutory sector*

It was felt by ITAV designers and service providers that flexibility in assessment of needs without focusing on diagnosis or the identification of a primary need would help to identify and prioritise treatment requirements **[EnC]**. ITAV advocated for assessment being driven by self-declared needs through listening to women's concerns **[EnC]**, with the assessment lead working with the person or case worker who knows the client best to help to articulate what their needs are from a service provider perspective **[EnC]**, which can also help women feel that they are being listened to and have influence over their own care, building trust in services **[O]**.

Although service providers agreed with this approach in principle, there wasn't evidence raised through the evaluation that changes to formal assessment in statutory services was happening in practice. Despite this barrier, the ITAV approach in engaging with women in this way was recognised by service users as being an improvement to how their needs were considered.

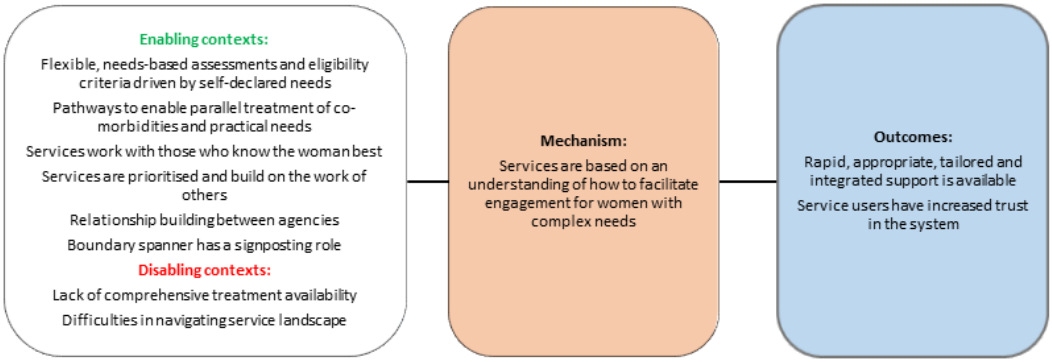
> *"[ITAV's clinician] probably was a bit more open to listening to us, a bit more. Takes us a bit more seriously … it helps me talk about what I need, and what I haven't had so far … she then spoke to [mental health service] for me and got an appointment" – 'Nadia', service user*

As service demand is much greater than supply, treatment should be prioritised and capitalise on the work that others are doing **[EnC]**. For example, statutory services could work more closely with partners in the voluntary sector to help fill the gaps until the system is better equipped to support greater service provision **[EnC]**. ITAV facilitated this through building relationships between organisations across the statutory and voluntary sectors **[EnC]**, and through undertaking a signposting role **[EnC]**.

> *"We need to be more aware of the voluntary sector and what they offer and all these many agencies that are on those calls 'cause we again I think yeah we don't have any resource or time in the statutory agencies and they [could help with that]. It's good to feel more confident about the voluntary sector and have better links there" - Service provider specialising in adult social care in the statutory sector*

The complete CMOC for Hypothesis 4 is shown in Figure 25.

Figure 25: CMOC for Hypothesis 4



Hypothesis 5: Services may be more willing to try new approaches **[O]**, by increasing their understanding of women with multiple disadvantage **[M]** through building partnerships and sharing experience **[EnC]**.

We saw in 7.6.3 that services can be rigid in their processes and approaches and attempt to fit all service users into the same pathways, despite differences in the types and severity of needs **[DisC]**. This was felt by service providers to be exacerbated by limited time to spend on developing more creative approaches to case management **[DisC]**. ITAV aimed to increase service providers' understanding of some of the alternative approaches that can be taken to support women with multiple needs in a way that they can rapidly apply **[O]**. A way in which ITAV achieved this was through facilitating the development of relationships and partnerships between services **[EnC]**, so that there was greater understanding of the options available.

> *"I think what was great about having people from different sectors in the room was that, I guess if you know one service is kind of running with a case like, say mental health, I guess you're kind of blinkered a little bit by what's available and what you know, whereas that discussion it did enable. People to think beyond what we would normally put in place, so that was really helpful." – Service provider specialising in mental health in the statutory sector*

A better understanding of the available approaches and services gave individual service providers the confidence to try new and different ways of supporting women with complex needs **[O]**. For example, understanding why women respond to professionals in a certain way, and where blockages in relationships can occur on both sides **[M]**, encouraged service providers to change their own responses and build tolerance and patience **[O]**.

"I did learn some things that I previously wouldn't have known about being from a social work background. [The training] came more from a psychology sort of background, talking about the limbic parts of the brain and explaining why people with complex needs can respond in the way they do with fight or flight … it was, I suppose, giving us a greater awareness and understanding of women" – Service provider specialising in adult social care in the statutory sector

It was felt by service providers that to do this effectively on an ongoing basis would require them to feel comfortable challenging each other about how best to support different individuals **[EnC]**, being open to hearing different views and learning from other agencies and specialisms **[EnC],** including dealing with barriers related to intersectional issues such as class, disability, race, sexuality and gender.

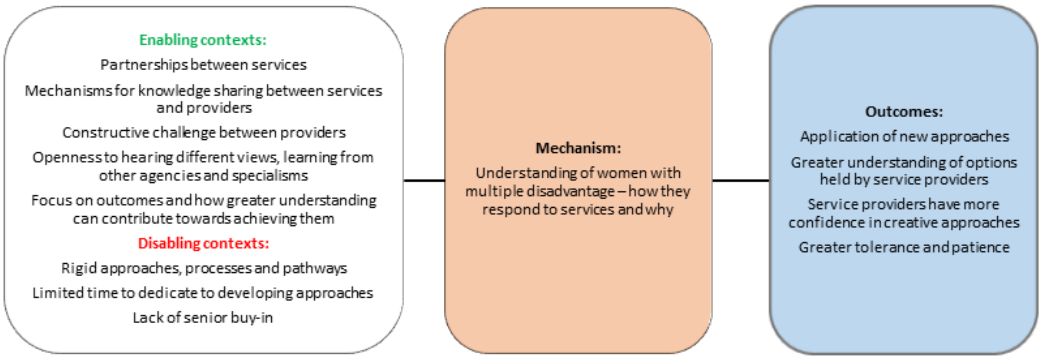
"I challenged [a senior stakeholder] in the next meeting. Kind of said I'm just highlighting something I've observed you do which is based on an unfair perception of the client … I will challenge every day. But others might not feel comfortable." – Service provider specialising in mental health in the statutory sector

Making these changes required support through service providers (both on-the-ground and management) being confident in challenging system norms for pathways to work with clients in a different way, recognising that there will never be a one-size-fits-all approach and applying a creative and logical approach based on understanding and outcomes **[EnC]**. Although many service providers interviewed felt they could raise these issues, almost all believed there to be a lack of more senior support for changes to services, which would be a barrier to implementation **[DisC]**.

"It needs them at the top with me at the bottom frontline kind of saying hello. You up there? This is what's happening. You need to change what you're doing because it's not working." Service provider specialising in complex needs in the statutory sector

The complete CMOC for Hypothesis 5 is shown in Figure 26.

Figure 26: CMOC for Hypothesis 5



Essential Principle 2: Service users need to feel heard and supported by services [M] to build trust in the system and foster engagement [O]

Through the analysis, five hypotheses together formed Essential Principle 2.

Hypothesis 6: A trauma-informed approach should be implemented **[EnC]** to build self-belief and trust in services **[M]** to increase engagement from service users **[O]**.

As introduced in 7.5, the individuals in the study had almost always experienced trauma over several years, but services were not designed with this in mind **[DisC]**. ITAV incorporated trauma-informed approaches through training for service providers, provision of individual clinical support and the inclusion of a principle of reasonable adjustment for women who have experienced trauma **[EnC]**.

> *"Our speciality is being trauma informed, specifically for women in the criminal justice system, understanding their needs that are very different to men. [it involves a lot more] working with mental health addiction, and domestic violence, past and present." – Service provider specialising in women's trauma in the voluntary sector*

A trauma-informed approach to service use **[EnC]** was felt by service providers to have enabled recovery and build women's confidence to access support **[O]**. This was felt to help to increase the accessibility of services and appointments **[O]**, and was achieved by ITAV through providing spaces for appointments that feel less daunting (e.g. community hubs) **[EnC]**, advocating for services to have multiple channels for engagement (such as phone options as well as in-person appointments, which can also help where stigmatisation could be a barrier to engagement) **[EnC]**, directly supporting users with tasks such as completing forms **[EnC]**, holding drop-in sessions in community spaces rather that strictly scheduled service delivery **[EnC]**,

and offering broader wellbeing activities such as classes and other safe spaces for women to spend time and build relationships **[EnC]**.

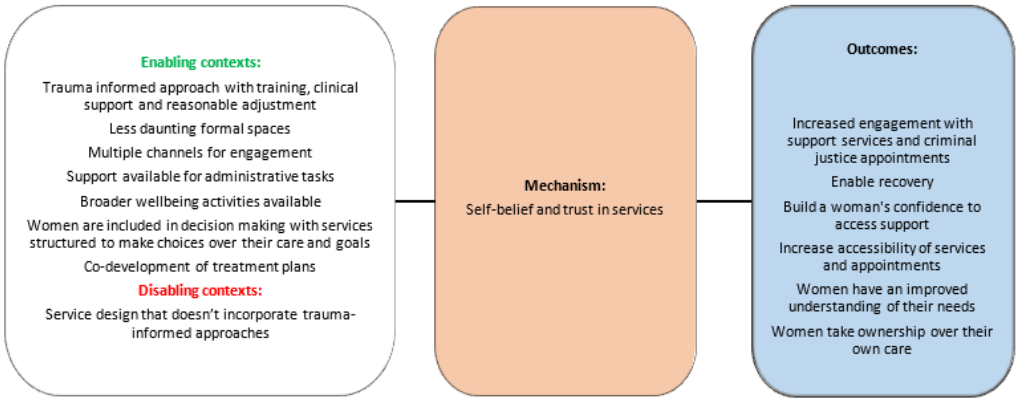
> *"We [now] do drop-ins, and that's where we do a lot of our workshops and a lot of our courses. And there is quite a large community there of women that don't have an advocate, but they just come to the hub to either do courses or just to do like be at the coffee mornings or just to just be around." – Service provider specialising in community based care in the voluntary sector*

ITAV have advocated for including women in decisions **[EnC]** as a way of empowering them to build their own understanding of their needs **[O]** and take more ownership over their care **[O]**, moving the balance of decision-making power towards the women seeking support as they feel better equipped to make an assessment and advocate for their preferred pathway **[O]**. To facilitate this change, ITAV structures their engagement with women such that they can make their own choices about what their goals are **[EnC]** and a plan to meet them is co-developed **[EnC]**.

> *"It's not a professional coming in… I know what your issues are. I'm going to sort everything out for you. I'm going to tell you what your goals are" - Service provider specialising in women's trauma in the voluntary sector*

The complete CMOC for Hypothesis 6 is shown in Figure 27.

Figure 27: CMOC for Hypothesis 6



Hypothesis 7: Women with complex needs require tailored long-term support **[EnC]** to give them confidence in the system and service providers **[M]** and encourage ongoing engagement **[O]**.

We saw in Chapter 5 that women with complex needs often require long-term support. Continued access to care when needed is offered by ITAV **[EnC]** to give services users confidence in their service provider and the health and support system more broadly **[M]**. Therapeutic work takes time, but often treatment programmes are time-limited and support can 'drop off' (either partially or completely) once a programme is complete **[DisC]**. There can also be restrictions around using an intervention more than once **[DisC]**, particularly when an individual has been discharged due to lack of engagement **[DisC]**. To better support this group, ITAV advocates that services offer people more than one chance at an intervention and the duration should be tailored to their needs **[EnC]**. Throughout the evaluation, this was evidenced as an offering of several voluntary services and by the clinical lead within the ITAV intervention, however a change in this approach was not evidenced in statutory services.

> *"A lifelong of complex trauma is not gonna be undone by 12 weeks of person centred therapy." – Service provider specialising in women's trauma in the voluntary sector*

The availability of ongoing support should be clearly communicated to women **[EnC]**, as even where these positive changes to service duration has happened, it was disconcerting and overwhelming to think that there is only limited time to access support, which can damage engagement and cause unnecessary stress to the service user **[DisC]**.

> *"I'm meant to have been here two years. I've been here four years and every time I say that it's like. That's so silly. Why would we move you out then? That'd be crazy. Well, if I'd known, I would have structured my whole life differently." – 'Nadia', service user*

As well as the flexibility to tailor the duration of treatment, service providers felt that the intensity of support provision should be flexible enough to effectively support women with complex needs **[EnC]**. Where waiting lists for formal treatment services make this challenging, ITAV facilitated the engagement of other services that run activities to support wellbeing (e.g. art clubs, walking groups), or even simply incorporated further opportunities for discussion and engagement **[EnC]** which service providers reflected as a positive mechanism for making the most of time and encouraging continued engagement **[O]**.

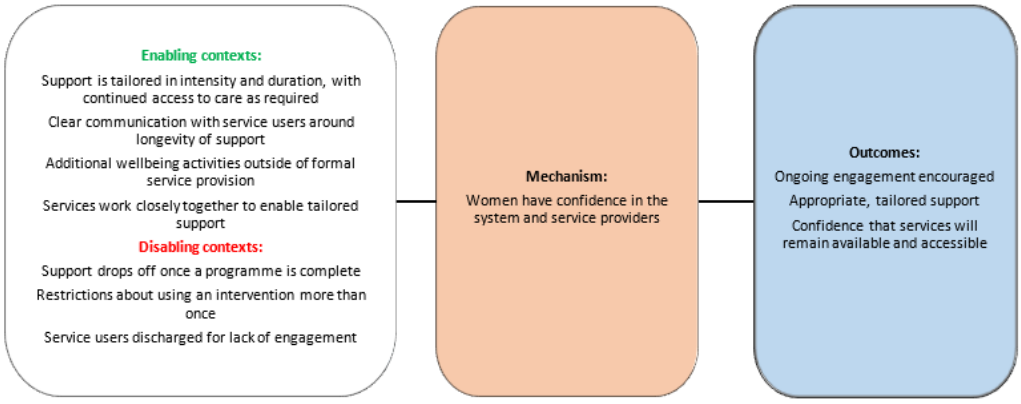
"We may be fighting for someone to respond, but again it's just supporting the person, even if it does get to that point. It's just trying to be a listening voice for them while we're trying to wait for these processes to do better and improve. 'cause it's that feeling of support, availability and consistency" – Service provider specialising in women's trauma in the voluntary sector

In the absence of systemic change to facilitate varying duration and intensity of support, ITAV aimed to achieve this by facilitating services working more closely to build a holistic understanding of the needs of the individual seeking to access them **[EnC]**. The service providers reflected on the fact that women with complex needs were often already known to other local services through previous contacts, so they were able to increase their understanding of individuals by sharing this knowledge and experience with each other **[EnC]**, enabling a more holistic approach to service provision and giving service users confidence that services will remain available and accessible **[O]**.

"The team I worked in was based in the voluntary sector, but included social workers, psychiatrists, psychologists, housing workers, nurses, drug and alcohol workers, so everybody was together and people would kind of move in and out of working directly with somebody, depending on what the needs were, but everybody kind of had a basic kind of understanding" – Service provider specialised in complex needs in the voluntary sector

The complete CMOC for Hypothesis 7 is shown in Figure 28.

Figure 28: CMOC for Hypothesis 7



Hypothesis 8: If women have a trusting relationship with their service providers and feel cared for [M], they are more likely to engage with services and access appropriate treatment [O].

ITAV has a principle of developing relationships based on trust and understanding [M], which ITAV built through aligning care to self-declared needs [EnC] to help women feel heard and supported [O]. Although some service users shared that they felt more 'heard' by the ITAV intervention staff, a barrier to more positive engagement presented when women did not feel like their case workers are there because they want to help [DisC], or when they are not seeing much immediate progress in gaining access to services and are sceptical about their competency [DisC].

> *"Nobody wants to listen. Right, especially if there's a bunch of medical professionals and I'm like, I could do your job. Nobody wants to hear I could do your job." – 'Nadia', service user*

Service providers shared that when an individual has felt understood by the people they are working with [M], they have been more willing to open up about their own needs and goals, which in turn has helped to facilitate appropriate assessment and associated service provision [O]. Service providers shared experiences of successes where they have been able to structure contact around existing positive relationships between case workers and clients [EnC], to preserve this relationship whilst providing multi-agency team support behind it [EnC] that ITAV was able to facilitate.

> *"If somebody was perhaps really anxious about working with men or anxious about working with people from different cultural backgrounds, you kind of gradually you started off with the people they might trust. And then you gradually sort of involve other people" – Service provider specialising in complex needs in the statutory sector*

Service providers found that as new relationships developed, it gave the service provider more confidence in managing the case [O], which created a cycle of improved support based on trust and understanding [O].

> *"Getting the take of various different professionals like how it would fit into their different services. It just feels like a really, really positive and supportive way to help people … while learning more*

about how to support our clients." – Service provider specialising in mental health in the statutory sector

Women with complex needs have often had negative experiences with services in the past **[DisC]**, and service providers commented that there is a risk that they may have their agency taken away from them if there is a situation that requires enforcement, either through enforced hospital admission or in relation to the criminal justice system **[DisC]** which can undo the efforts of ITAV and services to build trust in the support system.

"We kind of made the decision that she needed to go into hospital, but she refused point blank and eventually the police had to go up and get handcuffs. She wasn't handcuffed in the end, but might as well have been. So there is a risk about bringing someone into hospital as well because you really are taking away all of their agency" – Service provider specialising in adult social care in the statutory sector

This creates a challenging dynamic. Having people with lived experience inform service provision and be relatable role-models for service users was cited as an example of improving this broader trust, as service users can see the positive impact that services have had on a relatable individual **[EnC]**.

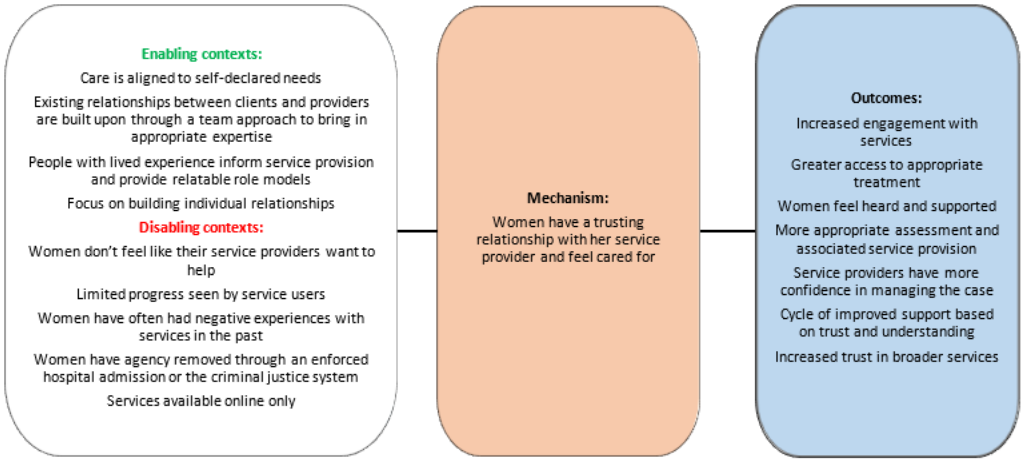
"We have lived experience [representatives] and we have peer advisors in all our services who are relatable and understanding in a way that sometimes traditional professionals are not. It enables people to access services in a completely different way" – Service provider specialising in mental health in the voluntary sector

A focus on building individual relationships **[EnC]** was also found to allow trust in broader services to develop **[O]**, but building trusting relationships with faceless services was thought to be impossible and this was made more challenging through the Covid-19 pandemic as many services moved online **[DisC]**.

"They've kind of become sort of faceless organisations and that is really anxiety inducing" – Service provider specialising in women's trauma in the voluntary sector

The complete CMOC for Hypothesis 8 is shown in Figure 29.

Figure 29: CMOC for Hypothesis 8



Hypothesis 9: Women can be empowered to build an understanding of their own needs and take ownership over their care **[M],** which can support more appropriate assessment of needs **[O]**.

As discussed above, including women in decisions around their own care **[EnC]** was found to support the development of trust as they feel heard and understood **[M]**, moving decision-making power towards the service user and *"giving her back her voice"* **[O]**, which can be particularly important for women who have experienced trauma and for women who are used to being told what is wrong with them, rather than being asked **[DisC]**.

> *"We absolutely [co-develop goals and plans with service users] always 'cause the big thing with trauma is people lose their voice. So they have to find their voice." Service provider specialising in trauma in the voluntary sector*

Building agency was found to be further supported by helping women to make decisions and do things for themselves rather than doing things for them **[EnC]**. Enabling women to practice and develop skills in a safe setting **[EnC]** was observed to build their confidence in their ability to care for themselves **[M],** increasing their personal agency **[O]**.

> *"Even if it's how they want their tea when they come in the hub where they wanna set which one, give as much choice as possible to get him used thinking for themselves about their needs and*

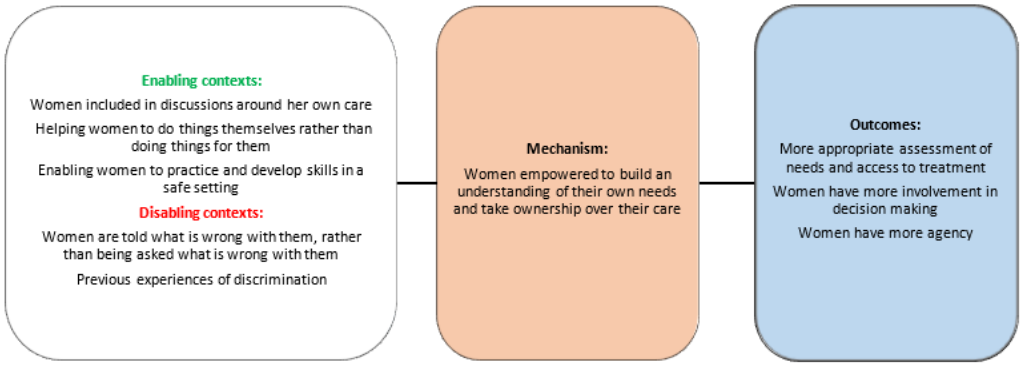
what they want" - Service provider specialising in trauma in the voluntary sector

We saw earlier that women may have experienced discrimination from services on the basis of their sex, race, class or physical disability, making them untrusting that the providers who are there to support them will take their concerns seriously **[DisC]**. Service providers felt this was particularly relevant when considering intersectionality; for example, where a Black woman's agency is removed through enforcement, as it can often be white people in senior clinical roles who are responsible for decision making around incarceration or hospital admissions.

"It was this elderly Black lady and we landed in on top of her just finishing her breakfast at half nine in the morning in her living room. Every single person from the psychiatrists, the police and myself were all white. Incredibly white. What she was saying was that she was refusing to take medications because they made her groggy and sometimes like these, some of these medications are awful and you can totally understand. But anyway, the decision was made to take her to hospital involuntarily." – Service provider specialising in social care in the statutory sector

The complete CMOC for Hypothesis 9 is shown in Figure 30.

Figure 30: CMOC for Hypothesis 9



Hypothesis 10: The development and maintenance of personal relationships **[EnC]** can increase a woman's belief that she is worthy of support **[M]**, increasing likelihood of service and appointment engagement **[O]**.

ITAV facilitated the development and maintenance of relationships by providing services and holding appointments in community spaces **[EnC]** where women seeking support can meet others in similar or relatable positions **[EnC]**. These connections were observed to result in role models, social skill development and increased self-confidence **[O]**.

> *"They see other women who have had similar experiences to them. See how well they are doing now. And it can really help to encourage them and realise that things can get better for them" – Service provider specialising in community based care in the voluntary sector*

On the advice of ITAV, some services (in the voluntary sector) worked with families of users rather than limiting their support to the service user directly **[EnC]**, which was seen to have benefits at multiple stages of service provision and result in increased trust in services **[O]**. In assessment, families were be listened to, to understand the breadth and depth of needs that a woman may have **[EnC]**, which those services found to be valuable in designing appropriate treatment and support, as family members were often the people who know their clients best. They also found that ongoing engagement was encouraged through families **[O]**, as it supported trust-building when a service user's family member encouraged participation **[EnC]**.

> *"It really helped with relationship building. I think for the people who are working with and help them to understand and trust more people." – Service provider specialising in trauma in the statutory sector*

However, this was felt to be nuanced, as some service providers reflected that If engagement with family isn't dealt with sensitively, it could be alienating and feel threatening to the service user. At worst, it could be perceived to be collusion or manipulation between the service and family member, particularly where there is a risk of enforced detainment through the criminal justice system or hospitalisation **[DisC]**.

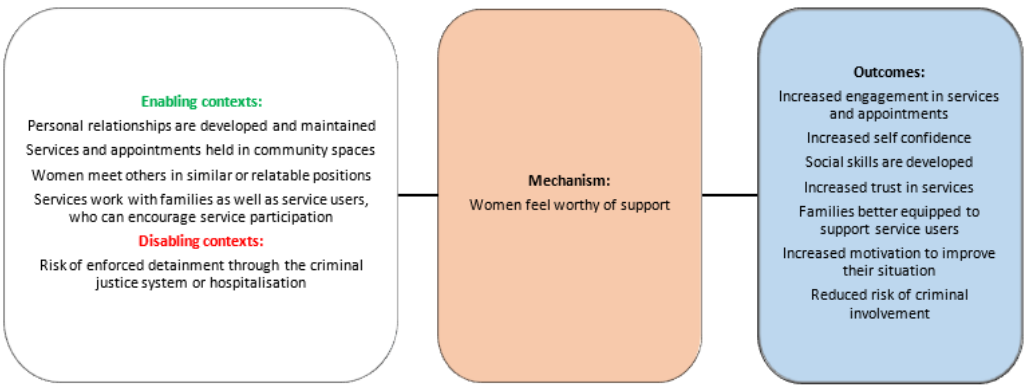
> *"And also her son had let us in so her son was kind of colluding with us. I don't know, in the long run, like what? What kind of damage are you doing?" – Service provider specialising in trauma in the statutory sector*

In some instances, services also provided direct support to family networks [EnC]. Increasing the support available to families was found to build their capability and capacity to further support the individual [O], with the added benefit of further improving familial relationships [O]. Although this wasn't directly evidenced in this study, service providers felt this could increase service user motivation to improve their situation, which could result in behaviour change and reduced risk of criminal involvement [O].

> *"We look at the support network and I think particularly if there are family members who are serious and really want to help, then we try to build a relationship with them. It's twofold relief. For the sake of the client we're dealing with it really does help a lot, particularly with communication if they are prepared to help communicate and especially if the client is open to that. But also there has sometimes been a recognition that we do need to support the family member as well and that's been a really helpful thing to be able to do so" – Service provider specialising in housing in the voluntary sector*

The complete CMOC for Hypothesis 10 is shown in Figure 31.

Figure 31: CMOC for Hypothesis 10



Essential Principle 3: Appropriate service delivery for women with complex needs [O] relies on flexible and effective cross-agency collaboration [M]

Through the analysis, five hypotheses were identified and together formed Essential Principle 3.

Hypothesis 11: The dismantling of imbalanced decision-making power structures between and within services **[EnC]** can build a joint understanding of how to reduce structural barriers to the provision of multi-agency support **[M]** and enable more flexible treatment delivery **[O]**.

We saw in 7.6 that there can be mutual frustration between services and that as a result they become disjointed and siloed **[DisC]**. All service providers interviewed felt that ITAV had improved relationships between services **[O]** by increasing engagement and knowledge sharing between agencies **[EnC]**, and through the creation of specific forums for providers to share their expertise with each other **[EnC]** and enable a multi-agency approach to case management **[M]**.

> *"They perhaps haven't got the skills or the knowledge of how to work in a different way with some of these people, or apply some of the approaches. So the 'It takes a village' work is helping to facilitate that and increase people's knowledge" – Service provider specialising in mental health in the statutory sector*

Hierarchies between services (particularly between voluntary and statutory organisations) were seen to be a barrier that needed to be addressed to increase the diversity of expertise, experience and views around a table when discussing individual cases and designing systems **[EnC]**, in a way in which everyone's opinion is shared and valued **[EnC]**. Although many service providers felt that their expertise was valued in the multi-disciplinary forums that ITAV created, some felt there was a remaining legacy of imbalance, particularly in relation to differences between voluntary and statutory sector organisations.

> *"The statutory services are so big and perhaps so corporate and powerful, the voluntary sector workers get a bit overlooked I suppose" – Service provider specialising in complex needs in the voluntary sector*

ITAV's focus on inclusion through bringing different agencies into discussions, including local community and faith-based organisations **[EnC]** was seen to support this dismantling of hierarchies **[M]** however, through bringing in organisations that may be less resourced but have a greater understanding of the local community and its residents **[O]**. Building positive relationships through ITAV interactions was observed to have made it easier to have more open and constructive discussions

around systems change, as individuals felt more comfortable sharing where things aren't going well and the issues that they are identifying **[EnC]**, though some still felt there was a lack of openness to learn from others who have different expertise and experience **[EnC]**.

> *"If there are particular learnings for particular teams, we're gonna out it. Not because we're trying to shame the system. It's actually trying to help the system to learn that actually that's not a good way of doing it. And if we work together we can improve it, so that's where the space of learning is, and if everyone was willing to be transparent to allow that to happen, then you know we probably would be sitting having some of these conversations." Service provider specialising in community-based care in the statutory sector*

The participation of senior stakeholders (including senior clinical staff) in forums such as complex case panels was felt by service providers to be a powerful mechanism to achieve senior buy-in **[EnC]** – which is required to achieve systemic change **[EnC]** – as hearing about the problems seen by people working on the ground was sometimes felt to be eye-opening. The self-selection bias in participation which is inherent in this type of intervention meant that those who engaged most fully, were often those who were already aware of the issues in service access for women with complex needs, so the involvement – or lack of – in different stakeholder groups at varying levels of authority **[EnC]** was seen as a critical indicator of whether improvements in services would be implemented **[O]**.

> *"I wonder if it's like one of those things where like the people who fill in surveys are helpful people who want to do it. So like, it's a very biased result, like the people involved in It Takes A Village are the people who want to see change." – Service provider specialising in complex needs in the voluntary sector*

It was felt that, for ITAV to achieve its objectives of concrete change, senior stakeholders needed to be open to learning rather than working on the assumption that they know best, and to share their learning with their peers **[EnC]**, which study participants felt wasn't happening consistently. This was disabling for professionals where they did not have senior support, and therefore felt powerless due to specific service boundaries that they were not personally able to change **[DisC]**.

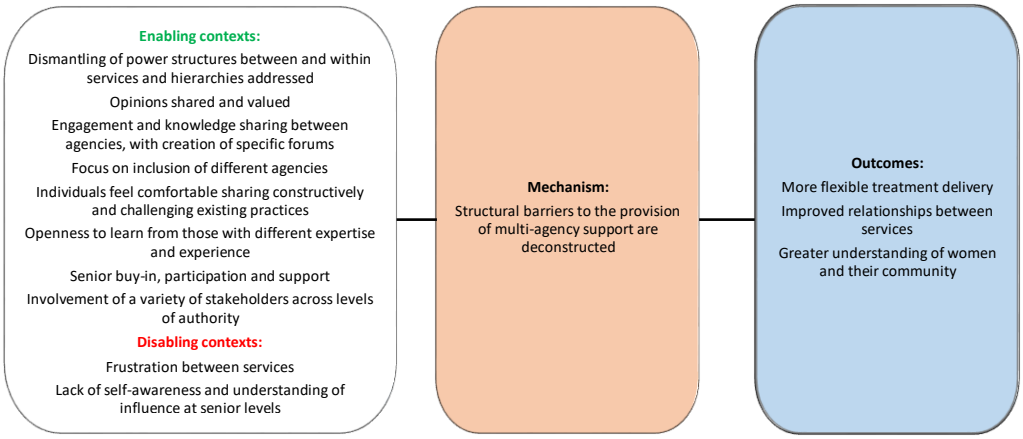
"No matter how logical or rational we're being, if they put a boundary in place, we can't do anything about that, and actually that goes higher up the level then in terms of who's making those decisions." – Service provider specialising in complex needs in the voluntary sector

Another barrier was a perceived lack of awareness by senior stakeholders of the influence that they have to create an inclusive environment where issues can be escalated in an open and transparent way to challenge existing practices **[DisC]**. Similarly, some service providers felt that this need for self-awareness also applied to considering how senior stakeholders talk about clients, as negative perceptions were sometimes perpetuated through the influence held by certain individuals **[DisC]**.

"I challenged the GPs and say some of you might need to be really careful on how you word things on consultations, because to the rest of the world, as a white GP he's actually quite influential" – Service provider in the statutory sector, describing her response to culturally insensitive notes in a consultation record that could have influenced a client's treatment

The complete CMOC for Hypothesis 11 is shown in Figure 32.

Figure 32: CMOC for Hypothesis 11



Hypothesis 12: Appropriate long-term funding, policies, processes and systems **[EnC]** are required to enable flexible multi-agency service provision **[M]** and facilitate support for women with complex needs that focuses on needs rather than rigidly defined pathways **[O]**.

In 7.6 we saw some of the challenges in service provision that stem from strict assessment and eligibility criteria, with a focus on primary need to define treatment pathways **[DisC]**. ITAV supported an increase in flexibility through guidelines that services should engage with each other – including those who have the best knowledge and understanding of the woman in question – before rejecting an application for access to support or discharging an individual from their programme, which was observed to happen during this evaluation **[EnC]**.

> *"Some services are under so much pressure to discharge people who aren't seeming to make insufficient beneficial use of services so are let go, but ITAV would push people to pause before doing that. Because it's a very long term game, isn't it?" – Service provider specialising in drug and alcohol misuse in the voluntary sector*

A 'no wrong door' approach with a focus on self-declared needs **[EnC]** allowed for more effective early engagement and an increase to the accessibility and continuity of treatment perceived by service providers **[O]**. More appropriate subject matter expertise and specialisms were brought into client pathways due to an increase in flexible policies underpinned by processes for joint working between services **[EnC]**, which allowed service providers to share the workload and burden of the complexity and prevent women being discharged from services prematurely **[O]**.

> *"[The complex case panels] have been a bit of a relief because I feel like the sort of people that are discussed on them are people who don't often, who aren't often getting the help that they need. And there's just something really nice to be, like, ah, here's a group of professionals spending an hour considering this person's life and like, looking at them holistically as a person." – Service provider specialising in mental health in the statutory sector*

ITAV aims to achieve systemic change to enable broader improvements in the flexibility of policies for early discharge of clients **[O]**. During the evaluation, this was seen to happen through ITAV representatives increasing service providers' understanding of reasonable expectations around engagement with women with complex needs, and the need to tailor the duration and intensity of support based on an individual's requirements, as described earlier **[EnC]**.

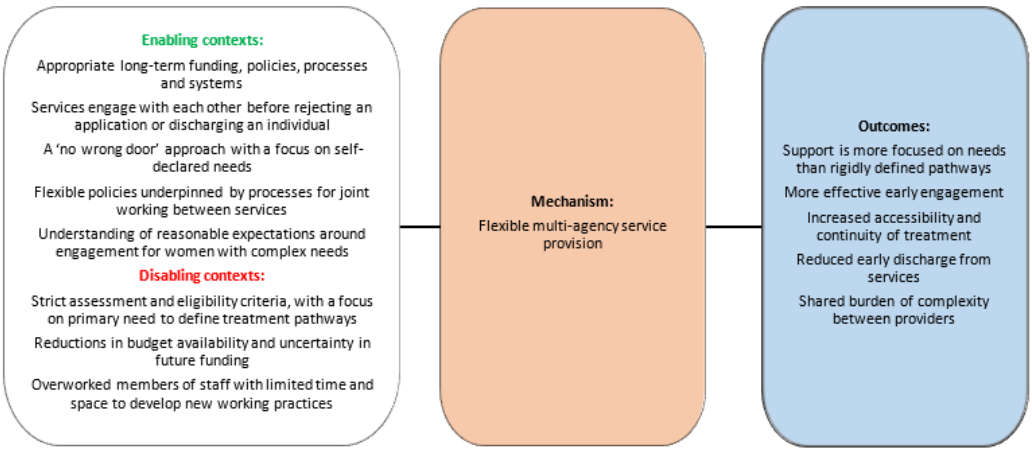
"It's absolutely the ability, the freedom and the confidence of people running services to challenge those norms and to say I need to work with an individual in an individual way. Because certainly when you get into in a complex multiple disadvantage everybody has so many things happening at any time. That there is never going to be a one-size-fits-all approach" – Service provider specialising in social care in the statutory sector

Funding and stability remained significant issues for services, as they were often aiming to reduce spend **[DisC]** and members of staff were already overworked **[DisC]**. This made it difficult for them to find the time to engage in forums, participate in training, or to find the mental space to develop new, more creative working practices **[DisC]**. The uncertainty in future funding across services **[DisC]**, particularly for voluntary sector programmes, creates a barrier for long-term planning and partnership development in line with ITAV recommendations, as well as having a negative impact on staff morale and motivation when the sustainability of jobs is uncertain.

"We're very aware that we can only run while we're funded to run. And so we're bidding at the moment for our contract to be renewed. And if it's not, then there will be a change in the continuity of our service… it's hard to have a really a really long term vision because you don't actually know where we're going to be" – Service provider specialising in community based care in the voluntary sector

The complete CMOC for Hypothesis 12 is shown in Figure 33.

Figure 33: CMOC for Hypothesis 12



Hypothesis 13: Services each have a unique view to bring to the table based upon their specialism, which can be brought together through a multi-agency approach **[M]** to enable more tailored service provision **[O]**.

ITAV is built on a principle that services each have a unique and valuable view and that they can learn from each other to build a more integrated and client-centred approach to service delivery **[EnC]**, whilst incorporating a variety of specialisms and experiences and appreciating the opportunities to learn from each other **[EnC]**. Interviewees gave examples of some professionals being closed off to learning from others and perceiving themselves to have more expertise than others **[DisC]**.

> *"There was a really good Women's Health meeting and there was one man there who done all this research and the best you could take from that is that he thinks 'oh I'm gonna educate all these people on this work that that I've done' like, as if he had nothing to learn himself from the room full of women he was teaching about their own bodies" – Service provider specialising in community based care in the statutory sector*

ITAV brought together a greater variety of expertise **[EnC]** to enable more tailored service provision **[O]** as teams were able to take a holistic approach to understanding client needs and identify more effective pathways for individual cases **[O]**, supporting each other to make transitions between service providers happen more smoothly **[EnC]**. To do that required wide-ranging participation in multi-agency forums, where representatives could build an understanding of what other services were offering and the expertise that individuals could therefore bring to a case **[EnC]**.

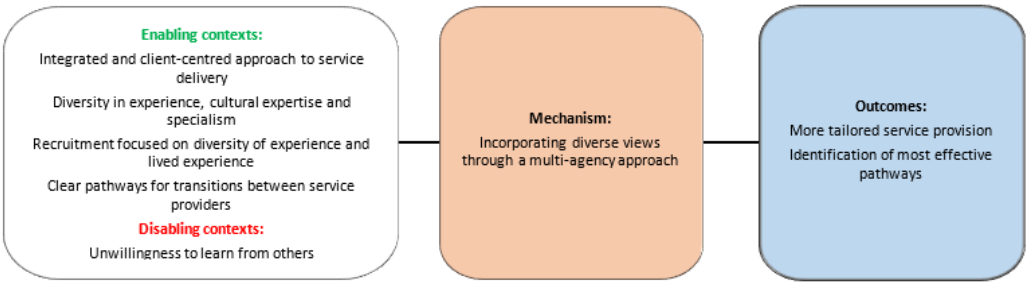
"So we got to really understand other people's jobs and roles and then you can make the team work and try to understand where they're coming from and what their 20 years of work experience would have done to them." – Service provider specialising in trauma in the voluntary sector

Diversity in experience, cultural expertise and specialism **[EnC]** was felt to have allowed for more creativity in service provision, as a diversity of views was enabled to come together to problem-solve in individual cases **[M]**. Some providers described building a sense of need to recruit for different types of expertise to achieve this diversity, particularly with respect to lived experience **[EnC]**.

"You know, one of the things I would [now] say we should recruit for more is lived experience. Why don't we do that more like we do with equality and diversity? Actually encourage people who've got relevant lived experience to apply for jobs." – Service provider specialised in complex needs in the statutory sector

The complete CMOC for Hypothesis 13 is shown in Figure 34.

Figure 34: CMOC for Hypothesis 13



Hypothesis 14: Effective relationships between services **[EnC]** increases empathy, trust and understanding of each service's priorities and objectives, enabling more productive multi-agency working **[M]** to provide more integrated service provision **[O]**.

Improving relationships between services was felt to provide benefits to service users directly by enabling integrated support **[O]**, and indirectly by increasing the confidence of service providers in helping users with complex needs **[O]**. ITAV did this by facilitating discussions at senior stakeholder level to build understanding of each service's strategic objectives and priorities **[EnC],** and at delivery stakeholder level to facilitate case management, application and delivery **[EnC]**. There was more

evidence of this being achieved at delivery stakeholder level, which was enabled through stronger relationships between service representatives, creating a multi-agency approach where knowledge and experience was shared between teams **[O]**.

> *"When [working between services] really doesn't work is when it's just a fight, or it's very 1 sided… regular communication and valuing each person's perspective and specialism… idealistically in a world where everybody like values and sees the importance of each other and regularly communicates, that is the best way" – Service provider specialising in improving criminal justice outcomes for women in the voluntary sector*

Developing understanding between stakeholders increased empathy between services by building an appreciation of the challenges each service is facing and the reasons that they are sometimes unable to support requests from other professionals **[EnC]**, although the evidence of this having happened was only referenced by a small number of service providers. A perceived advantage of building an understanding of each service's priorities and objectives **[EnC]** was that could reduce the number of requests falling outside the scope or infeasible for a service to deliver **[M]**, saving time and reducing frustration from services being misaligned with the expectations of others **[O]**. However, the size of statutory services is a barrier to being able to do this consistently **[DisC]**, without this being implemented in a systematised way.

> *"Interagency working in my experience is some of the hardest parts of the work, because often we aren't necessarily fully understanding of the agenda of each individual, each individual agency, and the priorities that they're working toward. So we need to get to know the services if we want this to work" – Service provider specialising in drug and alcohol misuse in the statutory sector*

Where strong relationships existed between services, this helped individual service providers feel less alone by fostering a feeling of shared responsibility **[EnC]**. Feeling sole responsibility for a complex case can be stressful and overwhelming **[DisC]**, so adopting a multi-agency team approach can help to ease this pressure **[EnC]**, particularly when these relationships are based on a willingness to help and support each other without a focus on gatekeeping **[EnC]**.

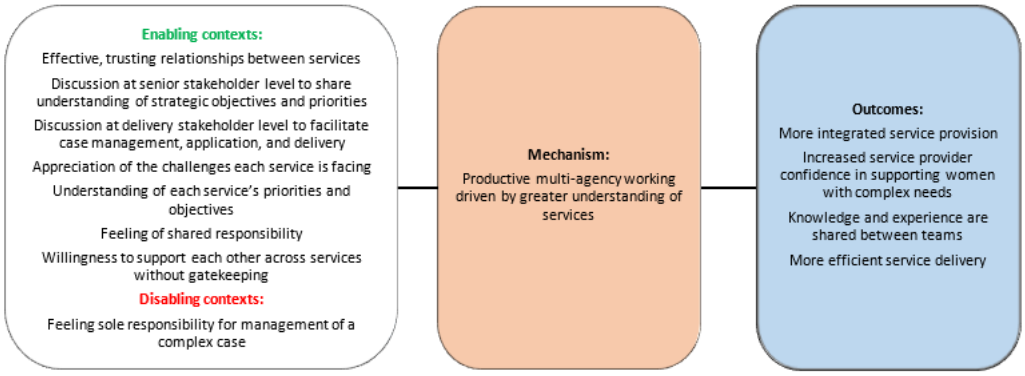
"It also just helps people feel like they're not on their own with it. You know, they don't have to solve it themselves." – Service provider specialising in complex needs in the voluntary sector

Improved and trusting relationships between service providers **[EnC]** enabled constructive conversations around sensitive issues, such as those related to discrimination or barriers that affect specific populations. Having a trusting relationship was also felt to help in deconstructing hierarchies between colleagues **[EnC]** and build the confidence of individual providers to discuss issues while feeling comfortable sharing their knowledge and experience **[EnC]**.

"I like to say that I challenge with compassion. It doesn't come from a place of anger. It doesn't come from a place of trying to humiliate everyone. But being from the Black community means I can easily recognise when someone is being disrespectful [in the way that they are describing a Black client], whether they mean to or not. So I challenge it." – Service provider specialising in community based care in the statutory sector

The complete CMOC for Hypothesis 14 is shown in Figure 35.

Figure 35: CMOC for Hypothesis 14



Hypothesis 15: Boundary-spanning roles and approaches **[EnC]** enable effective communication between services **[M]** for more integrated service provision **[O]**.

To facilitate cross-service working, the boundary-spanning role provided by ITAV was established **[EnC]**. Their purpose was to maintain an understanding of the service landscape **[EnC]**, maintain relationships with professionals within the relevant services **[EnC]**, and use this understanding to achieve effective navigation of

appropriate treatment pathways across services [O]. The boundary-spanner role helped service users to access their own care and gave service providers a greater understanding of available pathways [O]. The health and social care system is complex and often service provider frustration came from not having a clear understanding of where to go or how to access available support [DisC]. The boundary-spanner role effectively acted as a 'central directory' to improve understanding of the service landscape and bring the right people together at the right time [EnC].

> *"She seems to have been able to network so well to bring people together, so hopefully some of those relationships will keep going. You know, people are getting to know each other and building relationships" – Service provider specialising in mental health in the statutory sector*

Service flexibility and collaboration is limited to the services that providers know are available, which was made more difficult in the context of Covid-19 when some services moved online and closed physical spaces [DisC]. The need to work closely together and share learning and connections became even more important in creating opportunities for service identification and access [EnC]. The boundary-spanning role invested time in building relationships with different services and service users, to improve communication on both sides and provide wraparound support to those seeking treatment [EnC].

> *"I think the multi-agency approach has worked well and the networking that's happened between services as a result of the energy and commitment of [the boundary spanner role] … I think staff have not been as aware of a number of resources for people with complex needs previously but know a bit more now about drug and alcohol services, about our homelessness services outreach and hostels, that kind of thing." – Service provider specialising in mental health in the statutory sector*

Constrained service capacity limited the space that providers have to think about how to apply more flexible approaches, or other services that may be available to help [DisC], but the boundary-spanner role took on some of that mental burden [EnC]. The existence of this role was a comfort for providers when they didn't know what to do, as they were available to consult with about specific cases, or the system more

broadly **[EnC]**. Knowing that there was someone else there to advise on navigating the system and test ideas with helped to alleviate the pressure on individual providers **[O]**.

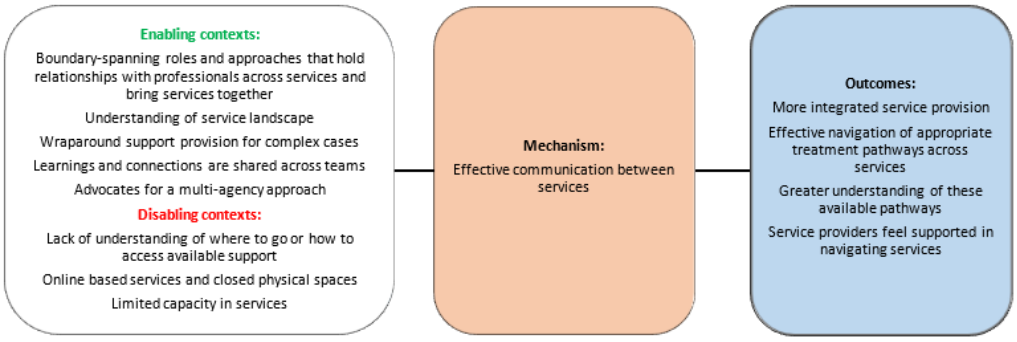
> *"Just takes some of that burden away because [the boundary spanner] was helping me to navigate [the system]." – Service provider specialising in mental health in the statutory sector*

The boundary-spanner role needed to be a continuous advocate for flexible, multi-agency working and apply their understanding of how services operated and the dynamics that they were working with to make it as smooth as possible **[EnC]**.

> *"[the boundary-spanner role's] enthusiasm for collaboration has really kept people going. Even when I'm rushed off my feet in crisis mode, I find the time to come along [to a multi-disciplinary meeting]. That's because of her." – Service provider specialising in adult social care in the statutory sector*

The complete CMOC for Hypothesis 15 is shown in Figure 36.

Figure 36: CMOC for Hypothesis 15



8.5 Differences in perspectives between study participants: a focus on the contexts of interview participants

As discussed in 4.3.1, an advantage of using a case study model was the ability to incorporate embedded units of analysis, which is compatible with a realist approach given the emphasis on context in generating outcomes. Although the study focused on a single intervention, I wanted to analyse outcomes relating to the type of participating organisation (specifically, voluntary and statutory organisations), as well to service users. Intersectional approaches also encourage a focus on context and

how contexts interact with each other, particularly gender and race. I therefore analysed data by embedded unit of analysis, but also by select individual-level contextual factors, in order to understand how interview participants' perspectives were influenced by these contexts. I present these differences below.

Deconstructing barriers to service access and working in a more flexible, trauma-informed way was more commonly valued and applied by voluntary sector organisations than statutory services, as voluntary sector organisations do not necessarily have the same rigid structures and strict eligibility criteria for who is able to access their services. This is the case for the provision of long-term support and stability, but also for broader wellbeing activities such as classes and peer-to-peer gatherings for service users. Over the course of the evaluation there was an underlying narrative of funding cuts to formal services that had resulted in a loss of services that were thought to be non-essential. Similarly, means of assessment and concerns around a heightened focus on primary need in designing pathways was mainly a concern for statutory services, as the voluntary sector can generally be more flexible in their approach to who they support and how.

Statutory services have a real willingness to understand more about how they can leverage local voluntary services and collaborate to provide more comprehensive care for service users and fill some of the gaps in their own knowledge and service provision. Boundary spanning roles are particularly valuable to service providers in this space who are not as linked into community resources. There was a feeling that the voluntary sector may have more insight into the local service landscape and community groups, which it could be helpful to utilise. However, there can be an over-reliance on the voluntary sector to do this, as sometimes service users will be referred in to broad support from voluntary services when trying to access a more specific type of support. Given the high caseloads in statutory services, however, there is more gatekeeping and service users are often bounced back. Despite this, there was a feeling in some voluntary organisations that they can feel looked down on by statutory services.

In interviews, representatives of statutory services often focused on how to make a case for working flexibly with women with complex needs, with an underlying need to justify any changes to processes within the service they were employed by. There was also a feeling that, if those participating are self-selecting, they are more likely to be the ones who want to see change and feel that they need to push for it and "sell"

the reasons it is required to senior stakeholders who may not feel the same way. However, in voluntary services it seemed to be taken for granted that flexibility in approach would be applied as needed.

The hypotheses related to Essential Principle 2 ("Service users need to feel heard and supported by services to build trust in the system and foster engagement") were all largely raised by service users and voluntary sector practitioners. One reason for this could be having the capacity and adaptability to work through these considerations, but it may also be because by the time statutory services are engaged an individual is often in crisis, at which stage having a softer, service user-led approach is no longer an option.

Building an understanding of culture was mostly spoken about openly by a member of the Black community. A white service provider who raised a similar concern prefaced it with, *"I don't know if anyone else has mentioned this before either, and it's a bit of an uncomfortable thing to say…"* which suggests that there is variance in the comfort people feel in discussing the topic. Nervousness around a lack of understanding of different cultures was mostly raised by statutory service providers, rather than smaller voluntary organisations and programmes, which tend to be based in communities already and more engaged with their cultures.

Similarly, I reviewed perspectives related to the gender of service providers interviewed. Although there weren't significant variances in perspectives across genders, issues related to race and class were only raised by women. Decision making power dynamics were also predominantly raised by women, with men only referring to power imbalances in relation to whether someone is "vulnerable" or not in the community, rather than discussing dynamics related to service user – service provider relationships or maintaining agency in cases of involuntary detainment (whether related to the criminal justice or healthcare system).

8.6 How the overarching programme theory evolved over the course of the evaluation

The programme theory was iterated throughout the evaluation as evidence was collected against the initial hypotheses. The more material revisions are discussed here, to show where the major differences were between the expectations for the ITAV intervention and how it was implemented.

One finding was related to how cultural differences can be misinterpreted and how this can be mitigated through education, having an understanding style, creating space to get to know individual service users beyond their diagnoses or listed primary need, and potentially through bringing people with lived experience into teams to help in the identification and removal of barriers. Through the evaluation, instances were raised of misinterpretations of cultural practices and how they had led to biases and a subsequent impact on engagement, driven by a lack of understanding of the historical context of care provision for certain communities and resulting in intergenerational knowledge sharing. Related to this, the role of societal expectations and stigmatisation came out more through subsequent interviews, particularly in relation to being a mother and the added stigmatisation for women using drug and alcohol services, particularly mothers with added fear of having children removed.

Thinking about how to effectively build a multi-agency team developed in three key ways. Firstly, in terms of viewing expertise and experience beyond technical specialisms, to also include factors such as flexibility of practices, background, understanding of communities, and networks. Secondly, in terms of dismantling decision-making power dynamics across the group, focusing on valuing everyone's views, supporting each other so that no-one feels they have sole responsibility over an individual's case, being comfortable sharing opinions and challenging the status quo. Finally, by underpinning flexible, multi-agency working with agreed policies, systems and procedures that give the team the ability to make changes to pathways and work jointly on cases, rather than have treatment plans defined exclusively by existing rigid pathways.

As the evaluation progressed, the need for more specific linkages between interdependent mechanisms became clear. Specifically, having better defined links between (i) how diagnosis, assessment and eligibility lead to coordination and prioritisation of care; (ii) the role of a trauma-informed approach in building self-belief, empowerment and agency, incorporating considerations of intersectionality; (iii) the nuance of triangulating the type, intensity and duration of services in designing effective treatment plans based on needs, which include consideration for broader wellbeing and more holistic care; and (iv) how personal support networks can increase a woman's belief that she is worthy of support, increasing likelihood of service engagement and participation, and how services providing additional support for family members can ultimately improve the outcomes of service users.

8.7 Key successes and challenges for ITAV to date

As discussed at the beginning of the chapter, service system change takes time to demonstrate impact, so to supplement the revised programme theory, I have synthesised the early indicators of progress made, aligned to the essential principles of the programme theory. I report on these early indicators to feed back to the intervention where successes and challenges had been identified and where there are key barriers to improvement. In the absence of a universally accepted set of criteria for early indicators of progress on systems change interventions, I developed a structure to assess progress against four criteria: (i) No material indicators of positive progress identified; (ii) Some indication of positive progress; (iii) Significant indication of positive progress; or (iv) Intended outcome(s) achieved. The criteria for this assessment are in Table 10.

Table 10: Criteria for assessment of progress

Assessment	**Criteria**
No material positive progress identified	• Interviewees do not proactively reflect on progress in relation to this essential principle; AND • Very little - if any - progress identified through observations
Some indication of positive progress	• Interviewees proactively reflect on progress in relation to this essential principle; OR • Some progress identified through observations To meet the criteria for this assessment, at least two participants across at least two embedded units of analysis should reflect on progress in relation to this essential principle
Significant indication of positive progress	• Interviewees reflect proactively on progress in relation to this essential principle; OR • Some progress identified through observations

	To meet the criteria for this assessment, at least half of all participants across at least two embedded units of analysis should reflect on progress in relation to this essential principle
Intended outcome(s) achieved	• Interviewees proactively reflect on outcome(s) being achieved in relation to this essential principle; OR • Outcome(s) being achieved is identified through observations

Essential Principle 1: Effective service provision requires a developed understanding of women with complex needs

The assessment of progress against this essential principle was '*Significant indication of positive progress*'. This is grounded in the consistent reflections from service providers that there was an increased understanding of women with complex needs (described below) with evidence from interviews that this increased understanding had translated into practical changes in service provision for women (albeit at case level rather than system level).

There was a **greater understanding of women with complex needs** amongst those who had engaged with the intervention. Most service providers interviewed raised the impact that the intervention had on their understanding of women with complex needs. The work had unearthed and identified some of the misunderstandings and misalignments, particularly in relation to reasons for lack of engagement and cultural differences. There was now an increased understanding amongst professionals of where blockages in relationships can occur on both sides and why different approaches to engagement are required. Some identified changes in practice as a result, specifically in feeling comfortable being more assertive in the need to actively engage with women.

> *"[ITAV] approaches have helped people look at things a different way and gain more understanding about the trauma that people have experienced and some really tangible approaches in in how to talk to somebody and how to think about working with people in a different way." – service provider specialising in mental health treatment for women*

Interviewees in both voluntary and statutory service provision saw the different training offerings as critical. The all-day training sessions were very well received and credited with reducing frustration and increasing patience and tolerance when working with women who had experienced trauma. They also provided practical advice on effective engagement. The short “Mic Drop” videos were a digestible source of information, brief but motivating, on topics that many service providers would not explicitly learn about otherwise, such as cultural practices, trauma and racial discrimination.

Another example was providers reporting holding off discharging women from services for lack of engagement, which was attributed to ITAV building understanding of why they might not be engaging and making a case for persevering rather than handing a woman another service rejection.

Overall, there was a reported feeling of acceptance, rather than avoidance, that there was a group of women with multiple disadvantage and that ITAV helps to shine a light on them and try to get them the best support possible, rather than ignoring them. This represents a significant cultural change in service provision, as overwhelmingly study participants (both service users and providers) had reported that members of this group had historically been either perpetually rejected from services due to their complexity, or outright overlooked.

Essential Principle 2: Service users need to feel heard and supported by services to build trust in the system and foster engagement

The assessment of progress against this essential principle was ‘*No material positive progress identified*'. It was driven by the limited movement in service user perceptions of the impact of ITAV to date. However, most elements of the intervention affected working practices ‘behind the scenes’ rather than direct engagement with service users, and were not changes that they would actively be made aware of over an 18-month period.

Service users’ perceptions of services had not changed much, though the facilitation of better communication between services was recognised. Some service users provided examples of rapid responses from services and good communication between agencies, facilitated by the boundary spanner role.

"Having a [boundary spanner role] that's pointed me in the right direction is helping me with the different services as well." – 'Sabah', service user

One explicitly showed support for the ITAV intervention and, in particular, the lead of the initiative.

"[the service designer] is great. We need more of [the service designer] in the world and that'd be a much nicer world." - 'Nadia', service user

Overall however, the positive changes identified by the women were largely focused on the role of individuals holding key roles within the intervention and, despite service providers identifying positive changes in wider service design, this was not recognised by service users, suggesting limited improvement in service users feeling trust in the wider system.

Essential Principle 3: Appropriate service delivery for women with complex needs relies on flexible and effective cross-agency collaboration

The assessment of progress against this essential principle was '*Some indication of positive progress*'. Accounts from several service providers suggested increased engagement, collaboration across services and an improved understanding of available resources. However, in coming to this assessment I balanced these positive indicators of progress with the limited translation into changes in service provision at service-level, e.g. through the creation of formal cross-service pathways; as well as limited senior stakeholder engagement, as several participants reflected on this being a barrier to ongoing multi-agency engagement.

ITAV had managed to **influence without authority**, which was largely the result of strong programme leadership. However, this has limitations for the future of the programme. Leadership was raised in most interviews as being a strength of the programme. The individual who designed and implemented the intervention was seen as an inspiring, energetic and motivating person who could bring people along with her. She was credited with getting the intervention off the ground as a result of her ability to bring people together.

"So what's happened sometimes is that we're not getting anywhere but just a quick e-mail from [programme lead] somehow seems to help" – service provider specialising in mental health services

However, interviewees sometimes found it hard to differentiate between the leadership of the intervention and the intervention itself. This suggests a heavy reliance on a single individual, without the systemic structures required for the intervention to be able to continue without her. This challenge has unsurprisingly been observed in other spaces (Leonard, Graham et al. 2004, Miller, Sorensen et al. 2006, Pryshlakivsky and Searcy 2021) and it can risk creating a single point of failure, and could also be a barrier to expanding the model (due to constraints on capacity) or replicating it elsewhere.

Despite not having systemic support, the intervention had influenced practice through the creation of multi-agency forums, attendance at training sessions, and some notable changes in approaches, discussed further below. Goodwill had been built through the implementation of the project and there had been senior participation in some meetings to provide additional authority, although this was not consistent. This might be challenging when it comes to changing behaviours. Although ITAV can try to encourage and convince people, they rely on others with the authority to make changes happen and are missing formal commitments from services to make the approach more consistent.

"It Takes A Village can do so much, but it can't force people's hands" – service provider specialising in adult social care

There had been enthusiasm for the approach and multi-agency buy-in, with representation at meetings from a wide range of groups. However, it is likely that there was a self-selection bias of the professionals who became involved in the intervention, in that they were likely people who were already keen to see changes in the system, as discussed in 8.4.

There was also **increased collaboration between services at individual case level**. Service providers who participated in the ITAV intervention reported having an increased understanding of the service landscape. Through the forums ITAV had created, links between individual providers were established to be taken forward in individual cases. Interviewees also made use of forums to reach out openly to the

group when specific requirements were raised by service users whom they weren't sure how to meet. This had resulted in more collaboration between services that were not previously aware of each other, although there might be a challenge in sustainability given that knowledge and links between services rests with individuals.

"[ITAV] has created an awareness of the possibility of working perhaps more collaboratively and working more flexibly." – service provider specialising in mental health services

The complex case panel that ITAV established was helpful in understanding more about the challenges that different services faced, as well as the specific options that could be available for a particular case, and this was also a valuable structural intervention, less reliant on individual interactions. It might also help when joint assessments are not operationally possible, so that cases benefit from the views of different specialties and knowledge sharing is facilitated.

"It felt like there was a lot of respect, but good kind of joint work in between the agencies there." – service provider specialising in criminal justice

However, pathway decisions can be difficult to make without senior stakeholder agreement, and service providers were not always sure of what had happened in the cases they had discussed. Without this feedback loop, there could be little shared learning about how effective the approaches discussed in the room were when put into practice. Sharing outcomes and learnings could also encourage continued participation and engagement from service providers.

Panel discussions had been helpful in bringing agencies together around shared objectives. Service providers felt that their views were more valued than they had been previously, with more of a willingness to take other agencies seriously and listen more carefully to differing views.

"People getting together to try and find some solutions rather than trying to bat things backwards and forwards … It was 'we're in this together'." – service provider specialising in adult social care

Overall, service providers recognised that forums had improved collaboration between teams on specific cases but felt there was still a long way to go to see changes at service level.

There had been **greater creativity in approaches**, and belief that new ways of working were possible. Interviewees saw benefit in ITAV creating energetic spaces for reflection and discussion, as forums for more creative thinking which could otherwise be hindered by heavy workloads. The new awareness of the possibility of flexible and collaborative working helped.

> *"An hour session can save a lot of time in the long run - step back and reflect rather than running around in circles" – service provider specialising in complex disadvantage*

> *"The sessions are more like playing with ideas as well about thinking 'We need to do things that way' but instead let's try this, and being very creative and fun and interesting … you know, people who come out from them, they're sort of laughing or chatting or joking. There's a real energy that comes from them." – service provider specialising in drug and alcohol services*

Further examples of working flexibly included sessions by a clinical therapist outside her immediate remit. The alternative was to wait for a referral to be accepted, which could have taken up to 12 weeks, and providing support for families alongside the individual service users being supported.

In summary, variable progress was identified across the Essential Principles articulated in the ITAV programme theory. However, there were some early signs of improved working practices, particularly in relation to cross-service collaboration and an increased understanding of women with complex needs, both of which enabled increased confidence in service providers managing complex cases. There had been minimal progress in relation to directly increasing service use, although this would be expected to come later in the embedding of the ITAV intervention as processes become more established and trust in services increases.

8.8 Impact of Covid-19 on service provision and access

Although the overall fallout of the Covid-19 pandemic on service provision and access was not fully understood when the study came to a close, some common themes came out of interviews.

Firstly, both during and coming out of the pandemic there was a movement towards professionals working from home. This had positive outcomes in terms of enabling more flexible working to allow for more diversity in staff, but it could also hinder relationship building with service users if they could only access a faceless person on the phone, rather than build a relationship in person. On the other hand, providing the option for service users to contact providers over the phone could dismantle some of the barriers to engagement, as it could be less daunting and more accessible. As well as potentially affecting service users' relationships with their case workers, it could also restrict their ability to develop a support network with peers and engage in the broader community. Coming into physical spaces to meet services and peers might help them to see how much support is available to them in the community, whereas it could be harder to see the bigger picture if you are only engaging with services over the phone.

During the pandemic a large proportion of services either moved online and became difficult to reach or closed completely. This made engaging with them even harder than usual and further damaged service users' trust. Some services had to pivot towards supporting the pandemic response, meaning increased waiting times and less service availability. In addition, delays experienced by case workers or care coordinators due to it being harder for them to speak with services themselves, also meant that many users felt they weren't being helped by anyone and were less willing to engage.

The impact was felt by service provider teams, whilst they also grappled with having to manage the impact of Covid-19 on their own service, as most had to close their doors, and gradually open up again. This affected the already fluid service landscape, but changes to services and staff were not consistently communicated during the pandemic which meant that providers weren't able to keep up with these changes and re-identify relevant contacts in community services.

> *"It feels like we're at the beginning again, like five years ago, where we were building up those relationships because there's less, there is just less personal contacts, personal relationships obviously, in two years people come and go" – Service provider working in the voluntary sector*

These challenges, layered on top of each other, had led to exhaustion in many of the service provider teams and frustration for service users from which they were still recovering.

8.9 Rigor and validity considerations: a realist evaluation applying a case study methodology

The quality of the case study was considered against four tests: construct validity, internal validity, external validity and reliability (Yin 1994). To address construct validity, multiple data collection methods were used and there was ongoing engagement and testing of findings with programme designers and practitioners to ensure reliability. Internal and external validity are addressed in the context of the realist methodology. Through a realist lens, the focus of validity is judgement of the degree to which the researcher has encapsulated multiple perspectives on a given situation (Porter 2007). I followed Pawson et al. Transparency, Accuracy, Purposivity, Utility, Propriety, Accessibility and Specificity (TAPUPAS) criteria (Pawson, Boaz et al. 2003) to enhance the trustworthiness of data collection and documentation. Reliability was addressed through the application of a specific research protocol and through consistent and comprehensive documentation processes. The steps I took to meet the TAPUPAS criteria are outlined below.

To address the **transparency** criteria I have discussed the aims, theoretical guidance, setting, methods and process of data analysis and will include them in all future reporting. To address **accuracy**, I have used participant's quotations as well as thematic summaries to accurately report the perspectives gathered and show how they informed the CMOCs identified during analysis. To address **purposivity**, I identified that a realist evaluation of multiple stakeholders in multiple cases experiencing the program would enable us to explore the CMOCs identified during the realist review. I conducted triangulation using data from multiple sources to address the research question. I used middle-range theory during each of the research phases. To address **utility**, I gathered multiple perspectives of a variety of stakeholder professions across embedded cases. I have also presented limitations to data collection and other sources of knowledge that would have added to utility throughout. To address **propriety**, I have followed ethical procedures of informed consent for all participants and the ethical guidelines of the university and council research boards that granted ethical approval. Each participant read and signed informed consent before each initial interview. Data were audio-recorded, transcribed

and anonymised. To ensure **accessibility**, although I have used academic language in line with publication standards, the research has also been fed back to both those developing the intervention and the organisations involved and service users who participated, in the form of a lay language summary document and presentation. Finally to address **specificity**, I am following RAMSES II reporting standards for realist evaluations in the academic paper I have developed which reports on the findings of this evaluation (Wong, Westhorp et al. 2016).

8.10 Conclusions

The leadership of the intervention was critical. Having someone who consistently advocated for the ITAV approach and modelled the behaviours and values that it encapsulates had fostered the spreading of ideas, encouraged high levels of participation across numerous services, and enabled influence without authority. The programme lead's approach had brought people along with her, inspiring and motivating changes in behaviour through education and collaboration.

> *"In my experience, it is down to passionate, committed individuals who are willing to have ideas and really be incredibly tenacious. To make them happen." – service provider working with women with complex disadvantage*

There was a notable shift in behaviours at individual provider level over a relatively short period (18-24 months). There was greater understanding of women with complex needs and resulting changes in perception of them, greater motivation to be tolerant and persevere in trying to support them, and more of an emphasis on shared responsibility to do so. Critically, this led to greater collaboration between services, which benefits both service users (through more thoughtful, tailored and integrated care planning) and service providers (who have help in navigating services and are no longer being left with sole responsibility for a complex case). Self-selection bias is a concern, as those participating (both in the ITAV intervention and in the realist evaluation) had done so voluntarily and might have been more likely to be interested in changing the system. Tarquinio et al. describe how accepting and being motivated to participate in a study can involve individual factors like empathy, level of education, personality, knowledge, opinions, health behaviour or interest in the topic (Tarquinio, Kivits et al. 2014), which is relevant for ITAV as a social good led intervention. This could be particularly relevant to the ability of ITAV to achieve its outcomes given most

of the individuals I spoke to were not senior decision makers. However, learnings can continue to be shared within services (perhaps facilitated by a more structured feedback loop within the intervention) through those who do participate, creating more advocates and changing behaviours in the process.

Broader systems change takes time and is exceptionally challenging in a system of this size and complexity. It depends on several factors which will not come easily in this context, such as senior buy-in and endorsement; culture, mindsets and behaviour change; policies and procedures to underpin the change; and funding implications and availability. This means that ITAV has an uphill battle to progress from the impact it has had on the ways of working of individual providers, to change system level practices.

Funding and service stability was a significant challenge. Services were struggling with the directive to reduce spend and members of staff were already overworked. It remains difficult to find the time or funds to develop new working practices or even attend training. Rigidity in funding streams also means that joint working is not supported. Instead, budget availability for a client is established based on 'primary need' which, as we have discussed, is not an effective measure of overall support requirements. The inflexibility of statutory services, coupled with the uncertainty in future funding for voluntary-based programmes, means that the service landscape is always changing, making long-term planning and partnership development challenging.

The overall feeling of acceptance, rather than avoidance, that a group of women with multiple disadvantages exists marks a valuable step in ensuring more comprehensive service delivery.

8.11 Chapter summary

In this chapter I have presented the results of the realist evaluation and discussion of essential principles and underlying hypotheses. I have discussed the theoretical basis behind the design of the ITAV intervention which formed the initial programme theory, based on three key mechanisms: (i) building an understanding of women with complex needs, which ITAV is aiming to do in relation to both the individual women it is trying to support and women with complex needs more broadly; (ii) service users have trust and understanding in the services supporting them, which ITAV is trying to

enable through adopting a trauma informed approach, facilitating the development of relationships between service providers and users, supporting women to identify their own needs and take agency over their own care, and using these priorities to guide treatment pathways; and (iii) flexible service provision and collaboration is necessary to support women with complex needs, which ITAV is trying to improve by building relationships and connections between services and creating opportunities and forums to share knowledge, experience and challenges, to create a more creative and collaborative approach.

At the conclusion of the evaluation, three Essential Principles were identified as being key to enabling more appropriate support for women with complex needs, each underpinned by a number of hypotheses. They are (i) effective service provision requires a developed understanding of women with complex needs; (ii) service users need to feel heard and supported by services to build trust in the system and foster engagement; and (iii) appropriate service delivery for women with complex needs is reliant on flexible, cross-agency collaboration.

Chapter 9 Concluding remarks

9.1 Introduction to chapter

In this final chapter, I briefly revisit the background and rationale for the PhD and summarise the key results from each chapter. I discuss my reflections on the research process, specifically with respect to the application of realist methods, evaluating interventions in real time, my experience of working with vulnerable women and the impact of Covid-19 on my research. I discuss the limitations of my work and propose future areas of research before concluding with some final comments.

9.2 Summary of thesis

9.2.1 Purpose of the PhD project

The purpose of the thesis was to develop the evidence base required to support and enable the delivery of more effective mental health interventions and diversion programmes for women, both at a global level and in the UK. Specifically, I aimed to contribute evidence around why interventions aimed at supporting this population are effective for some but not others, through reviewing what works to improve outcomes for women, how change happens and in which contexts.

One such intervention, It Takes A Village ("ITAV"), has been developed in a central London borough and represents an ambitious approach to working across systems to deliver integrated, interdisciplinary care for women with complex needs. In an environment where funding for support services is being squeezed, services need robust evidence on how interventions are implemented and the impact – if any – that they have, so an evaluation was required to understand and demonstrate impact. Through this evaluation, I aimed to contribute evidence of what the drivers are for the programme working effectively or otherwise, and how it may be improved and replicated in other contexts.

9.2.2 Literature base and relevant theory

Mental health conditions are highly prevalent in prison populations and this is particularly true for women (WHO 2009, Hawton, Linsell et al. 2014, Fazel, Hayes et al. 2016). Incarceration causes stress and increased risk of suicidal behaviour, as well as increased recidivism in some individuals (Holmes and Rahe 1967, Hayes 1989,

Joukamaa 1997). Meanwhile, crime poses a significant cost to communities (Piquero 2013, Allard 2014, Cohen 2019). In addition to the evidence presented on mental health being of particular concern for women offenders, women also differ from men in their risk factors for offending (Willis and Rushforth 2003, Thornton, Graham-Kevan et al. 2010, Van Voorhis, Wright et al. 2010), the impact of incarceration (Fazel, Hayes et al. 2016), and through the knock-on impact this has on their role as a parent (Hissel, Bijleveld et al. 2011, Wildeman and Turney 2014).

Co-morbidity is common and women with multiple disadvantage are likely to have related and interdependent treatment needs that contribute to offending behaviour and worsen outcomes (Lankelly Chase Foundation 2015). Women who commit criminal offenses often have multiple support needs requiring treatment, but encounter barriers that result in a lack of engagement (Magwood, Leki et al. 2019).

To address the over-representation of people with mental health conditions in prison populations, a solution that has been proposed is diversion programmes, which take a number of different forms, but ultimately aim to divert people from the criminal justice system to mental health services. Diversion programmes have overall been found to be effective, though this can be variable (Broner, Lattimore et al. 2004). There is limited understanding of the drivers of variation and what makes interventions effective for certain groups of individuals, but we know that for diversion programmes to work as intended, there needs to be a focus on the system people are diverted into as well as the diversion mechanism itself (Munetz and Griffin 2006). Specifically, the system needs to have the capacity and capability to address the multiple needs of women with complex disadvantage.

9.2.3 Theoretical framework

The primary theoretical basis for the project was intersectionality, informed by theoretical concepts from feminism, gender and female criminality. Intersectionality is based on the underlying assumption of heterogeneity within groups of ‘men’ and ‘women’ and recognises that individuals are defined by multiple, intersecting dimensions, such as gender, class, ethnicity, (dis)ability, sexuality and age (Hammarström, Johansson et al. 2014). This approach was developed as a critique against the dichotomous way of dividing gender without analysing differences within the group of men and within the group of women (Crenshaw 1989, Hankivsky and Cormier 2009, Hankivsky 2012).

Intersectionality requires an understanding of the multiple disadvantages and needs that a person may have to determine how best to address them. The complexity and severity of the issues faced by women with complex needs mean that for interventions to effectively tackle them, their design should draw upon evidence across gender, criminality, and multiple disadvantage. Intersectionality can provide not only a theoretical basis for evidence and analysis, but also tools for researchers to use in research design and analysis (Weber and Parra-Medina 2003).

The theoretical framework designed for the project was applied to research methods through (i) integrating relevant theoretical concepts in the development and application of analytical frameworks; (ii) an intersectional approach to research design through the focus on a specific study population; (iii) feminist methods of interrogation and analysis; and (iv) the application of realist methods to ensure that individual contexts (including gender, intersectionality and support needs) are understood.

9.2.4 Understanding diversion programmes as an intervention for women with mental health conditions: a realist review

I undertook a realist review to address Research Question 1: How do the key mechanisms associated with the delivery of interventions that include diversion as a component interact with contextual influences and with one another to explain the successes, failures and partial successes of diversion programmes as an intervention to improve the outcomes of women offenders with mental health conditions?

Through undertaking the literature review, several hypotheses were developed by grouping CMOCs thematically. When analysing these hypotheses, four essential principles were identified: Essential Principle 1: Successful diversion requires connections and coordination between services across the healthcare system; Essential Principle 2: The development and maintenance of relationships should be incorporated within programmes to maximise their effectiveness; Essential Principle 3: Major risk factors for recidivism remain relevant for offenders whether or not they have mental illness; and Essential Principle 4: Diversion programmes provide an opportunity for stabilisation of an individual's life, and effective programmes should enable this. Although structured as four separate essential principles, in reality they are interconnected and the mechanisms within each strand interact with each other to achieve change.

Overall, the realist synthesis concluded that, if an overarching objective of diversion programmes is to change behaviour, an individual's needs have to be understood, including those which are not directly related to mental illness. This includes, but should not be limited to, mental health needs, particularly through addressing trauma. The review found that care to promote mental health requires individual rather than agency-based plans, and that programmes require flexibility to be able to prioritise services and interventions based on need, building connections with other resources in the community where they are based. The review findings suggest that the quality of relationships can enhance, or even define, an individual's experience of a diversion programme, in terms of both a woman's relationship with the relevant service practitioner(s) and their broader support network. Finally, the findings also suggest a role for specific gendered tailoring of interventions, linked to previously mentioned factors.

The realist review was intended to provide a global, comprehensive view of what makes a diversion programme work, within which contexts and for whom. One of the key findings was the criticality of operationalisation based upon the local service landscape and that a diversion programme is only as effective as the services an individual is diverted into. I explored this further in the realist evaluation of ITAV.

9.2.5 It takes a village: a realist evaluation

I undertook a realist evaluation to address Research Question 2: How does the operationalisation and implementation of an intervention aiming to deliver integrated, interdisciplinary care for women in a London borough influence the outcomes of women with multiple disadvantage who are at risk of coming into contact with the criminal justice system, within which contexts and for whom?

I evaluated ITAV, an intervention aiming to improve service provision and use for people with complex needs in a central London borough through a new way of working with them, building on the current systems in the borough to help those who fall out of service provision or circulate between services without improving outcomes. Through in-depth interviews and a thematic network analysis of the data generated, I articulated the issues being experienced in service use and provision for women with complex needs in a comprehensive way.

These issues are complex and interlinked, particularly in a setting of restricted resources. However, despite gaps in understanding how to ensure that individuals with complex needs receive the care that they require, there is broad agreement on what the issues are across specialties within the health and social care sectors, which provides a foundation for designing interventions to address them. Three key issues were identified: i) a fundamental lack of understanding of women with complex needs that can be observed at a systemic level (for example, in the design of assessment and eligibility criteria) as well as individual provider level (for example, in engagement approaches), resulting in the inappropriate design and delivery of systems to support this group of women; ii) a lack of trust and understanding in services on the part of women with complex needs, which reduces engagement, openness and honesty between service users and providers, inhibiting the provision and access to appropriate care; and iii) service provision can be rigid in both the types of support provided and the way in which it is provided (for example, through the processes that providers follow, the amount of time they spend on each case, making collaboration between services challenging.

The ITAV intervention aims to provide a comprehensive package of support, some of which seeks to directly support service users, and some of which supports service providers to administer improved support and treatment. Three Essential Principles were identified to define the refined programme theory for ITAV, each underpinned by a number of hypotheses: i) Effective service provision requires a developed understanding of women with complex needs; ii) Service users need to feel heard and supported by services to build trust in the system and foster engagement; and iii) Appropriate service delivery for women with complex needs relies on flexible, cross-agency collaboration.

In the first 18-24 months of the ITAV intervention there had been material shifts in several behaviours and practices, summarised as follows: (i) ITAV had managed to influence without authority, which was largely the result of strong leadership, though this had limitations for the future of the programme; (ii) There was a greater understanding of women with complex needs amongst those who had engaged with the intervention; (iii) Increased collaboration between services at individual case level; (iv) There had been greater creativity in approaches, and belief that new ways of working are possible; and (v) How service users view services had not seen much movement, though good communication between services was recognised.

9.3 Developing our understanding of diversion and support for women with multiple disadvantage at risk of incarceration: what works, in which contexts and for whom

As we saw in Chapter 2, mental health conditions are highly prevalent in prison populations, particularly for women (WHO 2009) and co-morbidity is common, such that women with multiple disadvantage are likely to have related and interdependent treatment needs that contribute to offending behaviour and worsen outcomes (Lankelly Chase Foundation 2015). To address the over-representation of people with mental health conditions in prison populations, a solution that has been proposed is diversion programmes, which take several different forms, but ultimately aim to divert people from the criminal justice system to mental health services.

We know that to fully understand the effectiveness of interventions aiming to improve outcomes for women at risk of incarceration or recidivism, we need to consider the effectiveness of both the diversion intervention and the effectiveness of the system that women are diverted to (Munetz and Griffin 2006). The findings from the realist review and realist evaluation provide a route to understand how these programme theories overlap and complement each other and direct our efforts to provide comprehensive and tailored support for women with multiple disadvantage who are at risk of incarceration.

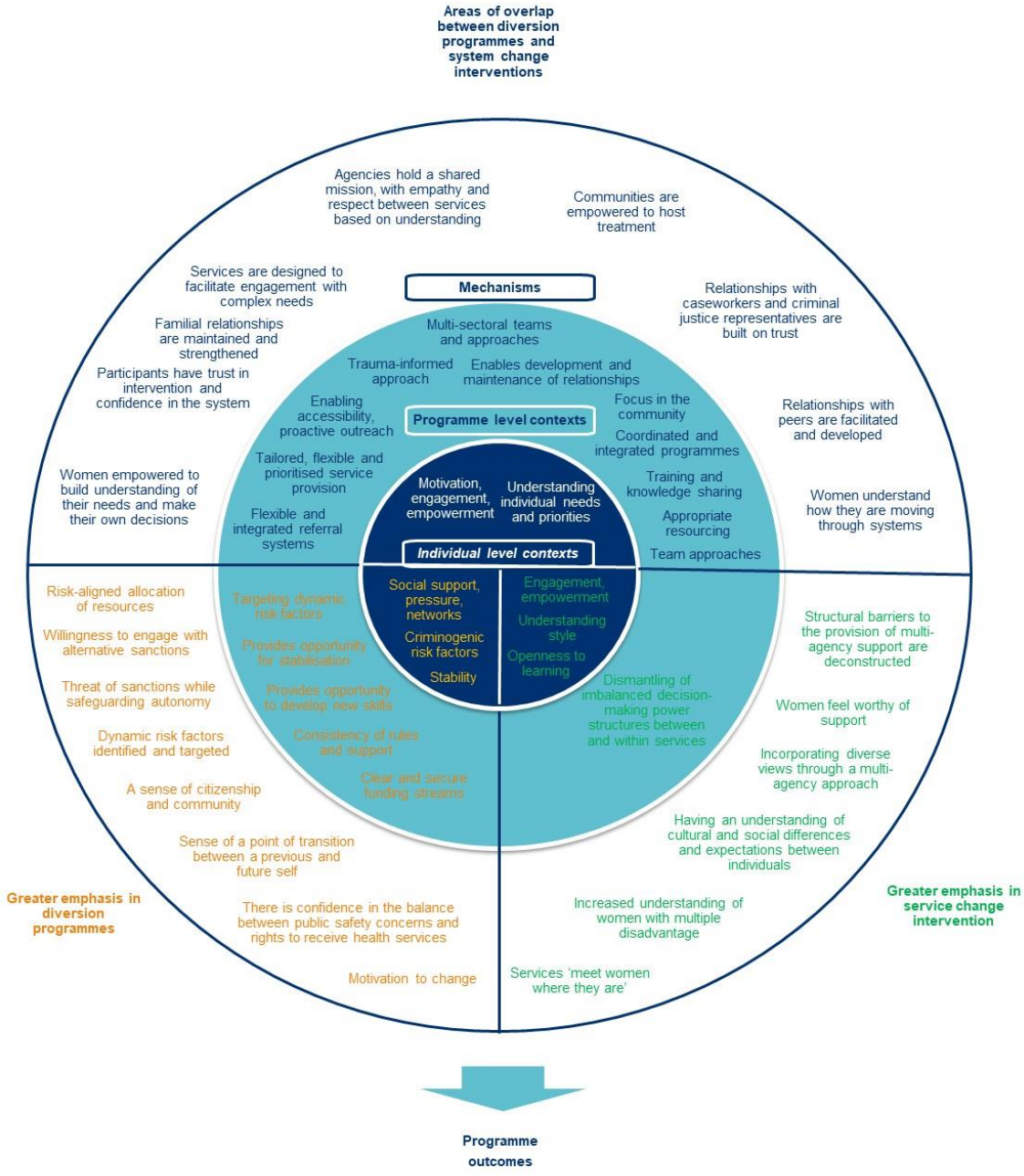
There is a clear overlap in relevant mechanisms driving effectiveness in both areas of intervention (the diversion element and the system element). Specifically, mechanisms relating to empowering women, facilitating the management of complex needs, building the trust of service users, enabling relationships between services, and clarifying processes and pathways are relevant drivers of effectiveness in both areas.

As would be expected, the findings of the realist review placed greater emphasis on measures relating to directly engaging with the criminal justice system such as approaches to sanctions, balancing public safety with offenders' wellbeing, and targeting dynamic risk factors to reduce recidivism. Findings from the realist evaluation of ITAV placed greater emphasis on understanding, in terms of how best to support women with complex needs, the impact of cultural and social differences and incorporating diverse views in case management. This speaks to the more

personalised approach taken by the ITAV intervention, whereas the literature on diversion programmes covered interventions that took in larger cohorts of participants.

This is summarised in the programme theory shown in Figure 37, which encapsulates the overarching findings.

Figure 37: Overview of findings: what drives the effectiveness of interventions aiming to reduce incarceration and improve wellbeing for women with complex needs



9.4 Implications for practice

There are three key findings that have implications for practice. First, when designing diversion programmes, the 'system' element is critical (Weisman 2004). It is not enough to be able to identify and divert women with complex needs away from the criminal justice system, as without an effective system of treatment and support which addresses the underlying issues, health, wellbeing and criminal justice outcomes will not be achieved (Case, Steadman et al. 2009, Draine and Solomon 1999, Alarid and Rubin 2018). Second, support systems need to be built around a woman's individual needs and be flexible, tailored and prioritised accordingly, rather than trying to fit women into existing restrictive pathways (Andrews, Bonta et al. 1990, McGuire 2002a, Latessa, Lowenkamp et al. 2006, Vieira, Skilling et al. 2009, Andrews and Bonta 2010a, Peterson-Badali, Skilling et al. 2014). This means an expansion of eligibility criteria, more coordination and integration between services, and proactive, preventative outreach and engagement before a woman is in crisis (Hean, Heaslip et al. 2010, Scott, McGilloway et al. 2013).

Finally, a finding from both the realist review and the evaluation was the need to incorporate trauma-informed practice to build service provider trust in services and in the specific providers that they work with. This supports the literature that argues that mental health conditions and underlying trauma must be addressed to enable recovery (Prins and Draper 2009, Gallagher, Nordberg et al. 2019), recognising the impact of trauma on a person's capacity for coping, as well as their sense of safety, ability to self-regulate, their sense of self, perception of control and self-efficacy, and interpersonal relationships (SAMHSA 2014), as well as being a driver of offending behaviour in women with multiple disadvantage (Prins and Draper 2009, Green, Miranda et al. 2005, Gallagher, Nordberg et al. 2019). This thesis builds on existing literature advocating the incorporation of trauma-informed practice as a way of increasing likelihood of programme completion through treating trauma concurrently with substance use disorders (Gallagher, Nordberg et al. 2019). A key barrier to engagement identified through the work is the lack of service provider understanding and training in trauma-informed service provision, meaning that a woman may be rejected or discharged from a service with little or no follow-up due to a lack of understanding, systems being seen as a threat rather than a system designed to support them, and therefore reduced accessibility of services. As well as training to address this, women should be empowered to take ownership over their own care by being included in goal setting and decision making.

9.5 Reflections on the research process

9.5.1 Application of realist methods

There are some challenges in the use of realist methods, starting with the significant barrier to entry posed by terminology. There is a lot of new terminology to use when working with realism, which is a barrier to learning and also to communication and engagement with other researchers. Thankfully, a selection of thorough learning materials is available (Rameses project 2022), but the learning process remains significant.

In applying the methodology, the challenge of identifying mechanisms and distinguishing them from contexts and outcomes is ongoing. This is particularly challenging when considering how mechanisms interact with each other. For example, we could have a mechanism which is “Services have a greater understanding of a woman’s needs” which contributes towards another mechanism of “Services are more willing to try new approaches”. Teasing out at which level we’re looking at outcomes rather than mechanisms is difficult and requires constant iteration and application of judgement.

Another challenge with the application of realist review methods is balancing the inclusion of evidence while ensuring its rigor. The focus when applying realist methods is on relevance, richness and achieving saturation, which includes incorporating a diverse range of evidence, such as reports, articles and periodicals. To mitigate the risks around this, clear and transparent communication is required and risk of bias should be considered in assessing confidence in findings.

The use of realism in reviews is becoming well established and there are several benefits to it. In particular: i) the iterative nature of the reviews in allowing for further searches to strengthen the evidence base, which can allow for more in-depth exploration and avoids the issue of more rigid systematic reviews only uncovering a small amount of evidence; ii) the extraction and use of evidence across a range of data sources and even fields can allow for a greater depth in analysis, as one can apply learnings from other spaces rather than relying on a narrow set of criteria; and iii) the use of interviews in the realist review was also useful for adding direction and being able to test narrative as it developed. Interviewees were able to make suggestions on areas that they felt weren’t fully supported, which led to further

searching and analysis. One challenge with realist methods is knowing when to stop searching. Given the iterative and flexible nature of the methodology, it is difficult to know when you have 'reached saturation' and should draw a line under data collection, given the consistent feeling that you might uncover something interesting and meaningful in the next round of searches.

For evaluations, there is a real opportunity to explore and document how realist methods work alongside other approaches. The application of the realist evaluation cycle, which includes the development of hypothetical CMOCs to then collect data against, provides a useful structure for data collection and analysis. However, realist evaluation is otherwise a flexible model which allows a choice of methods that are led by the type of theory to be tested (Pawson and Tilley 1997). This can create challenges in knowing exactly how methods work together, particularly where it may not have been done before. My research applied a case study methodology alongside realist principles, which was compatible with realist evaluation as both approaches benefit from theory-driven data collection and analysis (Yin 2003). Case studies have been used successfully in combination with realist evaluation principles before (Marchal, Dedzo et al. 2010, Rycroft-Malone, Fontela et al. 2010, Williams, Burton et al. 2013), though the lack of detail on approaches to incorporating realist principles in case study design meant there wasn't a blueprint to act as a starting point for best practice, resulting in a lot of upfront design work and uncertainty.

The method of analysis was more challenging to apply at first. Although thematic network analysis is compatible with a CMO heuristic (Pawson and Tilley 1997), I initially applied it to develop and articulate contexts, mechanisms and outcomes through basic, organising and global themes, respectively, to ensure that CMOCs were preserved through the analysis process. However, the subsequent stages of analysis involved the grouping of CMOCs to create hypotheses and the further analysis of hypotheses to create essential principles. Using a thematic network analysis structure for this worked well for the sake of analysis, but caused challenges in presentation. The way of using basic, organising and global themes to articulate findings evolved throughout the project, and sticking to the principles of realism (preserving the connections between contexts, mechanisms and outcomes) whilst maintaining the definitions held within thematic network analysis techniques (in particular, that basic themes are 'simple premises characteristic of the data') was challenging. I addressed this by being flexible in the application of approaches in the

presentation of visual models and by being clear in the text about what was being presented.

9.5.2 Evaluating systems change interventions in real time

Although realist evaluations can theoretically be undertaken at different stages of an intervention, published studies almost exclusively come at the end of a programme or intervention, often due to a need to assess impact in line with programme funding cycles.

The implementation of the ITAV intervention, aimed at bringing about significant changes in local health and social care systems, commenced in the middle of 2021. The programme was expected to span multiple years and yield tangible benefits over time. In contrast, the realist evaluation was conducted over a period of 18 months. In that time, one of the women I was interviewing died of causes related to the issues she required treatment for. If the prevailing approach is to evaluate interventions as they come to a close, it could mean waiting several years before identifying the effectiveness of interventions, delaying follow-up actions such as making improvements to interventions, rolling out further programmes, and adding evidence around what works. The death of one of the study participants was a stark reminder that a more proactive approach is essential to foster timely improvements, facilitate the expansion of interventions, and augment the body of knowledge on effective strategies for doing so.

Realist evaluations conducted in real time could provide a valuable tool in programmes with longer-term outcomes. Firstly, to provide live feedback on how they are working and secondly, to identify areas for improvement through the up-front development of evaluative frameworks that could then be monitored over time through applying a continuous evaluation approach at multiple points throughout implementation to provide ongoing feedback and make adjustments as the intervention progresses. This is useful for complex interventions operating in dynamic and changing environments and could be particularly valuable in complex systems change interventions, which often involve multiple stakeholders, complex processes, and unpredictable outcomes. Real-time realist evaluations would allow stakeholders to assess progress and impact and make adjustments to maximise effectiveness.

This aligns to the evolving methods of developmental evaluation, which “supports innovation development to guide adaptation to emergent and dynamic realities in complex environments” (Patton 2010) pg. 461. Developmental evaluation considers how multiple parts of complex systems (e.g. health and social care support systems) are connected, and is primarily focused on real-time use of evaluation findings (Patton 2016). This suggests suitability for evaluating interventions like ITAV, which involve complex system and implementation issues across a wide variety of stakeholders (Gagnon 2011). This is a growing and evolving area of evaluation practice (Laycock, Bailie et al. 2019) which complements realist evaluation approaches, specifically through alignment in the iterative nature of the evaluation process, the use of stakeholder engagement, the emphasis on contextual influences, its ability to deal with complexity, and the synthesis of multiple sources of data.

Both in my work, and as recognised in the literature on developmental evaluation (Laycock, Bailie et al. 2019) real-time evaluation also presents challenges, such as the need for rapid data collection and analysis, the potential for bias and subjectivity, the blurring of lines between the intervention and the evaluation, and the difficulty of capturing long-term impacts. These challenges need to be mitigated through careful planning and design approaches and through applying robust evaluation standards (Pawson, Boaz et al. 2003) to ensure validity and reliability.

9.5.3 Working with vulnerable people

The residents of the hostel I interviewed all had unresolved trauma, which made engagement challenging in several ways. Firstly, when discussing system use, which could mean reliving experiences that were highly distressing, a particular risk when the researcher is not a psychologist. This created discomfort as I was wary of inadvertently causing one of the interviewees to become distressed. An example was an interview which went on much longer than planned. I suggested pausing or stopping a number of times as the interviewee was clearly upset. However, this only appeared to upset them more as they felt very strongly about sharing their story, creating a tension as the researcher between wanting to give them space to calm down, whilst not wanting them to feel like they were being dismissed. Although I had an approach for what to do if an interview participant was in severe distress, I hadn’t anticipated this scenario and it was difficult to manage. The experience of interviewing was also distressing as a researcher, as the experiences that the residents described were upsetting, with the added complexity of guilt related to my personal experience

being so different. During my time working on the project I saw a lot of staff turnover, and staff were often stressed or upset due to working in a very intense environment. Both members of staff and researchers in this field will need to be supported if they are to work in the space over the long term.

The practicalities of working with women with complex needs were challenging (discussed further in the context of Covid-19). Their lives were often unpredictable, and I could not practically make an appointment to speak with an individual in advance. This meant that, in line with my research findings, I needed to go to them and create space for engagement on their terms. This meant a lot of waiting, assurances of attending that didn't materialise, and interruptions during the interviews themselves. Being realistic about the time required for engagement is something that needs to be built into research design. In addition, there was limited consistency in follow-up interviews as some women had moved out of the hostel (some unexpectedly), and one had very sadly died.

There are challenges around decision-making power dynamics and misalignment of priorities between the interviewee and interviewer. The interviewees often had immediate needs and priorities (one woman was keen to discuss a mouse problem she was having in the room of her hostel), but I was there with the aim of helping systems change, which is inherently far less immediate. I tried to mitigate this by providing feedback to the hostel on some issues as they were raised, but there was still misalignment in the timeline of how long change takes. Compensating participants for their time was also a challenge related to dynamics, as it was important to compensate people for their expertise, but it created an imbalance in which participants may have been speaking to me only for compensation. This was clearly the case in some instances.

Overall, the process of working with the women in this study has led me to see the world very differently, with a greater understanding of my own privilege, as well as the systemic challenges that hold people back. They have also taught me the importance of focusing on marginal improvements. The women in my ITAV study have all been let down by the system at one stage or another and that is often largely because service providers don't know how to help them. The impression I've had from interviews has been that they can be perceived as people who can't be 'cured'. Providers don't know what to do to help them, and so do nothing. Focusing on improving outcomes where possible, even just one small improvement at a time, can

create a more positive cycle of improvement which can support women to believe in themselves.

9.5.4 Limitations of this research

The realist review had two key limitations, both related to the availability of evidence. First, although the realist review was intended to be global, there was a lack of evidence outside of high-income settings, possibly due to the concentration of diversion programmes in the regions most reported on (in particular, the UK, USA, Canada, and Australia). Second, there was a lack of gender-focused or gender-specific studies. Although this is a limitation, expert consultations provided some assurance that the key differences between men and women's experiences of diversion programme effectiveness (as described in 5.10) were the critical differences they had experienced in practice.

The ITAV study had two key limitations. First, the ITAV intervention is primarily focused on achieving system change, which takes time to have material impact. This limited my ability to evaluate in depth the effectiveness of the intervention. However, I was able to use the evidence that I collected to refine ITAV's programme theory which can continue to be iterated as the ITAV programme progresses, and to complement this I also synthesised evidence relating to the key early successes and challenges experienced by the intervention, to provide an overall indication of its current effectiveness. The programme theory can act as an evaluative framework in the longer term. Second, engagement with service users was not always consistent given challenges in making appointments in advance, and changes in individual circumstances, such as place of residence. However, I was able to draw from a range of perspectives and synthesise views to create a holistic picture.

9.5.5 Impact of Covid-19

Women with complex needs are hard to reach in 'normal' circumstances. When the Covid-19 pandemic hit, the default was that research had to change and I could no longer undertake interviews in person. For interviewing service providers and observing professional forums, this did not present an issue, but interviewing service users turned out to be infeasible. To take one woman as an example, she consented to participate in the research, but did not have a phone and didn't want to speak over a videocall. On two separate occasions, she gained access to a mobile phone, but either lost it or had it stolen within a couple of days. Gaining consent was also an

issue as, although she was happy to consent without speaking to me in person, others were not and I wasn't able to physically be there to talk them through it, which meant that I relied on staff to facilitate the process. This meant restructuring the interviews (to combine the first and second round interviews as originally planned) while I re-applied for ethical approval to interview participants in person.

The pandemic also presented issues around staff capacity, both in facilitating interviews, but also in their capacity to speak to me about their own professional experiences. I'm deeply thankful that these professionals continued to make time for me, despite their high workloads and the additional stresses that the pandemic brought.

Finally, in 8.8 I discussed the impact of Covid-19 on the ITAV intervention itself. The implication for the research is that it is difficult to extract what the intervention could have achieved if it had not been compromised by the increase in pressure on staff, changes in funding, and services pivoting to support the pandemic response. It will take time for services to 'recover' and some have ended their service provision as a direct result of the pandemic.

9.6 Future research

9.6.1 Diversion programmes

The realist review has provided a strong understanding of the extent to which diversion programmes work, how, in which contexts and for whom. However, the literature base would particularly benefit from further research on three of the topics that were identified.

Firstly, how to foster positive peer relationships. Group sessions are highlighted in the literature as a primary way of promoting the development of peer relationships and learning (Panas, Caspi et al. 2003, Taxman and Bouffard 2003, Bellamy, Bledsoe et al. 2006). However, knowledge of how to foster peer relationships outside group settings, and for different types of offenders is limited (Webber and Fendt-Newlin 2017), despite a wide understanding that group sessions may not be appropriate for everyone. For example, in the use of offence-specific groups, dealing with clients' own experiences of being sexual abusers may be inappropriate in the context of sex offender treatment (Levenson 2014).

Secondly, how to develop feelings of citizenship and belonging. Although the literature articulates benefits of citizenship in creating individual connections to the rights, responsibilities, roles and resources available to them through public and social institutions to encourage participation (May and Wood 2005), in the context of criminal justice, there is limited evidence on how to encourage feelings of citizenship for individuals who have little or no previous experience of it (Clayton, O'Connell et al. 2012). How to effectively integrate mental health treatment and management in this context. The literature points to a need to incorporate a range of services for diversion programmes to be effective (Andrews, Bonta et al. 1990, McGuire 2002a, Latessa, Lowenkamp et al. 2006, Vieira, Skilling et al. 2009, Andrews and Bonta 2010a, Peterson-Badali, Skilling et al. 2014) and as described in Essential Principle 3 and Essential Principle 4 of the realist review this should include targeting criminogenic risk factors that are amenable to change (Bonta and Andrews 2007, Hanson, Bourgon et al. 2009, Andrews and Bonta 2010a, Skeem, Manchak et al. 2011, Hean, Willumsen et al. 2015), and practical needs such as housing (Erickson, Lamberti et al. 2009, Coffman, Shivale et al. 2017) and employment (English and Mande 1991, Smith 2017),. It remains the case, however, that mental health conditions and underlying trauma must be addressed to enable recovery (Prins and Draper 2009, Gallagher, Nordberg et al. 2019). There was limited evidence on achieving the effective integration of these services and how they should be prioritised, despite this being deemed critical to intervention success (see 5.8.1).

Finally, the perspectives of service-users could provide useful insight in testing and refining the programme theories generated through the review (Wong, Westhorp et al. 2016), to understand personal experiences of engaging with diversion programmes from a user-perspective, which is important when aiming to improve service improvement (Locock, Kirkpatrick et al. 2019).

9.6.2 Operationalisation of interventions to support women with complex needs

The evaluation of ITAV has provided a comprehensive set of hypotheses about what makes an intervention effective, in which contexts and for whom (see 8.3). However, the timing of the Covid-19 pandemic and the lack of available resource (human and financial) meant that the context around the intervention was very challenging, and it had to be implemented gradually. It would help to evaluate more established interventions in this space to gain insight into the potential of an intervention of this

nature when supported over a longer period, and specifically in the case of ITAV, continue to evaluate the intervention against the programme theory as it continues to embed itself.

The appropriate timing of evaluations is a question which is reportedly overlooked and understudied despite there being several reasons (organisational factors; learning and adoption capacity; and heterogeneous responses to an intervention, i.e. contextual influences) for delays to observable outcomes and therefore impact (King and Behrman 2009). One of the challenges with the evaluation of ITAV, was that there wasn't a set start date, after which all changes would be implemented by the intervention. Instead, changes were made gradually, with ongoing changes in service provider participation and evolution of implementation approaches, creating an 'implementation lag', which is recognised as a complicating factor in timing an evaluation (King and Behrman 2009).

In all of the interviews I held, the lack of resource was raised. It would be interesting and beneficial to understand the impact that a multi-agency approach could have in a less constrained setting, such as in a place where a greater level of funding is put towards support services for disadvantaged women. This would help to understand to what extent resources are the main barrier to successful implementation.

9.6.3 The application of evolving methods in new contexts

As discussed earlier, realist methodology is becoming more established in some areas (Rycroft-Malone, Fontenla et al. 2010), but realist evaluation is method-neutral (Belle, Westhorp et al. 2023), and as such, how it can work in conjunction with other methods is still relatively new.

As discussed in 9.5.1, there was not a 'blueprint' for undertaking a realist evaluation using a case study approach, which meant significant upfront work to design the approach. Development of publications establishing best practice and examples of ways of incorporating different methodologies within a realist framework (as I intend to do in relation to the case study example) would be useful, as would understanding which methods are most compatible.

9.7 Final comments

The women I had conversations with have been failed by the system at multiple junctures and they all require additional help and support which they do not currently have access to. This is largely due to the lack of funding being directed towards services, which has an impact on both service providers and service users and forces a focus on firefighting when people are in crisis, rather than investing in preventative measures or treatment at earlier stages of identification before conditions worsen. This must change if women are to be appropriately supported. It is a measure of their strength that they have managed to get through some of the hardships they have experienced.

It is important that their voices are heard when planning the design of treatment and support pathways, on both an individual and system basis. Engagement should be thoughtful, making use of existing research and resources where they are available, to balance the importance of having women advocate for themselves with asking them to continuously explain themselves and their histories, which can be exhausting and potentially retraumatising.

The enthusiasm I have seen around the implementation of the It Takes A Village intervention suggests that there is willingness to change practices to better support women with complex needs. Interviewees have been open to learning, sharing experiences and examining their behaviours (as well as formal service structures) to ensure that they are providing the best possible care, which gives me a lot of hope that positive changes to systems will be made in the future.

Appendix A References

Adler, F. (1975). *Sisters in crime: the rise of the new female criminal. .* New York: McGraw-Hill.

Adrian, P. M., Alvarado, R., Fritsch, R., Poblete, C., Villagra, C., Kastner, S., & Priebe, S. (2013). Prevalence Rates of Mental Disorders in Chilean Prisons. *PLOS one*, 1-8.

Agénor, M., Krieger, N., Austin, S. B., Haneuse, S., & Gottlieb, B. R. (2014). Sexual orientation disparities in Papanicolaou test use among US women: the role of sexual and reproductive health services. *American journal of public health*, 104(2), e68-e73.

Ahuja, R. (1996). *Sociological Criminology,.* New Delhi: New Age International Publishers Limited.

Alexander, P. E. (2012). A Prison Classroom, African American Literature, and the Pedagogy of Freedom. *Reflections*.

Allam, J., Middleton, D., & Browne, K. (2006). Different clients, different needs? Practice issues in community-based treatment for sex offenders. *Criminal Behaviour and Mental Health*, 69-84.

Alsop, R., Fitzsimons, A., & Lennon, K. (2002). *Theorizing gender.* Cambridge: Polity.

American Psychological Association. (n.d.). *Gender and Stress.*

Andersen, H. S. (2004). Mental Health in Prison Populations. A review – with special emphasis on a study of Danish prisoners on remand. *Acta Psychiatrica Scandinavica*, 5-59.

Andrews, D., & Dowden, C. (2006). Risk Principle of Case Classification in Correctional Treatment: A Meta-Analytic Investigation. *International Journal of Offender Therapy and Comparative Criminology*, 88-100.

Andrews, D., & Dowden, C. (2010). Managing correctional treatment for reduced recidivism: A meta-analytic review of programme integrity. *Legal and Criminological Phychology*, 173-187.

APA. (1987). *Diagnostical and statistical manual of mental disorders.*

Armstrong, E. (2020). *Marxist and Socialist Feminism.* Study of Women and Gender: Faculty Publications. Smith College.

Arnold, R. A. (1990). Process of victimization and criminalization of black women. *Social Justice*, 17(3), 153–166.

Association for Women's Rights in Development (AWID). (2004). *Intersectionality: A tool for gender and economic justice.* Women's Rights & Economic Change.

Atkinson, M., Jones, M., & Lamont, E. (2007). *Multi-agency working and its implications for practice: a review of the literature.* Slough: National Foundation for Educational Research.

Atkinson, M., Wilkin, A., Stott, A., Doherty, P., & Kinder, K. (2002). *multi-agency working: a detailed study.* Slough, Berkshire: National Foundation for Educational Research.

Auty, K. M., Farrington, D. P., & Coid., J. W. (2017). The Intergenerational Transmission of Criminal Offending: Exploring Gender-Specific Mechanisms. *The British Journal of Criminology*, 215–37.

Bachmann, C. L., & Gooch, B. (2018). *LGBT in Britain health report.* Stonewall.

Banks, K., Murry, T., Brown, N., & Powell Hammond, W. (2014). The impact of feminist attitudes on the relation between racial awareness and racial identity. *Sex Roles*, 70, 232-239.

Bastick, M., & Townhead, L. (2008). *Women in prison: a commentary on the United Nations standard minimum rules for the treatment of prisoners.* Geneva: Quaker United Nations Office.

Bauer, G. R., Churchill, S. M., Mahendran, M., Walwyn, C., Lizotte, D., & Villa-Rueda, A. A. (2021). Intersectionality in quantitative research: A systematic review of its emergence and applications of theory and methods. *SSM - population health*, Volume 14.

Bauman, Z. (2000). *Liquid modernity.* Cambridge, UK: Polity.

Bedolla, L. G. (2007). Intersections of inequality: Understanding marginalization and privilege in the post-civil rights era. . *Politics and Gender*, 3(2), 232-248.

Belle, S. V., Westhorp, G., & Marchal, B. (2023, 08 10). *Realist evaluation*. Retrieved from Better Evaluation: https://www.betterevaluation.org/methods-approaches/approaches/realist-evaluation

Benton, T., & Craib, I. (2010). *Philosophy of social science: The philosophical foundations of social thought. second.* Palgrave: Macmillan.

Berger, M. T., & Guidroz, K. (2009). *The intersectional approach: Transforming the academy through race, class, & gender.* Chapel Hill, NC: The University of North Carolina Press Chapel Hill. .

Bernard, A. (2012). The Intersectional Alternative: Explaining Female Criminality. *Feminist Criminology*, 3-19.

Bernard, A. (2013). The intersectional alternative Explaining female criminality. *Feminist Criminology*, 8, 3-19.

Bernard, A. (2013). The intersectional alternative Explaining female criminality. *Feminist Criminology*, 8, 3–19.

Best, D., & Laudet, A. (2010). *The Potential of Recovery Capital. .* London: Royal Society for the Arts.

Bhaskar, R. (1975). *A Realist Theory of Science.* Routledge .

Binswanger, I., Merrill, J., Krueger, P., White, M., Booth, R., & Elmore, J. (2011). Gender Differences in Chronic Medical, Psychiatric, and Substance-Dependence Disorders Among Jail Inmates. *AJPH*.

Bland, R. C., Newman, S. C., Dyck, R. J., & Orn, H. (1990). Prevalence of Psychiatric Disorders and Suicide Attempts in a Prison Population. *The Canadian Journal of Psychiatry*, 367-459.

Blau, F. D., & Kahn, L. M. (2017). The Gender Wage Gap: Extent, Trends, and Explanations. *Journal of Economic Literature*, 789-865.

Bonner, R. (2001). Rethinking Suicide Prevention and Manipulative Behavior in Corrections. *Jail Suicide/Mental Health Update*, 7-8.

Bowleg, L. (2012). The Problem With the Phrase Women and Minorities: Intersectionality—an Important Theoretical Framework for Public Health. *American Journal of Public Health 102*, 1267-1273.

Bracken-Roche, D., Bell, E., Macdonald, M., & al., e. (2017). The concept of 'vulnerability' in research ethics: an in-depth analysis of policies and guidelines. *Health Res Policy Sys* , 15, 8.

Brady, C., Burgess, R., & Osrin, D. (2022). Understanding diversion programmes as an intervention for women with mental health issues: A realist review. *SSM Mental Health*, 2.

Brah, A., & Phoenix, A. (2004). Ain't I a woman? Revisiting intersectionality. . *Journal of International Woman's Studies*, 5(3), 75-86.

Braidotti, R. (2006). Posthuman, All Too Human: Towards a New Process Ontology'. *Theory, Culture & Society*, 23 (7–8), pp.197–208.

Brakel, T. M., Dijkstra, A., Buunk, A. P., & Siero, F. W. (2012). Impact of Social Comparison on Cancer Survivors' Quality of Life: an experimental field study. *Health psychology*, 660-670.

Brinded, P. M., Simpson, A. I., Laidlaw, T. M., Fairley, N., & Malcolm, F. (2001). Prevalence of psychiatric disorders in New Zealand prisons: A national study. *Australian and New Zealand Journal of Psychiatry*, 35(2), 166–173.

Broidy, L., & Agnew, R. (1997). Gender and crime: A general strain theory perspective. *Journal of Research in Crime and Delinquency*, 34(3), 275-306.

Bui, H. N. (2004). *In the adopted land: Abused immigrant women and the criminal justice system.* Westport, CT: Praeger.

Burgess-Proctor, A. (2006). Intersections of race, class, gender, and crime future directions for feminist criminology. *Feminist Criminology*, 1, 27–47.

Burman, E. (2004). "From Difference to Intersectionality: Challenges and Resources.". *European Journal of Psychotherapy, Counseling and Health*, 6(4):293-308.

Butler, J. (1999). *Gender trouble: feminism and the subversion of identity.* New York: Routledge.

Buunk, B. P., Collins, R. L., Taylor, S. E., & VanYperen, N. W. (1990). The Affective Consequences of Social Comparison: either direction has its ups and downs. *Journal of Personality and Social Psychology*, 1238-1249.

Byng, R., Norman, I., & Redfern, S. (2005). Using Realistic Evaluation to Evaluate a Practice-level Intervention to Improve Primary Healthcare for Patients with Long-term Mental Illness. *Evaluation*, 11(1):69–93.

Caplan, S. E., Haslett, B. J., & Burleson, B. R. (2005). Telling it like it is: the adaptive function of narratives in coping with loss in later life. . *Health Communication*, 17(3), 233–251.

Carballo, J., Fernández-Hermida, J., Sobell, L., Dum, M., Secades-Villa, R., García-Rodríguez, O., . . . AlHalabí-Diaz, S. (2008). Differences among substance abusers in Spain who recovered with treatment or on their own. *Addict Behav.* , 33: 94-105.

Carlen, P. (1988). *Women, Crime & Poverty.* M. Keynes: Open University Press.

Carlen, P. (1988). *Women, crime and poverty.* London:: Open University Press.

Carolan, M., Burns-Jager, K., Bozek, K., & Chew, R. E. (2010). Women who have their parental rights removed by the state: The interplay of trauma and oppression. *Journal of Feminist Family Therapy*, 22, 171–186.

Case, B., Steadman, H. J., Dupuis, S. A., & Morris, L. S. (2009). Who Succeeds in Jail Diversion Programs for Persons with Mental Illness? A Multi-Site Study. *Behavioral Sciences and the Law*, 661-674.

Chambers, M., Gallagher, A., Borschmann, R., Gillard, S., Turner, K., & Kantaris, X. (2014). The experiences of detained mental health service users: Issues of dignity in care. *BMC Medical Ethics*, 15(50), 1–8.

Chantler, K. (2005). “From Disconnection to Connection: “`Race, Gender’ and the Politics of Therapy.”. *British Journal of Guidance and Counseling*, 33(2):239-56.

Chesney-Lind, M. (1986). Women and crime: The female offender. *Signs*, 12(1), 78-96.

Chesney-Lind, M. (1997). *The female offender: Girls, women and crime.* Thousand Oaks, CA: Sage.

Chesney-Lind, M., & Daly, K. (1988). Girls’ Crime and Woman’s Place: Toward a Feminist Model of Female Delinquency. *CRIME & DELINQUENCY*, Vol-35, No-1, (January), P. 5-29.

Chesney-Lind, M., & Morash, M. (2013). Transformative feminist criminology: A critical re-thinking of a discipline. *Critical Criminology*, 21, 287–304.

Chesney-Lind, M., & Pasko, L. (2013). *The female offender: Girls, women, and crime.* Thousand Oaks, CA: Sage.

Cho, S., Crenshaw, K., & McCall, L. (2013). Toward a field of intersectionality studies: Theory, applications, and praxis. *Signs: Journal of Women in Culture and Society*, 38(4), 785-810.

Chokshi, B., Pukatch, C., Ramsey, N., Dzienny, A., & Smiley, Y. (2023). The Generational Trauma Card: A Tool to Educate on Intergenerational Trauma Transmission. *Journal of Loss and Trauma*, 28:5, 464-471.

Clayton, A., O'Connell, M. J., Bellamy, C., Benedict, P., & Rowe, M. (2012). The Citizenship Project Part II: Impact of a Citizenship Intervention on Clinical and Community Outcomes for Persons with Mental Illness and Criminal Justice Involvement. *American Journal of Community Psychology*, 51: 114-122.

Cole, E. (2009). Intersectionality and research in psychology. *American Psychologist*, 64(3), 170-180.

Cole, E. R. (2008). Coalitions as a model for intersectionality: From practice to theory. . *Sex Roles* , 59(5/6), 443-453.

Collaborate for Social Change. (2022). *It Takes A Village: How to develop an approach to multiple disadvantage in Southwark.*

Collier, A. (1994.). *Critical Realism: An introduction to Roy Bhaskar's Philosophy.* Verso.

Collins, P. H. (2000). *Black feminist thought: Knowledge, consciousness, and the politics of empowerment (2nd ed.).* New York, NY: Routledge.

Collins, P. H. (2015). Intersectionality's definitional dilemmas. *Annual Review of Sociology*, 41, 1-20.

Collins, P. H., & Bilge, S. (2016). *Intersectionality.* Malden, MA: Policy Press.

Collins, P. H., & Bilge, S. (2016). *Intersectionality.* John Wiley & Sons.

Collins, P. Y., von Unger, H., & Armbrister, A. (2008). Church ladies, good girls, and locas: Stigma and the intersection of gender, ethnicity, mental illness, and sexuality in relation to HIV risk. *Social Science & Medicine*, 67, 389 – 397.

Connell, R. (1987). *Gender and power: Society, the person and sexual politics.* Stanford University Press.

Connell, R. (2005). *Masculinities.* Berkeley: University of California Press.

Connell, R. (2009). *Gender: In world perspective.* Cambridge: Polity Press.

Connell, R. (2012). Gender, health and theory: conceptualizing the issue, in local and world perspective. *Soc Sci Med*, 74:1675–83.

Connell, R., & Messerschmidt, J. (2005). Hegemonic masculinity: rethinking the concept. *Gend Soc*, 19:829–59.

Corrado, R. R., Cohen, I., Hart, S., & Roesch, R. (2000). Comparative Examination of the Prevalence of Mental Disorders Among Jailed Inmates in Canada and the United States. *International Journal of Law and Psychiatry*, 633-647.

Crenshaw, K. (1989). *Demarginalizing the intersection of race and sex: a black feminist critique of antidiscrimination doctrine, feminist theory, and antiracist politics, .* Chicago: University of Chicago Legal Forum.

Crenshaw, K. (1991). Mapping the margins: Intersectionality, identity politics, and violence against women of color. *Stanford Law Review*, 43(6), 1241-1299.

Crenshaw, K. (1991). Mapping the margins: Intersectionality, identity politics, and violence against women of colour. *Stanford law review*, 43: 1241–1299.

Crenshaw, K. (1991). Mapping the margins: Intersectionality, identity politics, and violence against women of colour. *Stanford Law Review*, 43: 1241–1299.

Crenshaw, K. (1991). Mapping the margins: Intersectionality, identity, politics, and violence against women of color. *Stanford Law Review*, 43(6), 1241–1299.

Crenshaw, K. (1993). Demarginalizing the intersection of race and sex: A black feminist critique of antidiscrimination doctrine, feminist theory and antiracist politics. In D. K. Weisberg, *Feminist legal theory foundations* (pp. 383-395). Philadelphia, PA: Temple.

Crenshaw, K. (2011). Postscript. In H. Lutz, M. T. Vivar, & L. Supik, *Framing intersectionality: Debates on a multifaceted concept in gender studies* (pp. 221–233). Surrey, England: Ashgate.

Crenshaw, K. (2012). From Private Violence to Mass Incarceration: Thinking Critically About Women, Race and Social Control. *UCLA Law Review*, 59(6): 1418, 1428–1472.

Crenshaw, K. (2015). Opinion | Why intersectionality can't wait. *Washington Post.*

Curran, D. J., & Renzetti, C. M. (2001). *Theories of Crime.* Boston: Allyn and Bacon.

Curtin, N., Stewart, A., & Cole, E. (2015). Challenging the status quo: The role of intersectional awareness in activism for social change and pro-social intergroup attitudes. *Psychology of Women Quarterly*, 39(4), 512-529.

Daly, K. (2010). Feminist perspectives in criminology: A review with Gen Y in mind. *The Handbook of Criminal Theory*.

Daly, K. (2010). Feminist perspectives in criminology: A review with Gen Y in mind. . In E. McLaughlin, & T. Newburn, *The SAGE handbook of criminological theory* (p. p. 237). London: Sage.

Daly, K., & Chesney-Lind, M. (1988). Feminism and criminology. *Justice Quarterly*, 5(4), 497-535.

Davis, K. (2008). Intersectionality as buzzword: A sociology of science perspective on what makes a feminist theory successful. *Feminist Theory*, 9(1), 67–85.

Deane, M., Steadman, H., Borum, R., & al, e. (1999). Emerging partnerships between mental health and law enforcement. *Psychiatric Services*, 50:90-101.

Diáz-Cotto, J. (2006). *Chicana lives and criminal justice: Voices from el barrio.* Austin, TX: University of Texas Press.

Dill, B. T., & Zambrana, R. E. (2009). *Emerging intersections: Race, class, and gender in theory, policy, and practice.* New Brunswick, NJ: Rutgers University Press.

Dobson, R. (2019). Policy responses to 'rough sleepers': Opportunities and barriers for homeless adults in England. *Critical Social Policy*, 39(2), 309–3213.

Doyal, L. (2009). Challenges in researching life with HIV/AIDS: an intersectional analysis of black African migrants in London. *Culture, Health & Sexuality*, 11(2), 173 – 188.

Duckworth, M. P., & Follette, V. M. (2012). *Retraumatization: Assessment, treatment, and prevention. .* Routledge/Taylor & Francis Group.

Duran, A., & Jones, S. (2019). Using Intersectionality in Qualitative Research on College Student Identity Development: Considerations, Tensions, and Possibilities. *Journal of College Student Development*, 60(4), 455-471.

Dy, A. M., Martin, L., & Marlow, S. (2014). Developing a Critical Realist Positional Approach to Intersectionality. *Journal of Critical Realism*, 13:5, 447-466.

Easton, G. (2010). Critical realism in case study research. Ind Mark Manag. . 39(1):118-28.

Edmund, D. S., & Bland, P. J. (2011). *Real tools: Responding to multiabuse trauma. Alaska Network on Domestic Violence and Sexual Assault.* USA: National Center on Domestic and Sexual Violence. Retrieved from http://www.ncdsv.org/images/ANDVSA_RealToolsRespondingToMulti-AbuseTraumaToolKit_2011.pdf

European Monitoring Centre for Drugs and Drug Addiction. (2004). *Annual report 2004: the state of the drugs problem in the European Union and Norway.* Lisbon: European Monitoring Centre for Drugs and Drug Addiction.

Evans, C. (2019). Adding interactions to models of intersectional health inequalities: Comparing multilevel and conventional methods. *Social Science and Medicine*, 95-105.

Fausto-Sterling, A. (2019). Gender/Sex, Sexual Orientation, and Identity Are in the Body: How Did They Get There? *The Journal of Sex Research*, 56 (4-5), pp.529-555.

Fazel, S., & Seewald, K. (2018). Severe mental illness in 33 588 prisoners worldwide: systematic review and meta-regression analysis. *The British Journal of Psychiatry*, 200(5), 364-373.

Fazel, S., Hayes, A., Bartellas, K., & Clerici, M. (2016). Mental health of prisoners: prevalence, adverse outcomes, and interventions. *The Lancet Psychiatry*, 871-881.

Fineman, M. (1995). *The Neutered Mother, the Sexual Family and Other Twentieth Century Tragedies. .* New York: Taylor & Francis.

Fish, J. (2008). Navigating queer street: Researching the intersections of lesbian, gay, bisexual and trans (LGBT) identities in health research. . *Sociological Research Online*, 13 (1), 12.

Flax, J. (1999). Women do theory. . In M. Pearsall, *Women and values: Readings in recent feminist philosophy* (pp. 9-13). Belmont, CA: Wadsworth.

Fletcher, A., Jamal, F., Moore, G., Evans, R., Murphy, S., & Bonell, C. (2016). Realist complex intervention science: Applying realist principles across all phases of the Medical Research Council framework for developing and evaluating complex interventions. *Evaluation*, 22(3):286–303.

Forrester, A., Till, A., Simpson, A., & Shaw, J. (2018). Mental illness and the provision of mental health services in prisons. *British Medical Bulletin*, Volume 127, Issue 1, 101–109,.

Fovet, T., Plancke, L., Amariei, A., Benradia, I., Carton, F., Sy, A., . . . Roelandt, J. (2020). Mental disorders on admission to jail: A study of prevalence and a comparison with a community sample in the north of France. *Eur Psychiatry*, 27;63(1.

Fowler. (2002). *Drugs, crime and the drug treatment and testing order.* London: Trade Union and Professional Association for Family Court and Probation Staff .

Francis, B., & Paechter, C. (2015). The problem of gender categorisation: addressing dilemmas past and present in gender and education research. *Gender and Education*, 27 (7), pp.776–790.

Francis, B., Soothill, K., & Fligelstone, R. (2004). Identifying Patterns and Pathways of Offending Behaviour. *European Journal of Criminology* , 1:1, 48-87.

Frankenberg, R. (1993). *White women, race matters: The social construction of whiteness.* Minneapolis: University of Minnesota.

French, D. P., Sutton, S. R., Marteau, T. M., & Kinmonth, A. L. (2010). The impact of personal and social comparison information about health risk. *British Journal of Health Psychology*, 187-200.

Future learn. (2022, 09 11). *Social science for tackling antimicrobial resistance*. Retrieved from Future learn: https://www.futurelearn.com/info/courses/social-science-for-tackling-antimicrobial-resistance/0/steps/66203

Gagnon, M. (2011). Moving knowledge to action through dissemination and exchange. . *J Clin Epidemiol.* , 64(1):25–31.

Gendreau, P., Little, T., & Goggin, C. (1996). A META-ANALYSIS OF THE PREDICTORS OF ADULT OFFENDER RECIDIVISM: WHAT WORKS. *Criminology*, 575-607.

Gill, C., & Wilson, D. (2016). Improving the Success of Reentry Programs: Identifying the Impact of Service–Need Fit on Recidivism. *Criminal Justice and behavior*, 336-359.

Gillborn, D. (2015). Intersectionality, Critical Race Theory, and the Primacy of Racism: Race, Class, Gender, and Disability in Education. *Qualitative Inquiry*, 21(3), 277–287.

Gilligan, C. (1982). *In a different voice: Psychological theory and women's development.* . Cambridge, MA: Harvard University Press.

Goodwin, B. J., Interligi, C. J., Kasardo, A. E., McHugh, M. C., & Poet, A. D. (2019). Who is the woman in the psychology of women? Addressing diversity and intersectionality. In J. A. Mena, & K. Quina, *Integrating multiculturalism and intersectionality into the psychology curriculum: Strategies for instructors* (pp. 51–62). American Psychological Association.

Gordon, B. G. (2020). Vulnerability in Research: Basic Ethical Concepts and General Approach to Review. *Ochsner Journal*, 20:34–38.

Greenwood, R., & Christian, A. (2008). What happens when we unpack the invisible knapsack?: Intersectional political consciousness and inter-group appraisals. *Sex Roles*, 59, 404-417.

Griffin, K. A., Cunningham, E. L., & George Mwangi, C. A. (2016). Defining diversity: Ethnic differences in Black students' perceptions of racial climate. *Journal of Diversity in Higher Education*, 9(1), 34–49.

Griffin, P. (1990). The Back Door of the Jail: Linking mentally ill offenders to community mental health services. In H. Steadman, *Jail Diversion for the*

Mentally Ill: Breaking Through the Barriers. Longmont, Colo: National Institute of Corrections.

Gunn, K., & Maden, A. (1991). Treatment needs of prisoners with psychiatric disorders. *BMJ*, 338–341.

Guzman, R., Korcha, R., & Polcin, D. (2020). "I have more support around me to be able to change": A Qualitative Exploration of Probationers' and Parolees' Experiences Living in Sober Living Houses. *National Library of Medicine*, 51-65.

Halliday, M. (2022). *Bromley Briefings Prison Factfile.* London: Bromley Trust.

Hammarström, A., Johansson, K., Annandale, E., & al., e. (2014). Central gender theoretical concepts in health research: the state of the art. . *J Epidemiol Community Health.*, 68(2):185–90.

Hancock, A. M. (2013). *Empirical intersectionality: a tale of two approaches,.* UC Irvine L.

Hankivsky, O. (2012). Women's health, men's health, and gender and health: Implications of intersectionality. *Social Science & Medicine*, 74, 1712-1720.

Hankivsky, O. (2012). Women's health, men's health, and gender and health: implications of intersectionality. *Soc Sci Med.*, 74:1712–20.

Hankivsky, O., & Cormier, R. (2009). *Intersectionality: moving women's health research and policy forward. .* Vancouver: Women's Health Research Network.

Hankivsky, O., Grace, D., Hunting, G., Ferlatte, O., Clark, N., Fridkin, A., & Laviolette, T. (2012). Intersectionality-based policy analysis. . *An intersectionality-based policy-based analysis framework*, pp. 33-45.

Harmon, M., & Boppre, B. (2018). Women of Color and the War on Crime: An Explanation for the Rise in Black Female Imprisonment. *Journal of Ethnicity in Criminal Justice*.

Harper, G., & Chitty, C. (2004). Impact of Corrections on Reoffending: A Review of WhatWorks. *National archives*.

Haskins, N., Ziomek-Daigle, J., Sewell, C., Crumb, L., Appling, B., & Trepal, H. (2016). The intersectionality of African American mothers in counselor education: A phenomenological examination. . *Counselor Education and Supervision*, 55(1):60-75.

Hawton, K., Linsell, L., Adeniji, T., Sariaslan, A., & Fazel, S. (2014). Self-harm in prisons in England and Wales: an epidemiological study of prevalence, risk factors, clustering, and subsequent suicide. *Lancet*, 383: 1147–54.

Hean, S., Heaslip, V., & Warr, J. (2010). A women's worker in court: A more appropriate service for women defendants with mental health issues? *Perspectives in public health*, 91-96.

Hean, S., Willumsen, E., Odegard, A., & Bjorkly, S. (2015). Using Social Innovation as a Theoretical Framework to Guide Future Thinking on Facilitating Collaboration Between Mental Health and Criminal Justice Services. *Int Journal of Forensic Mental Health*, 280-289.

Heidensohn, F. (1985). *Women & Crime.* UK: Macmillan Education UK.

Heidensohn, F., & Silvestri, M. (1995). Gender and Crime. In *Oxford Handbook of Criminology.* London: Oxford University Press.

Hennessy, B., Hunter, A., & Grealish, A. (2023). A qualitative synthesis of patients' experiences of re-traumatization in acute mental health inpatient settings. *Journal of Psychiatric and Mental Health Nursing*, 279-593.

Hiday, V., & Scheid-Cook, T. (1991). Outpatient commitment for "revolving door" patients: compliance and treatment. *J Nerv Ment Dis*, (2):83-8.

Hill, S. (2016). Axes of health inequalities and intersectionality. *Health Inequalities: Critical Perspectives*, 95.

Hissel, S., Bijleveld, C., & Kruttschnitt, C. (2011). The well-being of children of incarcerated mothers: An exploratory study for the Netherlands. . *European Journal of Criminology*, 8(5), 346–360.

Hitchens, B., Carr, P., & Clampet-Lundquist, S. (2017). The Context for Legal Cynicism: Urban Young Women's Experiences With Policing in Low-Income, High-Crime Neighborhoods. *Race and Justice*.

Howard, R., Phipps, E., Clarbour, J., & Rayner, K. (2015). "I'd trust them if they understood learning disabilities" support needs of people with learning disabilities in the Criminal Justice System. *Journal of Intellectual Disabilities and Offending Behaviour*.

Howards, J., & Alamilla, R. M. (2016). 'Gender and Identity'. In S. J. Ferguson, *Race, Gender and Social Class: Dimensions of Inequality and Identity.* California: Sage.

Hoye, S., & Severinsson, E. (2008). Intensive care nurses' encounters with multicultural families in Norway: an exploratory study. . *Intensive Crit Care Nurs* , Dec;24(6):338–48.

Human Rights Watch. (2003, 10 21). *Ill-Equipped: U.S. Prisons and Offenders with Mental Illness*. Retrieved from Human Rights Watch: https://www.hrw.org/report/2003/10/22/ill-equipped/us-prisons-and-offenders-mental-illness#_ftn600

Hunter, R., Gorely, T., Beattie, M., & Harris, K. (2022). Realist review. *International Review of Sport and Exercise Psychology*, 15:1, 242-265,.

imprisonment, W. o. (2016). Harmon, Mark; Boppre, Breanna. *Journal of Ethnicity in Criminal Justice*, 309-332.

Iyer, A., Sen, G., & Ostlin, P. (2008). The intersections of gender and class in health status and health care. *Global public health*, 3(S1), 13 – 24.

Jagosh, J., Bush, P., Salsberg, J., Macaulay, A., Greenhalgh, T., Wong, G., & al., e. (2015). A realist evaluation of community-based participatory research: partnership synergy, trust building and related ripple effects. *BMC Public Health*, 15(1):725.

James, D., & Hamilton, L. (1991). The clerkenwell scheme: assessing efficacy and cost of a psychiatric liaison service to a magistrates' court. *Br Med J*, 303: 282–285.

Janik, J. (1992). Dealing with mentally ill offenders. *FBI Law Enforcement Bulletin*, 61:22-26.

Jessop, B. (2005). Critical realism and the strategic-relational approach. New Form A J Cult Theory. *Polit*, 56:40–53.

Jewkes, Y., Jordan, M., Wright, S., & Bendelow, G. (2019). Designing 'Healthy' Prisons for Women: Incorporating Trauma-Informed Care and Practice (TICP) into Prison Planning and Design. *Int. J. Environ. Res. Public Health*, 16, 3818.

Jones, M. K., & Day, S. X. (2019). An Exploration of Black Women's Gendered Racial Identity Using a Multidimensional and Intersectional Approach. *Sex Roles*, 79(1), 1-15.

Jones, S. M., & Wirtz, J. G. (2006). How does the comforting process work? an empirical test of an appraisal-based model of comforting. *Human Communication Research*, 32(3), 217–243.

Jordan, K., Schlenger, W. E., Fairbank, J. A., & Caddell, J. M. (1996). Prevalence of Psychiatric Disorders Among Incarcerated Women. *Arch Gen psychiatry*, 513-519.

Jule, A. (2014). Gender Theory. *Michalos, A.C. Encyclopedia of Quality of Life and Well-Being Research. Springer, Dordrecht*.

Kahan, D., Lamanna, D., Rajakulendran, T., Noble, A., & Stergiopoulos, V. (2020). Implementing a trauma-informed intervention for homeless female survivors of gender-based violence: Lessons learned in a large Canadian urban centre. *Health Soc Care Community*, 28.

Kapilashrami, A., Hill, S., & Meer, N. (2015). What can health inequalities researchers learn from an intersectionality perspective? Understanding social dynamics with an inter-categorical approach? *Social Theory & Health*, 13, 288-307.

Kelly, M. (1994). *Critique and power: Recasting the Foucault/Habermas debate.* Boston: MIT Press.

Kim, B. E., Gilman, A. B., Kosterman, R., & Hill, K. G. (2019). Longitudinal associations among depression, substance abuse, and crime: A test of competing hypotheses for driving mechanisms. *Journal of Criminal Justice*, 50-57.

Kim, S., Johnson, T., Goswami, S., & Puisis, M. (2011). Risk factors for homelessness and sex trade among incarcerated women: A Structural equation model. *J Int Womens Stud.*, 12(1):128-148.

Kimmel, M., & Aronson, A. (2010). *The gendered society reader.* New York: Oxford University Press.

King, E. M., & Behrman, J. R. (2009). Timing and Duration of Exposure in Evaluations of Social Programs. *The World Bank Research Observer*, 55–82.

Knight, M. (2002). The intersections of race, class, and gender in the teacher preparation of an African American social justice educator. *Equity & Excellence in Education*, 35(3), 212- 224.

Knight, M., Bunch, K., Tuffnell, D., & Patel, R. (2021). *MBRRACE-UK Saving Lives, Improving Mothers' Care – Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2017-19.* MBRRACE-UK.

Kumar, B., Meyer, H., Grøtvedt, L., Søgaard, A. J., & Strand, B. H. (2008.). *The Oslo Immigrant Health Profile.* Oslo: Norwegian Institute of Public Health.

Lacouture, A., Breton, E., Guichard, A., & Ridde, V. (2015). The concept of mechanism from a realist approach: a scoping review to facilitate its operationalization in public health program evaluation. *Implement Sci.*

Lamberti, J., Weisman, R., & Faden, D. (2004). Forensic Assertive Community Treatment: Preventing Incarceration of Adults With Severe Mental Illness. *Psychiatric Services*.

Landsberg, G. (2004). *Planning for system care change for the mentally ill involved with the criminal justice system in New York City: a blueprint for action but obstacles to implementation.* Community Mental Health Report.

LankellyChase Foundation. (2015). *The Hard Edges.* London: LankellyChase Foundation.

Lapalme, J., Haines-Saah, R., & Frohlich, K. L. (2019). More than a buzzword: how intersectionality can advance social inequalities in health research. *Critical Public Health*, 1-7.

Laycock, A., Bailie, J., Matthews, V., & Bailie, R. (2019). Using developmental evaluation to support knowledge translation: reflections from a large-scale quality improvement project in Indigenous primary healthcare. *Health Research Policy and Systems* , volume 17, 70 .

Leeser, R. (2011). *English indices of deprivation 2010: a London perspective.* London: Greater London Authority.

Leonard, M., Graham, S., & Bonacum, D. (2004). The human factor: the critical importance of effective teamwork and communication in providing safe care. *BMJ Quality & Safety*, 13:i85-i90.

Levenson, J. (2014). Incorporating trauma-informed care into evidence-based sex offender treatment. *Journal of Sexual Aggression*, 9-22.

Levine-Rasky, C. (2011). Intersectionality theory applied to whiteness and middleclassness. *Social Identities*, 17(2), 239-253.

Liamputtong, P. (2007). *Researching the vulnerable.* England: SAGE publications.

Lien, E., Nafstad, P., & Rosvold, E. (2008). Non-western immigrants' satisfaction with the general practitioners' services in Oslo, Norway. . *Int J Equity Health*, 7:7.

Liu, H., & al., e. (2013). Gender in Marriage and Life Satisfaction Under Gender Imbalance in China: The Role of Intergenerational Support and SES. *Social Indicators Research, vol. 114, no. 3*, 915-933.

Locock, L., Kirkpatrick, S., Brading, L., & al., e. (2019). Involving service users in the qualitative analysis of patient narratives to support healthcare quality improvement. Res Involv Engagement of patient narratives to support healthcare quality improvement. *Res Involv Engagem*, 5,1.

Long, J., Sullivan, C., & Woodldredge, J. (2018). Matching Needs to Services: Prison Treatment Program Allocations. *Criminal Justice and Behavior*, 674-696.

López, N., & Gadsden, V. L. (2016). *Health inequities, social determinants, and intersectionality.*

Lorber, J. (1997). *The variety of feminisms and their contributions to gender equality.* Oldenburg, Germany: Bibliotheks-und Informations System der Universität Oldenburg.

Ludick, M., & Figley, C. R. (2017). Toward a mechanism for secondary trauma induction and reduction: reimagining a theory of secondary traumatic stress. *Traumatology*, 23(1), 112.

Macionis, J., & Plummer, K. (2008). *Sociology A Global Introduction (4th ed).* Essex: Prentice Hall.

Maden, T., Swinton, M., & Gunn, J. (1994). Psychiatric disorder in women serving a prison sentence. *The British Journal of Psychiatry*, 164, 44–54.

Mann, S., & Huffman, D. (2005). The Decentering of Second Wave Feminism and the Rise of the Third Wave. *Science & Society*.

Marchal, B., Dedzo, M., & Kegels, G. (2010). A realist evaluation of the management of a well- performing regional hospital in Ghana. *BMC Health Services Research*, 10,24.

Marchal, B., Dedzo, M., & Kegels, G. (2010). A realist evaluation of the management of a wellperforming regional hospital in Ghana. *BMC Health Serv Res*, 10(1):24.

Marchal, B., van Belle, S., van Olmen, J., Hoerée, T., & Kegels, G. (2012). Is realist evaluation keeping its promise? A review of published empirical studies in the field of health systems research. *Evaluation*, 18(2):192–212.

Marlowe, D., Festinger, D., Foltz, C., Lee, P., & Patapis, N. (2005). Perceived deterrence and outcomes in drug court. *Behavioural science and the law*, 183-198.

Marsh, C. A., Browne, J., Taylor, J., & Davis, D. (2017). A researcher's journey: Exploring a sensitive topic with vulnerable women. *Women and birth*, 63-69.

Matias, C., Mitchell Viesca, K., Garrison-Wade, D., Tandon, M., & Galindo, R. (2014). "What is critical whiteness doing in our nice field like critical race theory?": Applying CRT and CWS to understand the white imaginations of White teacher candidates. *Equity & Excellence in Education*, 47(3), 289-304.

Matthews, R. (2009). Beyond “so what” criminology; Rediscovering realism. *Theor Criminol.*, 13(3):341–62. .

May, V. M. (2015). *Pursuing intersectionality, unsettling dominant imaginaries. .* New York, NY: Routledge.

McCall, L. (2005). The complexity of intersectionality. . *Signs*, 30(3), 1771-1800.

McIntosh, L. G., Rees, C., Kelly, C., Howitt, S., & Thomson, L. D. (2022). *Understanding the Mental health needs of Scotland's prison population.* Edinburgh: Scotish Government.

McKean, L., & Ransford, C. (2004). *Current Strategies for Reducing Recidivism.* Chicago: Center for Impact Research.

Messerschmidt, J. (1993). *Masculinities and Crime.* Maryland: Rowman and Littlefield Publishers, Inc.

Messerschmidt, J. W. (1993). *Masculinities and crime: Critique and reconceptualization of theory.* Lanham, MD: Rowman and Littlefield Publishers, Inc.

Messerschmidt, J. W. (1997). *Crime as structured action: Gender, race, class, and crime in the making.* Thousand Oaks, CA: Sage.

Michelson, T., & Kluger, A. (2021). Can Listening Hurt You? A Meta-analysis of the Effects of Exposure to Trauma on Listener's Stress. *International Journal of Listening*, 1-11.

Miller, W. R., & Rollnick, S. (2002). *Motivational interviewing: Preparing people for change, 2nd ed.* The Guilford Press.

Miller, W. R., Sorensen, J. L., Selzer, J. A., & Brigham, G. S. (2006). Disseminating evidence-based practices in substance abuse treatment: A review with suggestions. *Journal of Substance Abuse Treatment*, 25-39.

Monro, S. (2005). Beyond Male and Female: Poststructuralism and the Spectrum of Gender. *International Journal of Transgenderism*, 8:1, 3-22.

Morant, N., Lloyd-Evans, B., Lamb, D., & al., e. (2017). Crisis resolution and home treatment: stakeholders' views on critical ingredients and implementation in England. *BMC Psychiatry*, 17, 254 .

Munetz, M. R., & Griffin, P. A. (2006). Use of the Sequential Intercept Model as an Approach to Decriminalization of People With Serious Mental Illness. *Psychiatric services*, 544-549.

Naess, M. (1992). Norwegian and immigrant patients at a health care center. Are there real differences? *Tidsskr Nor Laegeforen*, 112(3):361–4.

Naidoo, S., & Mkize, D. (2012). Prevalence of mental disorders in a prison population in Durban, South Africa. *African Journal of Psychiatry*, 30-35.

Naples, M., & Steadman, H. (2003). Can persons with co-occurring disorders and violent charges be successfully diverted? *The International Journal of Forensic Mental Health*, 2(2), 137–143.

Nash, J. C. (2008). Re-thinking intersectionality. *Feminist review* , 89(1), 1-15.

National Audit Office. (2017). *Mental health in prisons.* London: National Audit Office.

National Research Council. (2014). The growth of incarceration in the United States: Exploring causes and consequences. *Committee on Causes and Consequences of High Rates of Incarceration.* Washington, DC: The National Academies Press.

NHS England. (2024, February 17). *Liaison and Diversion*. Retrieved from NHS England: https://www.england.nhs.uk/commissioning/health-just/liaison-and-diversion/ld-faqs/

Nixon, K. L., Radtke, H. L., & Tutty, L. M. (2013). "Every Day It Takes a Piece of You Away": Experiences of Grief and Loss Among Abused Mothers Involved With Child Protective Services. *Journal of Public Child Welfare*, 7:2, 172-193.

Norlock, K. (2019). Feminist Ethics. *Standford Encyclopedia of Philosophy*.

Office of National Statistics. (2011). Retrieved from http://www.ons.gov.uk/ons/taxonomy/index.html?nscl+Population+Estimates+by+Ethnic+Group

Omdahl, B. L., & O'Donnell, C. (1999). Emotional contagion, empathic concern and communicative responsiveness as variables affecting nurses' stress and occupational commitment. *Journal of Advanced Nursing*, 29(6), 1351–1359.

Owen, B. (1998). *"In the mix": Struggle and survival in a women's prison.* Albany, NY: SUNY Press.

Parmar, A. (2017). Intersectionality, British criminology and race: Are we there yet? . *Theoretical Criminology*, 21(1), 35–45.

Parsons, T. (1959). The social structure of the family. In R. N. Anshen, *The Family: its Functions and Destiny.* New York: Harper and Row.

Patton, M. Q. (2010). *Developmental Evaluation: Applying Complexity Concepts to Enhance Innovation and Use.* Guilford: Guilford Press.

Patton, M. Q. (2016). What is essential in developmental evaluation? On integrity, fidelity, adultery, abstinence, impotence, long-term commitment, integrity, and sensitivity in implementing evaluation models. *Am J Eval.*, 37(2):250–65.

Pawson, R. (2006). Digging for nuggets: how 'Bad' research can yield 'Good' evidence. *Int J Soc Res Methodol.*, 9(2):1364-5579.

Pawson, R. (2006). *Evidence-based policy.* London: SAGE Publications Ltd.

Pawson, R. (2013). *The Science of Evaluation: a realist manifesto.* SAGE Publications Ltd.

Pawson, R., & Tilley, N. (1997). *Realistic Evaluation.* London:: Sage.

Pawson, R., Greenhalgh, T., Harvey, G., & Walshe, K. (2004). *Realist synthesis: an introduction.* Manchester: University of Manchester.

Payne, J. (1998). The attractions of joined up thinking. *Adults Learning*, 10(4): 12–14.

Pilcher, J., & Whelehan, I. (2016). *Key concepts in gender studies.* Thousand Oaks, CA: Sage Ltd.

Pittman, C. T. (2010). Race and Gender Oppression in the Classroom: The Experiences of Women Faculty of Color with White Male Students. *Teaching Sociology*, 183-196.

Polcin, D., & Korcha, R. (2015). Motivation to maintain sobriety among residents of sober living recovery homes. *Substance Abuse Rehabilitation*, 6: 103-111.

Pondé, M. P., Freire, A. C., & Mendonça, M. S. (2011). The Prevalence of Mental Disorders in Prisoners in the City of Salvador, Bahia, Brazil. *Journal of forensic sciences*, 679-682.

Potter, H. (2006). An argument for Black feminist criminology: Understanding African American women's experiences with intimate partner abuse using an integrated approach. *Feminist Criminology*, 1(2), 106-124.

Potter, H. (2008). *Battle cries: Black women and intimate partner abuse.* New York: New York University Press.

Potter, H. (2013). Intersectional criminology: Interrogating identity and power in criminological research and theory. *Critical Criminology*, 21, 305–318.

Potter, H. (2015). *Intersectionality and criminology: Disrupting and revolutionizing studies of crime.* New York, NY: Routledge.

Prison Reform Trust. (2022). *Why focus on reducing women's imprisonment?* London: Prison Reform Trust.

Prochaska, J., DiClements, C., & Norcross, J. (1992). In search of how people change. Applications to addictive behaviors. *Americal Phychology*, 1102-14.

Pryshlakivsky, J., & Searcy, C. (2021). Life Cycle Assessment as a decision-making tool: Practitioner and managerial considerations. *Journal of Cleaner Production*, 309.

QSR International Pty Ltd. (2020) NVivo (released in March 2020), h.-q.-d.-a.-s. (n.d.).

Radeloff, D., Hövel, M. t., Brennecke, G., Stoeber, F. S., Lempp, T., Kettner, M., . . . Bennefeld-Kersten, K. (2021). Suicide after reception into prison: A case-control study examining differences in early and late events. *PLOS ONE*, 1-13.

Rakow, L. F., & Wackwitz, L. A. (2004). *Feminist communication theory: Selections in context.* Thousand Oaks, CA: Sage.

Ramos, C., & Brassel, S. (2020). Intersectionality: When Identities Converge. *Catalyst*.

RAND Corporation. (2021). *Outcome Evaluation of the National Model for Liaison and Diversion.* Santa Monica, Calif., and Cambridge, UK: RAND Corporation.

Randell, R., Honey, S., Hindmarsh, J., Alvarado, N., Greenhalgh, J., Pearman, A., & al., e. (2017). A realist process evaluation of robot-assisted surgery: integration into routine practice and impacts on communication, collaboration and decision-making. . *Health Services and Delivery Research.*, Vol. 5.

Re-Entry Policy Council. (2005). *Charting the Safe and Successful Return of Prisoners to the Community.* New York: Council of State Governments.

Reiman, J. (2003). *The rich get richer and the poor get prison: Ideology, class, and criminal justice (7th ed.). .* Boston, MA: Allyn & Bacon.

Repper, J., & Carter, T. (2011). A review of the literature on peer support in mental health services. *Journal of Mental Health*, 20:4, 392-411.

Richardson, S., & Asthana, S. (2006). Inter-agency Information Sharing in Health and Social Care Services: The Role of Professional Culture . *British Journal of Social Work*, 36, 657–669.

Richie, B. E. (2012). *Arrested justice: Black women, violence, and America's prison nation.* New York: New York University Press.

Rippon, G. (2019). *The Gendered Brain: The New Neuroscience that shatters the Myth of the Female Brain.* London: The Bodley Head.

Ritchie, B. E. (2004). Feminist ethnographies of women in prison. *Feminist Studies*, 30(2), 438-450.

Robert, E., Samb, O., & Marchal, B. (2017). Building a middle-range theory of free public healthcare seeking in sub-Saharan Africa: a realist review. *Health Policy Plan.*, 1–13.

Robinson, T. (1993). "The Intersections Of Gender, Class, Race, And Culture: On Seeing Clients Whole." . *Journal of Multicultural Counseling and Development*, 50-8.

Rodriguez, J. K., & Ridgway, M. (2023). Intersectional reflexivity: Fieldwork experiences of ethnic minority women researchers. *Gender, Work & Organization*, 1273-1295.

Rosette, A., & Tost, L. (2013). Perceiving social inequity: When subordinategroup positioning on one dimension of social hierarchy enhances privilege recognition on another. *Psychology Science*, 24(8), 1420-1427.

Rycroft-Malone, J., Fontela, M., Bick, D., & Seers, K. (2010). Arealistic evaluation: the case of protocol-based care. *Implementation Science*, 38.

Salazar, C. F., & Abrams., L. P. (2005). "Conceptualizing Identity Development in Members of Marginalized Groups.". *Journal of Professional Counseling: Practice, Theory and Research*, 33(1):47-59.

Sands, R. G., Bourjolly, J., & Roer-Strier, D. (2007). Crossing Cultural Barriers in Research Interviewing. *Qualitative Social Work*, 6:3, 353-372.

Schulz, A. J., & Mullings, L. (2006). Gender, race, class, & health: . *Intersectional approaches*.

Schulz, A., & Mullings, L. (2006). *Gender, race, class and health: Intersectional approaches. .* San Francisco: Jossey-Bass.

Sen, G., & Iyer, A. (2012). Who gains, who loses and how: Leveraging gender and class intersections to secure health entitlements. *Social Science & Medicine*, 7(4),1802 - 1811.

Shaw, J., & Turnbull, P. (2006). Suicide in custody. *Psychiatry*, 286-288.

Shields, S. A. (2008). Gender: An intersectionality perspective. . *Sex Roles*, 59(5/6), 301-311.

Simpson, S. S. (2000). *OF CRIME & CRIMINALITY: The Use of Theory in Everyday Life.* California: Pine Forge Press.

Singleton, N., Meltzer, H., Gatward, R., Coid, J., & Deasy, D. (1998). *Psychiatric morbidity among prisoners in England and Wales.* London: The Stationery Office.

Small, K. (2000). Female Crime in the United States 1963-1998: An Update. *Gender Issues*, 75-90.

Smith, A. (2005). *Conquest: Sexual violence and American Indian genocide.* Cambridge, MA: South End Press.

Spelman, E. V. (1988). *Inessential woman: Problems of exclusion in feminist thought. .* Boston, MA: Beacon Press.

Srivastava, K., & al., e. (2017). Misogyny, Feminism, and Sexual Harassment. *Industrial Psychiatry Journal*, 111-113.

Stamarski, C. S., & Leanne, S. (2015). Gender Inequalities in the Workplace: The Effects of Organizational Structures, Processes, Practices, and Decision Makers' Sexism. *Frontiers in Psychology*.

Steadman, H. J. (2003). *Prioritizing and designing options for jail diversion in your community.* Delmar, NY.

Steadman, H. J., & Naples, M. (2005). Assessing the Effectiveness of Jail Diversion Programs for Persons with Serious Mental Illness and Co-Occurring Substance Use Disorders. *Behavioral Sciences and the Law*, 163–170.

Steffensmeier, D., & Allan, E. (1996). Gender and Crime: Toward a Gendered Theory of Female Offending. *Annual Review of Sociology*, 22:1, 459-487.

Stevens, E. (2013). Safeguarding vulnerable adults: exploring the challenges to best practice across multi-agency settings. *The Journal of Adult Protection*, 85-95.

Stevenson, C. (2013). A qualitative exploration of relations and interactions between people who are homeless and use drugs and staff in homeless hostel accommodation. *Journal of Substance Use*, 134-140.

Stockfelt, S. (2018). We the minority-of-minorities: a narrative inquiry of black female academics in the United Kingdom. *British Journal of Sociology of Education*, 1012-1029.

Subcommittee on Criminal Justice. (2004). *New Freedom Commission on Mental Health.* Rockville, Md: Substance Abuse and Mental Health Services Administration.

Substance Use and Mental Health Services Administration. (2014). *Trauma-Informed Care in Behavioral Health Services.* Rockville (MD): Center for Substance Abuse Treatment (US).

Sullivan, A. (2020). Response to Fugard and Hines. *International Journal of Social Research Methodology*, 23(5), pp.539-540.

Suls, J., Martin, R., & Wheeler, L. (2002). Social Comparison: Why, With Whom, and With What Effect? *Current Directions in Psychological Science*, 11(5), 159–163.

Swavola, E., Riley, K., & Subramanian., R. (2016). Overlooked: Women and Jails in an Era of Reform. . *New York: Vera Institute of Justice*.

Sweeney, A., Clement, S., Filson, B., & Kennedy, A. (2016). Trauma-informed mental healthcare in the UK: What is it and how can we further its development? *Mental Health Review Journal*, 21(3), 174–192.

Sweeney, A., Filson, B., Kennedy, A., Collinson, L., & Gillard, S. (2018). A paradigm shift: Relationships in trauma-informed mental health services. *BJPsych Advances*, 24(5), 319–333.

Syed, M. (2010). Disciplinarity and methodology in intersectionality theory and research. *American Psychologist,*, 65(1), 61-62.

Tajfel, H., & Turner, J. C. (2004). *The Social Identity Theory of Intergroup Behavior.* Psychology Press.

Tarquinio, C., Kivits, J., Minary, L., Coste, J., & Alla, F. (2014). Evaluating complex interventions: Perspectives and issues for health behaviour change interventions. *Psychology & Health*, 35-51.

Taxman, F., Thanner, M., & Weisburd, D. (2006). Risk, Need, And Responsivity (RNR): It All Depends. *Crime Delinq*, 52(1): 28–51.

Taylor, R. (2004). *Women in prison and children of imprisoned mothers: preliminary research paper. .* Geneva: Quaker United Nations Office.

Teplin, L. A., Abram, K. M., & McClelland, G. M. (1996). Prevalence of Psychiatric Disorders Among Incarcerated Women. *Arch Gen Psychiatry*, 505-512.

Thornton, A. J., Graham-Kevan, N., & Archer, J. (2010). Adaptive and maladaptive personality traits as predictors of violent and nonviolent offending behavior in men and women. *Aggressive behaviour*, 141-217.

Tonry, M. (2011). *Punishing race: A continuing American dilemma.* Oxford University Press.

Tung, T., Hsiao, Y., Shen, S., & al., e. (2019). The prevalence of mental disorders in Taiwanese prisons: a nationwide population-based study. *Soc Psychiatry Psychiatr Epidemiol* , 54, 379–386.

UK House of Commons. (2022). *Women in Prison.* London: UK House of Commons.

University College London. (2023, 11 23). *Apply to the UCL Research Ethics Committee*. Retrieved from University College London: https://www.ucl.ac.uk/research-ethics/apply-ethical-approval/apply-ucl-research-ethics-committee

Van Voorhis, P., Wright, E. M., Salisbury, E., & Bauman, A. (2010). Women's Risk Factors and Their Contributions to Existing Risk/Needs Assessment: The Current Status of a Gender-Responsive Supplement. *Criminal Justice and Behavior*, 37(3), 261–288.

VanDeMark, N. (2007). Policy on reintegration of women with histories of substance abuse: a mixed methods study of predictors of relapse and facilitators of recovery. *Subst Abuse Treat Prev Policy.* , 2: 28-38.

VanderZee, K. L., & Buunk, B. P. (1993). Social comparison as a mediator between health problems and subjective health evaluations . *British journal of social pshychology*, 53-65.

Varvin, S. (2009). Physicians' attitude towards treating refugee patients. *Tidsskr Nor Laegeforen*, 129(15):1488–90.

Veenstra, G. (2001). Race, gender, class, and sexual orientation: Intersecting axes of inequality and self-rated health in Canada. *International Journal for Equity in Health*, 10 (1), 1-11.

Vicens, E., Tort, V., Dueñas, R., Muro, Á., Pérez-Arnau, F., Arroyo, J., . . . Sarda, P. (2011). The prevalence of mental disorders in Spanish prisons. *Crim Behav Ment Health*, 21: 321-332. .

Vieira, T., Skilling, T., & Peterson-Badali, M. (2009). Matching court-ordered services with treatment needs: Predicting treatment success with young offenders. *Criminal Justice and Behavior*, 36(4), 385–401.

Villalón, R. (2010). *Violence against Latina immigrants: Citizenship, inequality, and community.* New York: New York University Press.

Viruell-Fuentes, E., Miranda, P., & Abdulrahim, S. (2012). More than culture: Structural racism, intersectionality theory, and immigrant health. . *Social Science & Medicine,*, 75, 2099-2106.

Vogel, M. (2014.). *Addressing Pedagogical Solitude. A Realist Evaluation of Organisation Development at a German Higher Education Institution.* London: Univeristy of London.

Walker. (2007). The inter-generational transmission of trauma: the effects of abuse on the survivor's relationship with their children and on the children themselves. *Eur.j. ofPsychothempy, Counselling & Healrh*, 28 1-296.

Walker, J., Illingworth, C., Canning, A., Garner, E., Woolley, J., Taylor, P., & Amos, T. (2013). Changes in mental state associated with prison environments: a systematic review. *Acta Psychiatrica Scandinavica*, 427-436.

Walsh, C. A., & Rutherford, G. E. (2009). Characteristics of Home: Perspectives of Women Who Are Homeless. *The qualitative report*, 229-317.

Walsh, C. A., Beamer, K., Alexander, C. E., & Shier, M. L. (2010). Listening to the silenced: Informing homeless shelter design for women through investigation of site, situation, and service. *Social Develeopment Issues*, 35-49.

Warner, L. (2008). A best practices guide to intersectional approaches in psychological research. . *Sex Roles*, 59(5-6), 454-463.

Webber, M., & Fendt-Newlin, M. (2017). A review of social participation interventions for people with mental health problems. *Soc Psychiatry Psychiatr Epidemiol.* , 52(4):369-380.

Weber, L. (2016). Defining Contested Concepts. In S. J. Ferguson, *Race, Gender and Social Class: Dimensions of Inequality and Identity.* California: Sage.

Weber, L., & Parra-Medina, D. (2003). Intersectionality and Women's Health: Charting a Path to Eliminating Health Disparities. *Advances in Gender Research*, Vol. 7, pp. 181–230).

Wertheimer, D. (2000). *Creating Integrated Service Systems for People with Co-Occurring Disorders Diverted from the Criminal Justice System: The King County (Seattle) Experience.* Rockville, MD : Substance Abuse and Mental Health Services Admin.

Wesely, J., & Miller, J. (2018). Justice System Bias Perceptions of the Dually Marginalized: Observations from a Sample of Women Ex-offenders. *Victims & Offenders*.

West, C., & Zimmerman, D. (1987). Doing gender. . *Gend Soc.* , 1:125–51.

WHO. (1993). *The ICD-10 classification for mental and behavioural disorders. Diagnostic criteria for research.*

WHO Regional Office for Europe. (2023). *Status report on prison health in the WHO European region 2022.* Copenhagen: WHO Regional Office for Europe.

Wildeman, C., & Turney, K. (2014). Positive, Negative, or Null? The Effects of Maternal Incarceration on Children's Behavioral Problems. *Demography*, 51 (3): 1041–1068.

Williams, J., Spencer, Z., & Wilson, S. (2020). I am Not Your Felon: Decoding the Trauma, Resilience, and Recovering Mothering of Formerly Incarcerated Black Women. *Crime & Delinquency*.

Williams, L., Burton, C., & Rycroft-Malone, J. (2013). What works: a realist evaluation case study of intermediaries in infection control practice. *Journal of Advanced Nursing*, 69(4):915-26.

Willingham, B. C. (2011). Black women's prison narratives and the intersection of race, gender, and sexuality in US Prisons. *Critical Survey*, 23(3), 55–66.

Willis, K., & Rushforth, C. (2003, October). The Female Criminal: An Overview of Women's Drug Use and Offending Behaviour. *Trends and issues in crime and criminal justice*, 264.

Wilson, D., & Neville, S. (2009). Culturally safe research with vulnerable populations. *J Aust Nurs Prof*, 69-79.

Wilson, J. M., Fauci, J. E., & Goodman, L. A. (2015). Bringing trauma-informed practice to domestic violence programs: A qualitative analysis of current approaches. *American Journal of Orthopsychiatry*, 85(6), 586–599.

Wong, G., Westhorp, G., Manzano, A., & al., e. (2016). RAMESES II reporting standards for realist evaluations. *BMC Med* , 14, 96.

Wong, G., Westhorp, G., Pawson, R., & Greenhalgh, T. (2013). *Realist Synthesis: RAMESES Training Materials.*

World Health Organisation. (2007). *Interventions to address HIV in prisons: HIV care, treatment and support.* Geneva: World Health Organisation.

World Health Organization. (2007). *Unequal, unfair, ineffective and inefficient: gender inequity in health. Why it exists and how we can change it.* Geneva: World Health Organization.

World Health Organization Regional Office for Europe. (2007). *Health in prisons. A WHO guide to the essentials in prison health.* Copenhagen: World Health Organization Regional Office for Europe.

World Health Organization Regional Office for Europe. (2009). *Declaration on women's health in prison: correcting gender inequity in prison health.* Copenhagen.

Yuval-Davis, N. (2015). Situated intersectionality and social inequality. *Raisons politiques*, (2), 91-100.

Zygmunt, A., Olfson, M., Boyer, C., & Mechanic, D. (2002). Interventions to improve medication adherence in schizophrenia. *Am J Phychiatry*, 1653-64.

Appendix B Search strategy

Below are the search strategies for the following electronic databases: MEDLINE, EMBASE, PsycINFO, PscyARTICLES, Social policy and practice, ASSIA, IBSS.

As I am using a realist methodology, searches will be iterative and as such, I will run searches that are not described below.

Medline, EMBASE, PscyINFO, PscyARTICLES, Social policy and practice

Search #1

1. Prisoners/
2. Prisons/
3. Incarcerat*.mp.
4. Police.mp.
5. Probation.mp.
6. Parole.mp.
7. Crim*.mp.
8. Arrest.mp.
9. Prison*.mp.
10. 1 or 2 or 3 or 4 or 5 or 6 or 7 or 8 or 9
11. Women/
12. Female/
13. wom?n.mp.
14. female*.mp.
15. 11 or 12 or 13 or 14
16. mental competency/ or mental health/ or psychology, applied/
17. Anxiety/
18. Mental Disorders/
19. Mental health.mp.
20. mental wellbeing.mp.
21. mental well-being.mp.
22. 16 or 17 or 18 or 19 or 20 or 21
23. Diversion service*.mp.
24. Community service.mp.
25. Prearrest diversion.mp.
26. Pre-arrest diversion.mp.
27. Deferred adjudication.mp.
28. Alternative sentenc*.mp.
29. Suspended sentenc*.mp.
30. 23 or 24 or 25 or 26 or 27 or 28 or 29
31. 10 and 15 and 22 and 30
32. remove duplicates from 31

Search #2 – criminal thinking

1. Prisoners/
2. Prisons/
3. Incarcerat*.mp.
4. Police.mp.
5. Probation.mp.
6. Parole.mp.
7. Crim*.mp.
8. Arrest.mp.
9. Prison*.mp.
10. 1 or 2 or 3 or 4 or 5 or 6 or 7 or 8 or 9
11. Crim* think*
12. 11
13. Diversion service*.mp.
14. Prearrest diversion.mp.
15. Pre-arrest diversion.mp.
16. Deferred adjudication.mp.
17. Alternative sentenc*.mp.
18. Suspended sentenc*.mp.
19. 13 or 14 or 15 or 16 or 17 or 18
20. 10 and 12 and 19
21. remove duplicates from 20

Search #3 – relationships

1. Prisoners/
2. Prisons/
3. Incarcerat*.mp.
4. Police.mp.
5. Probation.mp.
6. Parole.mp.
7. Crim*.mp.
8. Arrest.mp.
9. Prison*.mp.
10. 1 or 2 or 3 or 4 or 5 or 6 or 7 or 8 or 9
11. Mother*
12. Parent*
13. Family
14. Friend*
15. Support network*
16. Relation*
17. 11 or 12 or 13 or 14 or 15 or 16
18. Diversion service*.mp.
19. Prearrest diversion.mp.
20. Pre-arrest diversion.mp.
21. Deferred adjudication.mp.
22. Alternative sentenc*.mp.
23. Suspended sentenc*.mp.
24. 19 or 20 or 21 or 22 or 23
25. 10 and 17 and 24
26. remove duplicates from 25

Search #4 – stabilisation through disruption

1. Prisoners/
2. Prisons/
3. Incarcerat*.mp.
4. Police.mp.
5. Probation.mp.
6. Parole.mp.
7. Crim*.mp.
8. Arrest.mp.
9. Prison*.mp.
10. 1 or 2 or 3 or 4 or 5 or 6 or 7 or 8 or 9
11. Stabili*
12. Disrupt*
13. Cycle
14. 11 or 12 or 13
15. Diversion service*.mp.
16. Prearrest diversion.mp.
17. Pre-arrest diversion.mp.
18. Deferred adjudication.mp.
19. Alternative sentenc*.mp.
20. Suspended sentenc*.mp.
21. 19 or 20 or 21 or 22 or 23 or 24
22. 10 and 14 and 21
23. remove duplicates from 22

Search #4 – integration of systems

1. Prisoners/
2. Prisons/
3. Incarcerat*.mp.
4. Police.mp.
5. Probation.mp.
6. Parole.mp.
7. Crim*.mp.
8. Arrest.mp.
9. Prison*.mp.
10. 1 or 2 or 3 or 4 or 5 or 6 or 7 or 8 or 9
11. System integrat*
12. Support integrat*
13. Integrate*
14. 11 or 12 or 13 or 14 or 15 or 16
15. Diversion service*.mp.
16. Prearrest diversion.mp.
17. Pre-arrest diversion.mp.
18. Deferred adjudication.mp.
19. Alternative sentenc*.mp.
20. Suspended sentenc*.mp.
21. 19 or 20 or 21 or 22 or 23
22. 10 and 17 and 25

23. remove duplicates from 26

Searches following first round interviews:

ASSIA and IBSS and criminology

Search #1

Noft(Prisoner* OR prison* OR incarcerat* OR police OR probation OR parole OR crim* OR arrest) AND noft(wom*n OR female) AND noft(mental competency OR mental health OR psychology OR anxiety OR mental disorder* OR mental wellbeing OR mental well-being) AND noft(diversion service* OR community service OR pre-diversion OR prearrest diversion OR deferred adjudication OR alternative sentenc* OR suspended sentenc*)

Search #2 – criminal thinking

Noft(Prisoner* OR prison* OR incarcerat* OR police OR probation OR parole OR crim* OR arrest) AND noft(Crim* think*) AND noft(diversion service* OR pre-diversion OR prearrest diversion OR deferred adjudication OR alternative sentenc* OR suspended sentenc*)

Search #3 – relationships

Noft(Prisoner* OR prison* OR incarcerat* OR police OR probation OR parole OR crim* OR arrest) AND noft(mother* OR Parent* OR Family OR Friend* OR Support network* OR Relation*) AND noft(diversion service* OR pre-diversion OR prearrest diversion OR deferred adjudication OR alternative sentenc* OR suspended sentenc*) [added limit to journals in last 10 years]

Search #4 – stability

Noft(Prisoner* OR prison* OR incarcerat* OR police OR probation OR parole OR crim* OR arrest) AND noft(Stabili* OR Disrupt* OR Cycle) AND noft(diversion service* OR pre-diversion OR prearrest diversion OR deferred adjudication OR alternative sentenc* OR suspended sentenc*)

Search #5 – system integration

Noft(Prisoner* OR prison* OR incarcerat* OR police OR probation OR parole OR crim* OR arrest) AND noft(System integrat* OR Support integrat* OR Integrate*) AND noft(diversion service* OR pre-diversion OR prearrest diversion OR deferred adjudication OR alternative sentenc* OR suspended sentenc*)

Searches to follow first round interviews:

Motivation to change

Noft(Prisoner* OR prison* OR incarcerat* OR police OR probation OR parole OR crim* OR arrest) AND noft(diversion service* OR pre-diversion OR prearrest diversion OR deferred adjudication OR alternative sentenc* OR suspended sentenc*) AND noft(motivation OR motivation to change OR inspir*) AND (wom*n OR female)

Graduation as a right of passage

Noft(Prisoner* OR prison* OR incarcerat* OR police OR probation OR parole OR crim* OR arrest) AND noft(diversion service* OR pre-diversion OR prearrest diversion OR deferred adjudication OR alternative sentenc* OR suspended sentenc*) AND noft(graduation OR right of passage) AND (wom*n OR female)

Legal leverage or threat of sanctions

Noft(Prisoner* OR prison* OR incarcerat* OR police OR probation OR parole OR crim* OR arrest) AND noft(diversion service* OR pre-diversion OR prearrest diversion OR deferred adjudication OR alternative sentenc* OR suspended sentenc*) AND noft(leverage) AND (wom*n OR female)

Risk and responsivity principle

Noft(Prisoner* OR prison* OR incarcerat* OR police OR probation OR parole OR crim* OR arrest) AND noft(diversion service* OR pre-diversion OR prearrest diversion

OR deferred adjudication OR alternative sentenc* OR suspended sentenc*) AND noft(risk and responsivity) AND (wom*n OR female)

Dynamic risk factors

Noft(Prisoner* OR prison* OR incarcerat* OR police OR probation OR parole OR crim* OR arrest) AND noft(diversion service* OR pre-diversion OR prearrest diversion OR deferred adjudication OR alternative sentenc* OR suspended sentenc*) AND noft(dynamic risk*) AND (wom*n OR female)

Family relationships

Noft(Prisoner* OR prison* OR incarcerat* OR police OR probation OR parole OR crim* OR arrest) AND noft(diversion service* OR pre-diversion OR prearrest diversion OR deferred adjudication OR alternative sentenc* OR suspended sentenc*) AND noft(motivation OR treatment adherence OR adherence) AND noft(family) AND (wom*n OR female)

Relationships with peers

Noft(Prisoner* OR prison* OR incarcerat* OR police OR probation OR parole OR crim* OR arrest) AND noft(diversion service* OR pre-diversion OR prearrest diversion OR deferred adjudication OR alternative sentenc* OR suspended sentenc*) AND noft(motivation OR treatment adherence OR adherence) AND noft(peer*) AND (wom*n OR female)

Citizenship and community

Noft(Prisoner* OR prison* OR incarcerat* OR police OR probation OR parole OR crim* OR arrest) AND noft(diversion service* OR pre-diversion OR prearrest diversion OR deferred adjudication OR alternative sentenc* OR suspended sentenc*) AND noft(motivation OR treatment adherence OR adherence) AND noft(citizenship OR belonging OR community) AND (wom*n OR female)

Relationship with caseworkers / practitioners / judges

Noft(Prisoner* OR prison* OR incarcerat* OR police OR probation OR parole OR crim* OR arrest) AND noft(diversion service* OR pre-diversion OR prearrest diversion OR deferred adjudication OR alternative sentenc* OR suspended sentenc*) AND noft(motivation OR treatment adherence OR adherence) AND noft(caseworker* OR practitioner* OR judge*) AND (wom*n OR female)

Concurrent substance disorders

Noft(Prisoner* OR prison* OR incarcerat* OR police OR probation OR parole OR crim* OR arrest) AND noft(diversion service* OR pre-diversion OR prearrest diversion OR deferred adjudication OR alternative sentenc* OR suspended sentenc*) AND noft(drug disorder OR alcohol disorder OR drug abuse OR alcohol abuse OR co-occurring) AND (wom*n OR female)

Education and employment

Noft(Prisoner* OR prison* OR incarcerat* OR police OR probation OR parole OR crim* OR arrest) AND noft(diversion service* OR pre-diversion OR prearrest diversion OR deferred adjudication OR alternative sentenc* OR suspended sentenc*) AND noft(stabilisation OR education OR job OR employment OR training OR vocation) AND (wom*n OR female)

Housing

Noft(Prisoner* OR prison* OR incarcerat* OR police OR probation OR parole OR crim* OR arrest) AND noft(diversion service* OR pre-diversion OR prearrest diversion OR deferred adjudication OR alternative sentenc* OR suspended sentenc*) AND noft(stabilisation OR housing OR home OR hostel) AND (wom*n OR female)

Poverty

Noft(Prisoner* OR prison* OR incarcerat* OR police OR probation OR parole OR crim* OR arrest) AND noft(diversion service* OR pre-diversion OR prearrest diversion OR deferred adjudication OR alternative sentenc* OR suspended sentenc*) AND noft(poverty) AND (wom*n OR female)

Access to services

Noft(Prisoner* OR prison* OR incarcerat* OR police OR probation OR parole OR crim* OR arrest) AND noft(diversion service* OR pre-diversion OR prearrest diversion OR deferred adjudication OR alternative sentenc* OR suspended sentenc*) AND noft(access to services OR service access OR access) AND (wom*n OR female)

Balancing public safety concerns and individuals' rights to receive health services

Noft(Prisoner* OR prison* OR incarcerat* OR police OR probation OR parole OR crim* OR arrest) AND noft(diversion service* OR pre-diversion OR prearrest diversion OR deferred adjudication OR alternative sentenc* OR suspended sentenc*) AND noft(public safety OR rights OR worthy) AND noft(wom*n OR female)

Training / knowledge sharing

Noft(Prisoner* OR prison* OR incarcerat* OR police OR probation OR parole OR crim* OR arrest) AND noft(diversion service* OR pre-diversion OR prearrest diversion OR deferred adjudication OR alternative sentenc* OR suspended sentenc*) AND noft(practitioner training OR knowledge sharing) AND noft(wom*n OR female)

Appendix C Data extraction table

Overview		
Title		
Author		
Year		
Type: Primary study / Review / Grey literature		
Type: Article, Journal, etc.		
Study intervention		
Methods		
Participants		
Country		
Study of participants or practitioners?		
More detail		
Relevance		
Relevance Rating: Very relevant / moderately relevant / less relevant		
Does it address a mechanism, context, or outcome?		
Rigour Rating: Very rigorous / moderately rigorous / less rigorous?		
Risk of bias:	**Author's judgement**	**Support for judgement**
Experimental studies		
Sequence generation: did the study contain a sufficiently detailed description of the method used to generate the allocation sequence so as to enable an assessment of whether it should have produced comparable groups?		

Allocation concealment: did the study contain a sufficiently detailed description of the method used to conceal the allocation sequence, enabling an assessment of whether participants and staff could have foreseen intervention schedules before or during recruitment?		
Blinding: did the studies describe any measures used to blind outcome assessors in sufficient detail so as to assess possible knowledge of which intervention a given participant might have received?		
Incomplete outcome data: did studies report data on attrition, including the numbers involved (compared with total randomised) and the reasons?		
Selective outcome reporting: did investigators attempt to assess the possibility of selective outcome reporting?		
Other sources of bias: was the study apparently free of other problems that could put it at a high risk of bias?		
Evidence: context		
What is the contextual factor?		
How does this contextual factor contribute to an initial theory?		
Location: Page number		
How do the authors interpret this result?		
Does the interpretation contribute to our initial theories?		
Mechanism 1, 2, 3, all..?		
Position Support, refute, other?		
Evidence: mechanism proposed		
What is the mechanism proposed?		
How and why does it generate an outcome?		
How does it fit with the initial theories?		
Location: Page number, paragraph		
How do the authors interpret this result?		
Does the interpretation contribute to our initial theories?		

Evidence: outcome of the mechanism		
What is the outcome proposed?		
How is this outcome defined?		
How does it fit with the initial theories?		
Location: Page number, paragraph		
How do the authors interpret this result?		
Does the interpretation contribute to our initial theories?		
Additional comments about this literature		
Any citations in this article that could be appropriate for the review		

Appendix D Realist review: Context-Mechanism-Outcome configurations

Essential Principle 1: Successful diversion requires connections and coordination between services across the healthcare system Hypothesis 1: Coordinated and integrated collaboration between healthcare and criminal justice systems, allows for flexible, prioritised and adaptable access to relevant services, particularly for complex case management Hypothesis 2: Having a focal point in the community can enable continuity of care and appropriate identification of follow-on services, and provides additional benefits to the community within which a programme is based Hypothesis 3: Multi-sectoral teams, training and knowledge sharing can enable teams to work together towards a common goal of health improvement, which supports the identification and facilitation of effective treatment				
Contexts	**Mechanisms**	**Outcomes**	**Refs: included studies**	**Confidence in findings**
Programme design - enabling H1: Specialized diversion programmes must link clients into effective treatment services H1: Models of service delivery need to be created and assessed, to accompany any diversion program H1: Cognitively-based interventions targeting behavioural and situational factors, access to care, and legal leverage Immediate assignment of a case manager with a small caseload H3: Judges trained to recommend non-grant-funded public and private interventions H3: Identify and address antisocial cognition and attitudes H3: Healthcare providers and policy makers recognise importance of ensuring access to services that target modifiable risk factors H1: Treatment and support services should be delivered in as comprehensive and integrated a manner H3: Eligibility criteria to include those with multiple risk factors	Mechanism: **Women understand how they are moving through systems** Explainer: If an intervention can provide access to a continuum of	Access to a wider range of appropriate services Positive mental health outcomes Increased engagement Reduced	(English and Mande 1991, Ryder, Kraszlan et al. 2001, Clayfield, Fisher et al. 2005, Cosden, Ellens et al. 2005, May and Wood	High

H1: Coordination of mental health and criminal justice services H3: incorporation of probation officers as team members Programmes should be implemented as an intensive treatment and support program rather than a coercive extension of probation H3: Formal forensic training, or clinicians trained in the CJ system H2: Provide a feeling of availability of services to prevent feeling of resignation around inability to fully address issue H2: Follow-on services arranged prior to release H2: If residential element, release during normal workday hours to allow for seamless transition H3: Offering access to all offenders on probation, irrespective of age, gender or type of offence H2: Assisting offenders to register with local health services H3: Assessment and screening by clinical professionals H3: Client- treatment matching - clients are referred to different treatments based upon certain characteristics of the client H3: multidisciplinary team with capacity to access a range of services related to housing, addiction, vocational rehabilitation, and social services, in addition to formal mental health care H3: Training arrangements to support screening and assessment H3: Assessment supported by multi-agency arrangements H1: Clear protocols, e.g. decision trees, to determine what happens on the basis of the result of screening and assessment Case managers empowered to make decisions Individuals - disabling H1: Severity of drug abuse problems	services, the fragmentation can be minimised and women can understand how they are moving through systems	recidivism Promote treatment adherence Cost-effectiveness	2005, Gordon, Barnes et al. 2006, Davis, Fallon et al. 2008, Erickson, Lamberti et al. 2009, Hean, Heaslip et al. 2010, Lange, Rehm et al. 2011, Dyer 2012, Scott, McGilloway et al. 2013)	
Programme design - enabling H2: Programme developed within context of the community and as part of the continuum of services	Mechanism: **Communities are**	‘Bleeding’ of new treatments in to	(Steadman, Deane et al.	High

available - strength of the essential services found in the community H3: Training for crisis intervention officers – knowledge of mental health approaches to incidents H2: Availability of beds at an appropriate level of security H2: Specific, long term funding H1: Diversion programmes should be implemented all together as a system of diversion H2: Planners must recognise MHC permanence, think prospectively, and take action to implement strategies to provide resources for the indefinite support of MHCs H2: Public engagement to allow partnerships to forge, increases community involvement and creates a more responsive court H2: Long-term staffing; court officials and law enforcement personnel should be provided with appropriate training to ensure continued staff replenishment H2: Most contacts with patients and others involved in their treatment (such as family members) occur in the patient's home or in community settings, not in mental health offices H2: Respond quickly to patient emergencies, even when they occur after regular business hours H2: Broad knowledge of community resources H2: Centrality of community partnerships - police departments view the program as part of its community policing initiatives H2: Retain social bonds with the community H2: Community partnerships, e.g. business leaders with buy in at a senior level Access to creative and social clubs Programme design - disabling H3: Lack of professional staffing H2: Segregated funding streams H2: Slim empirical basis H2: Undue reliance on grant funding	**empowered to host treatment** Explainer: Empowering communities to host treatment enables continuity of planning and specific funding of programmes and enables discussion around broader community benefits of diversion programmes	the community to improve community services Reduced risk of incarceration Promote goals of diversion programmes More accurate assessment Maximise patient options Increased opportunities (e.g. employment)	2000, Wertheimer 2000, Bond, Drake et al. 2001, Cosden, Ellens et al. 2005, Acquaviva 2006, Prins and Draper 2009, Winstone and Pakes 2009, Lange, Rehm et al. 2011, Cloud and Davis 2013, Aarten, Denkers et al. 2014, Alarid and Rubin 2018)	

Programme design - enabling H1: Diversion programmes cannot focus solely on 'diversion from the criminal justice system' but also have to focus on 'diversion into the mental health system' H1: Separation of CJ and mental health goals Goal setting in partnership with offenders H1: Recovery model approach rather than punitive H1: Active coordination of functions for a particular client based on risk status and ongoing monitoring of treatment H1: Enforcement capability enables broadening of inclusion criteria H1: Policy and program development needs to be structured so that these interests are not mutually exclusive H1: Focus on avoiding incarceration rather than on avoiding criminal charges	Mechanism: **There is confidence in the balance between public safety concerns and rights to receive health services** Explainer: Confidence in the balance between public safety concerns and rights to receive health services enables a broadening of participation and accessibility of diversion programmes	Increased access to treatment services	(Draine and Solomon 1999, Broner, Nguyen et al. 2003, Marlowe 2003, Naples and Steadman 2003, Broner, Lattimore et al. 2004, Case, Steadman et al. 2009, Coffman, Shivale et al. 2017, Alarid and Rubin 2018)	Moderate

Programme design - enabling H1: Build buy in for diversion efforts and develop relationships between agencies through planning workshops H3: Cross-systems education and training to raises awareness of available services, resources, people and processes H1: Creation of a hub to address issues H1: Dedicated lead person to work across systems – active management H1: Willingness to change beliefs, behaviours, practices and policies H1: Focus on doing and adapting – working around barriers H3: Frequent communication among stakeholders H1: Collaboration on funding applications H1: Formal partnerships to share and conserve resources H1: Shared information systems H1: Delineation of responsibilities with focus on improving health H1: Extra layer of service that coordinated activities H1: Assessment, management, support provision and service input should not focus on any one element or any one discrete or isolated stage, such as police station or court H1: Points of intervention at multiple points in the pathway, with a focus on early intervention where possible H1: A minimum of three practitioners and which provides a proactive, holistic service across the whole offender pathway H3: Individualised support package which aims to improve overall emotional health and wellbeing H1: Case-centred approach H3: Strategic management should equally reflect the importance of multi-agency involvement H1: Multi-agency involvement with regular review and follow up H1: Information exchange policy, particularly re. confidentiality, data protection, human rights, risk &	Mechanism: **Agencies hold a shared mission, with empathy and respect between services** Explainer: Coordination across agencies can build a shared mission, empathy and respect between services, and therefore increase a programme's ability to identify clients and appropriate services	Increased availability of funding Improved access to services Streamlined process for offenders Fewer "mistakes" Increased willingness of courts to act on recommendations Reduced offending	(Draine and Solomon 1999, James 2000, Steadman, Deane et al. 2000, Wertheimer 2000, O'Callaghan, Sonderegger et al. 2004, Herinckx, Swart et al. 2005, Gordon, Barnes et al. 2006, Hartford, Carey et al. 2006, Prins and Draper 2009, Winstone and Pakes 2009, Hean,	Moderate

child protection H1: Shared agreements on activities, roles and responsibilities H3: Joint training arrangements with multi-agency partners H1: Psychiatric triage or drop-off centre - immediately places the person in crisis within the purview of the mental health system Programme design - disabling H1: Interpersonal or interagency concerns, e.g. competition among agencies serving the same population H2: Agency staff turnover meaning continuous new relationships H1: Disparity between expected roles and actual availability H1: Segregated funding streams			Heaslip et al. 2010, Dyer 2012, Dooris, McArt et al. 2013, Hean, Willumsen et al. 2015, Coffman, Shivale et al. 2017, Kane, Evans et al. 2018, Bonfine and Nadler 2019, Forrester, Hopkin et al. 2020)	

Essential Principle 2: The development and maintenance of relationships should be incorporated within programmes to maximise their effectiveness Hypothesis 4: Social support and pressure can motivate people to change Hypothesis 5: Diversion programmes that are designed to enable the development and maintenance of relationships can result in greater treatment and programme adherence

Contexts	**Mechanisms**	**Outcomes**	**Refs: included studies**	**Confidence in findings**
Programme design - enabling H4: Requires women to set a schedule to meet the needs of her family H4: Allows for maintenance of social connections H5: An intervention that reduces drug use H4: possibilities for relationship building with children living with or not living with their natural mothers needs to be centrally placed H4: When exclusive gender-based programmes are impractical, attention to mothers' unique needs can become part of the interventional approach by health care and criminal justice professionals H4: Opportunities to practice new skills in the community environment H4 & H5: Families provided education and support; families involved in treatment plans where appropriate H4 & H5: Family psychoeducation involves a partnership between family members and consumers of mental health services Programme design – disabling H4 & 5: Distance of treatment from family and friends Individual - enabling H5: High social capital H4: Changes in life circumstances such as a good marriage or a stable job are related to desistance	Mechanism: **Familial relationships are maintained and strengthened** Explainer: If an intervention allows for the maintaining and strengthening of familial relationships, as this enables women to form social bonds, which are a central criminogenic need relevant for reducing recidivism This is particularly relevant for women who have children, as: most women intend or	Lower recidivism Treatment adherence Less family conflict Increase in emotional support received from family members Increased self-worth	(Henderson, Schaeffer et al. 1998, Bond, Drake et al. 2001, May and Wood 2005, Lamberti 2007, Green and Rempel 2012, Vandermause, Severtsen et al. 2013, Aguiar and Leavell 2017, Smith 2017, Gallagher, Nordberg et al. 2019)	High-moderate

Individual - disabling H5: Negative attitudes towards medications H5: Substance abuse H4 & 5: Lack of family caring and supervision	wish to be 'good' mothers, even when they are using illicit drugs stigma experienced by non-custodial mothers can be an added assault to the self-worth of recovering mothers a programme can restructure/revision their mothering experiences			
Programme design - enabling H4: Group sessions for social coping and skills development H8: Based upon social learning theory, programmes should be action oriented and use interventions that reinforce appropriate behaviours while extinguishing inappropriate behaviours H8: Treatment methods should be skills-oriented, active and designed to improve problem solving in social interaction, based on cognitive behavioural techniques H4: Gender specific groups, allow women to feel more safe when discussing experiences and sharing feelings	Mechanism: **Relationships with peers are facilitated and developed** Explainer: If an intervention allows for the building of relationships with peers, this enables	Reduces sense of isolation Opportunity to learn to cope with mental illnesses including addictions Increased sense of worth and	(Henderson, Schaeffer et al. 1998, Dooris, McArt et al. 2013)	Moderate

	women to form social bonds, which are a central criminogenic need relevant for reducing recidivism	abilities Feeling of support Increased social skills		
Programme design - enabling H5: Consistent and organised enforcement of rules Employing ex-offenders to act as role models H4: Supportive approach from practitioners H5: Judge serves as a "lynchpin" by incorporating traditional court process knowledge with therapeutic recommendations of the MHC H5: Team Approach: shared caseloads, meets daily to discuss patients, solve problems, and plan treatment and rehabilitation efforts. H5: Team has responsibility for each patient; members contributing expertise as appropriate - increased continuity of care over time. H4: Low Patient-Staff Ratios: small enough to ensure adequate individualization of services H4: relationships between community corrections officers and the people under their supervision that are characterized by caring, fairness, trust, and an authoritative (not authoritarian) style H4: Problem-solving strategies and positive pressures Individual - enabling H4: probationers with strong social bonds H4: quality of the relationship with clinicians H5: Consistency of the client's experience with the personnel who provided service coordination to	Mechanism: **Relationships with caseworkers and criminal justice representatives are built on trust** Explainer: If an intervention allows for building a trusting relationship with caseworkers / practitioners / judge, this can create an increased sense of belief and support	Graduation from programme Attitude towards treatment Treatment adherence Continuity of care Reduced recidivism Lowered risk of staff burn out and greater job satisfaction for	(Bond, Drake et al. 2001, Prins and Draper 2009, Peterson, Skeem et al. 2010, Sarteschi, Vaughn et al. 2011, Dooris, McArt et al. 2013, Canada and Epperson 2014, DeGuzman, Korcha et al. 2019)	High

clients Individual - disabling H4: Over-dependence and blurring of boundaries H5: Staff turnover		diversion programme staff		
Programme design - enabling H4: Social integration, with emphasis on supporting clients' access to housing, work, friends, and public and social activities H4: Increasing 'social capital' through community connectedness Individual - enabling H4: Social networks	Mechanism: **A sense of citizenship and community** Explainer: If an intervention encourages the development of a feeling of citizenship and community, participants will feel more connected to rights, responsibilities, roles, & resources for people through public and social institutions	Increases self-efficacy Sense of belonging Increased access to services	(Rowe, Bellamy et al. 2007, Rowe, Benedict et al. 2009)	Moderate

Essential Principle 3: Major risk factors for recidivism remain relevant for offenders whether or not they have mental illness Hypothesis 6: If a diversion programme is designed to address criminogenic risk factors as well as mental health treatment, there is a greater opportunity to reduce the risk of offending Hypothesis 7: Tailoring service provision to account for immediate and urgent needs, the type of crime committed and history of criminal justice involvement can maximise the effectiveness of diversion programmes by targeting specific risk factors and needs Hypothesis 8: Diversion programmes can create an opportunity for participants to develop new skills, making space for behaviour change and an overall change in outlook				
Contexts	**Mechanisms**	**Outcomes**	**Refs: included studies**	**Confidence in findings**
Programme design - enabling H6: Clinicians understand the behaviour change process H6: Motivational interviewing H8: Openness, flexibility and support H8: Offenders practise new skills, attitudes, behaviours H8: Cognitive-behavioural and social learning strategies H7: Adapt for offender characteristics H8: Including offenders' goals in case management H8: Frequency, quality, and length of judge interaction (particularly if the judge is optimistic) H8: Groups, through breaking down denial and building interpersonal skills. H8: Groups tailored to gender, any disorders/addictions and type of offence to encourage sharing in a safe environment H8: Labelling techniques to encourage self-monitoring and evaluation helps to regulate behaviour H8: Strengths focused approach with small achievable goals H8: Practical approach, highlighting tangible aims to ensure engagement H8: Incorporation of specific, personal goals set in partnership	Mechanism: M**otivation to change** Explainer: If an intervention can increase a woman's motivation to change, this can create a change in lifestyle and outlook, through: Women becoming more open to high levels of supervision and intensity of	Increased rates of graduation of the programme Reduced offending Maintained sobriety / treatment / programme adherence	(Allam, Middleton et al. 1997, O'Callaghan, Sonderegger et al. 2004, Herinckx, Swart et al. 2005, Dooris, McArt et al. 2013, Bosker and Witteman 2016, DeGuzman,	High-moderate

H7: Able to prioritise focus areas to show quick, early progress H8: Incorporation of creative and social clubs, to learn new skills in a safe and supported environment Individual - enabling H8: Reason for entering the programme – to improve self rather than avoid prison H8: Mutual support through relationships with peers and staff	services Women becoming more likely to comply with court requirements Women forming a positive therapeutic alliance with the team Empowering women to build upon successes within the programme		Korcha et al. 2019)	
Programme design - enabling H6: Targets dynamic criminogenic needs for reducing recidivism H7: match modes of service to their abilities and styles H7: Intensive structure and monitoring for high-risk offenders with more severe criminal dispositions and drug-use histories H6: Risk assessed through dynamic factors which can be changed through therapeutic interventions focused on these needs H8: Basis in cognitive-behavioural and social learning strategies H7: Delivered to match characteristics (such as strengths, personality, gender, preferences, motivations) and circumstances of offenders H7: Screen on basis of risk for future offenses – align resources to this H8: CBT which is intensive, with individual sessions and focus on anger control	Mechanism: **Risk-aligned allocation of resources** Explainer: If an intervention is aligned to a risk and responsivity model, resources can be directed towards those with highest risk of reoffending and the programme can be tailored accordingly	Appropriate allocation of resources Improved behavioural patterns Drug abstinence (drug court) Increased rates of graduation of the programme	(Marlowe 2003, Prins and Draper 2009, Balyakina, Mann et al. 2014, Hean, Willumsen et al. 2015, Bosker and Witteman 2016)	High

		Reduced recidivism		
Programme design - enabling H8: Collaborative partnerships: mental health professionals and probation or parole officers/judges/police as applicable H8: Allows for complete avoidance of criminal record/jail H8: Safeguard autonomy - the perception of free will presents psychological benefits and positive therapeutic effects H8: Patients receive empathy, options, and a clear rationale about the decisions made H8: Incorporating probation officers promotes effective communication and facilitates the use of legal leverage to promote treatment adherence when necessary H8: Mental health and criminal justice staff work together toward common goals H8: Partnerships based on shared belief in treatment as an alternative to incarceration and a commitment to problem-solving, not punitive approaches to behavioural problems H8: Clinicians should be knowledgeable about the criminal justice system and prepared to work in	Mechanism: **Threat of sanctions while safeguarding autonomy** Explainer: If an intervention involves a threat of sanctions and autonomy is safeguarded, this can encourage participants	Improved adherence Reduced reoffending Engagement with services Retention in programme Increased rates	(Brown 1997, Marlowe 2003, Lamberti, Weisman et al. 2004, O'Callaghan, Sonderegger et al. 2004, Marlowe, David S. Festinger et al. 2005,	Moderate

partnership H8: Close supervision – regular communication and reporting H7: enhanced judicial monitoring may have only increased perceived deterrence for the higher-risk offenders Programme design - disabling H8: Involving probation officers in mental health treatment can result in increased threats of jail and use of incarceration H8: Enforcement-oriented approach to collaboration where mental health professionals primarily report infractions Individual - enabling H8: Patients become active participants in their own care H8: When people perceive themselves as having choice, control and self-determination over their behaviour, they perform better, are more persistent and feel more motivated H7: Older participants and female participants tended to have greater perceptions of deterrence H7: Recidivists given fully suspended sentences are less likely to be reconvicted than recidivists sentenced to short-term imprisonment Individual - disabling H7: Non-adherent participants perceive legal leverage as being more coercive compared to those who are adherent H7: Less deterrence - those with prior drug abuse treatment histories H7: First offenders given fully suspended prison sentences had a greater risk of being reconvicted compared with first offenders sentenced to short-term imprisonment due to suppression effect	to complete the programme to avoid incarceration and the stigma of a criminal record	of court / programme completion	Harvey, Shakeshaft et al. 2007, Lamberti 2007, Cid 2009, Cusack, Steadman et al. 2010, Aarten, Denkers et al. 2014)}	

Programme design - enabling H6: Directly target dynamic risk factors H6: Additional criminogenic interventions need to be incorporated into traditional mental health services H6: Addresses a number of different criminogenic needs H6: Support/training on accommodation, education and employment H8: Incorporate highly structured cognitive-behavioural interventions H6: Cognitive behavioural correctional programmes targeting criminogenic needs as impulsivity, emotional regulation, and criminal thinking H6: Criminal thinking and psychiatric symptomatology conceptualized as comorbid, yet distinct, disorders and treated concurrently Individual - enabling H7: Individuals with co-occurring psychopathy may benefit from interventions that target antisocial attitudes, skills, and cognitions H7: Treatment needs, both psychiatric and criminogenic, become increasingly important with elevated criminal thinking or increased psychiatric symptomatology Individual - disabling H6: Offenders with multiple problems and criminogenic needs Younger age during treatment H7: Younger age of involvement in crime (particularly if violent) H7: Comorbid diagnosis of antisocial personality disorder H7: Previous failed diversion programme H7: First degree relatives with drug abuse problems / criminal histories	Mechanism: **Dynamic risk factors identified and targeted** Explainer: Dynamic risk factors are amenable to change, so if an intervention targets dynamic risk factors, criminal risk factors (which remain better predictors of criminal offending than clinical factors) can be reduced	Reduced criminal involvement / recidivism Reduced criminal thinking Increased personal confidence and hope	(Peterson, Skeem et al. 2010, Wilson, Kathleen et al. 2014, Bartholomew, Morgan et al. 2018)	High

Programme design - enabling H7: Gender-responsive interventions H7: Trauma-informed interventions for those experiencing psychological distress Individual - enabling H8: Heightened levels of motivation to make life changes	Mechanism: **Sense of a point of transition between a previous and future self** Explainer: If programme 'Graduation' is seen as a rite of passage, this can mark a point of transition between a previous and future self	Reduced offending	(Lamb, Weinberger et al. 1988, Herinckx, Swart et al. 2005, Harvey, Shakeshaft et al. 2007, McNiel and Binder 2007, Davis, Fallon et al. 2008, Nordberg 2015, Gallagher, Nordberg et al. 2019)	High

Essential Principle 4: Diversion programmes provide an opportunity for stabilisation of an individual's life, and effective programmes should enable this

Hypothesis 9: Diversion programmes are only as effective as the services they link to, which requires flexible and integrated referral systems to enable engagement with relevant services

Hypothesis 10: Diversion programmes can motivate, facilitate and enable individuals to engage with relevant services through increasing accessibility to participants Hypothesis 11: Sufficient levels of resourcing with knowledgeable staff are required for successful assessment and identification of needs that are robust and not limited to one primary issue				
Contexts	**Mechanisms**	**Outcomes**	**Refs: included studies**	**Confidence in findings**
Programme design - enabling H10: Proactive approach to addressing substance disorder H10: Working style to win the respect and trust of substance abusers H11: Adequate resourcing of intervention and ongoing support H9: Links to appropriate, resourced treatment services Intensity and duration of time spent in programme Treatment supervision and monitoring H10: Threat of sanctions H10: Motivational interviewing H9: Formal agreement on structured treatment by offenders with mental disorders, their relatives and service providers H11: Multi-disciplinary staffing H9: Comprehensive, integrated outpatient treatment programmes H9: Programmes tailored to clients' severity of dependence Programme design - disabling H11: Focus on recording one primary issue Individual - enabling H10: Timing of entering the programme – when the offender is most susceptible to entering a treatment	Mechanism: **Management of co-occurring substance use disorder** Explainer: If an intervention can enable a woman to manage her co-occurring substance use disorder, this both addresses a principal factor in contact with the criminal justice system and enables stabilisation to ensure the client attends any court hearings	Treatment adherence Reduced recidivism Cost savings Reduced violent behaviour Fewer parole violations	(Brown 1997, Bond, Drake et al. 2001, Ryder, Kraszlan et al. 2001, O'Callaghan, Sonderegger et al. 2004, Cosden, Ellens et al. 2005, Harvey, Shakeshaft et al. 2007, Lamberti 2007, Erickson, Lamberti et al. 2009,	High

plan H10: Stable employment Individual - disabling H10: Severity of co-occurring drug and/or alcohol use			Prins and Draper 2009, Scott, McGilloway et al. 2009, Dooris, McArt et al. 2013, Scott, McGilloway et al. 2013, Balyakina, Mann et al. 2014, Clark, Dolan et al. 2017, Alarid and Rubin 2018)	
Programme design - enabling H9: Access to educational and vocational training H9: Access to appropriate housing H9: Incorporation of a residential treatment component H10: Focus on everyday problems in living and help patients develop skills and support networks in natural settings H9: Relationship-building and tangible help, especially with regard to both education and facilitation around finances and housing H9: Fully staffed teams also include employment specialists who help patients to find and keep jobs in	Mechanism: **Developed foundations across housing, education and employment**	Increased housing stability Increased use of services Reduced recidivism	(English and Mande 1991, Bond, Drake et al. 2001, Lamberti, Weisman et al. 2004, Case,	High

integrated work settings H9: Supported employment which is flexible H9: Supported housing models—transitional and permanent H9: Program components that promote career growth Individual - enabling H10: Employment which requires completion of the programme Individual - disabling H10: Lower previous educational attainment H10: History of violence and active psychosis – reluctance of housing providers to serve high risk individuals	Explainer: If an intervention allows a woman to develop foundations across housing, education and employment, this positions a woman to be able to take opportunities	Builds dignity	Steadman et al. 2009, Erickson, Lamberti et al. 2009, Prins and Draper 2009, Steadman, Osher et al. 2009, Coffman, Shivale et al. 2017, Smith 2017, Swartz and Tabahi 2017, DeGuzman, Korcha et al. 2019)	
Programme design - enabling H11: Robust mental health screening and open referral mechanisms H11: Screening allows the scheme to service not only those who are referred to them but also to proactively identify their clientele. H9: Flexibility of service provision	Mechanism: **Participants have trust in intervention**	Increased accuracy in statements Appropriately	(Bond, Drake et al. 2001, May and Wood 2005,	High-moderate

H10: Accessible materials, e.g. for those with learning disabilities H10: Support through legal processes, e.g. attending court H11: Staff with specialist expertise to manage specific disorders H11: Training and awareness of issues across the system H9: Communication with family, particularly around movements between services H9: Information sharing across teams H11: Identification of when healthcare services are most appropriate H10: Time-Unlimited Services H10: Facilitate attendance (travel vouchers, geographically close) H10: Self-selected modes of delivery H9: Allows for rapid access in response to patient emergencies, even if out of regular business hours Programme design - disabling H9: Resistance to serving clients who are labelled "forensic." Individual - disabling H10: Females with Learning Difficulties, in particular, felt disrespected by professionals who don't understand their condition	Explainer: If an intervention can increase the accessibility as well as the availability of services, this can increase trustworthiness of the intervention and the programme can support a broader inclusion criteria	addressed needs Development of long-term therapeutic relationships	Hartford, Carey et al. 2006, Harvey, Shakeshaft et al. 2007, Winstone and Pakes 2009, Howard, Phipps et al. 2015, Swartz and Tabahi 2017, Kane, Evans et al. 2018, Gallagher, Nordberg et al. 2019)	
Programme design - enabling H10: Focus on community bonds H10: Persistence in engaging reluctant patients, both during initial contacts and after they have enrolled Individual - enabling H10: Younger inmates more likely to participate in alternative sanctions and serve more community	Mechanism: **Willingness to engage with alternative sanctions**	Programme completion Increased engagement with services	(Bond, Drake et al. 2001, May and Wood 2005, Hartford,	High-moderate

service H10: Higher levels of education - more likely to agree to participate in boot camp and probation but not community service H10: Married respondents more likely to participate in probation but less likely to participate in boot camp H10: Gender had no significant impact on whether an inmate decided to participate in an alternative sanction H10: Females may prefer alternative sanctions and be willing to opt for longer durations of alternative sanctions because they tend to have stronger ties to family and community than do men Individual - disabling H10: Higher education levels willing to spend fewer months in probation H10: Those with more experience of alternative sanctions were less likely to agree to participate in any length of community service	Explainer: If an intervention can build a woman's willingness to engage with alternative sanctions, this can encourage participants to participate with other services and maintain relationships		Carey et al. 2006, Harvey, Shakeshaft et al. 2007, Winstone and Pakes 2009, Howard, Phipps et al. 2015, Swartz and Tabahi 2017, Kane, Evans et al. 2018, Gallagher, Nordberg et al. 2019)	

Programme design - enabling H10: Encouragement to accept mental health treatment from all programme practitioners H11: Clear definitions of mental illness H10: Self-management and recovery focused on providing individuals with skills to monitor and control mental well-being H10: Psychopharmacology H9: Trauma-specific interventions, both to identify and treat H11: Assessment in primary care / community settings Builds understanding of why the woman is there	Mechanism: **Women empowered to make their own decisions** Explainer: If an intervention can enable a woman to manage her mental health issue, this provides stability to empower women to make their own decisions	Reduced symptoms and hospitalisation Increased patient choice Reduced costs	(Bond, Drake et al. 2001, Prins and Draper 2009, Scott, McGilloway et al. 2009)	High-moderate

Appendix E Interview guides and questionnaires

First interview guide service providers

Introduction

- Overview of project
- What I'm trying to achieve through interviews

Aim 1: Assess baseline confidence levels

- I will talk through the questionnaire to ensure an understanding of:
    - Drivers of stated confidence levels of working with complex cases
    - Perceptions around why this differs to their ideal level
    - Difficulties of working with this cohort
    - Beliefs around what would improve confidence levels

Aim 2: Understand the theory behind the programme design

- Does the interviewee have any theories about why the intervention is expected to 'work'?
- Introduce the theory of change as it currently stands
    - Is anything missing?
    - Is anything there which shouldn't be?
    - Is there anything you would disagree with?
- Introduce proposed areas of focus.
    - What do you think of these areas of focus?
- For each area of focus:
    - What is likely to make this element of the service effective?
    - What may make this work better? (prompt: characteristics of beneficiary, mechanisms for providing the service)
    - What may make this less effective?

Aim 3: Understand where practitioners feel they add value and for whom

- Where does the interviewee personally feel they will add the most value through this intervention?
- For each:

    - What is the outcome of this?
    - Where does this tend to work best? (prompt: characteristics of beneficiary, mechanisms for providing the service)
    - In which circumstances can it be ineffective?
- Do you have any examples of cases which have confirmed or refuted these theories?

Wrap up with discussion around next steps (i.e. second interview) and potential areas of follow up

Subsequent interview guide service providers

Introduction - recap

- Overview of project
- What I'm trying to achieve through interviews

Aim 1: Assess changes in confidence levels

- I will talk through the questionnaire to ensure an understanding of:
    - Drivers of stated confidence levels
    - Perceptions around any changes to confidence levels and the drivers of these changes as relate to specific elements of the passport and to specific programme theories as identified in the initial interviews
    - Perceptions around why this differs to their ideal level
    - Perceptions around any difficulties in implementing the passport, or in the passport achieving its objectives
    - Beliefs around what would improve confidence levels

Wrap up and discussion around next steps and potential areas of follow up

First interview guide service users

Introduction

- Overview of project
- What I'm trying to achieve through interviews

- Recap of participant information and consent forms

Aim 1: Assess baseline levels of service use

- I will talk through the questionnaire to ensure an understanding of:
    - Drivers of stated service use
    - Perceptions around why this differs to their ideal level of service use
    - Difficulties of navigating the system / accessing services
    - Beliefs around what would improve service use

Aim 2: Understand where beneficiaries feel the passport could add value to them

- I will talk through the intervention and ask for opinions on whether this is something which beneficiaries would expect to be helpful
- I will seek to understand perceptions around:
    - Which elements of this seem helpful
    - Which elements do not
    - What would increase the likelihood of this being a successful tool
    - What would decrease the likelihood of this being a successful tool

Aim 3: Assess changes in service use over the first six months

- I will talk through the questionnaire to ensure an understanding of:
    - Drivers of stated service use
    - Perceptions around any changes to service use and the drivers of these changes as relate to specific elements of the passport and to specific programme theories as identified in the initial interviews
    - Perceptions around why this differs to their ideal level of service use
    - Perceptions around any difficulties in utilising the passport, or in the passport achieving its objectives
    - Beliefs around what would improve service use

Wrap up with discussion around next steps and potential areas of follow up

Subsequent interview guide service users

Introduction

- Overview of project
- What I'm trying to achieve through interviews
- Recap of participant information and consent forms

Aim 1: Assess changes in service use

- I will talk through the questionnaire to ensure an understanding of:
    - Drivers of stated service use
    - Perceptions around any changes to service use and the drivers of these changes as relate to specific elements of the passport and to specific programme theories as identified in the initial interviews
    - Perceptions around why this differs to their ideal level of service use
    - Perceptions around any difficulties in utilising the passport, or in the passport achieving its objectives
    - Beliefs around what would improve service use

Wrap up and discussion around next steps and potential areas of follow up

Questionnaire – to accompany interview 1 with service practitioners

Details of participant

1. What is your name
2. What is your age
3. How many years of experience do you have working with multiple disadvantage individuals?
    a. < 2
    b. 2 < 5
    c. 5 < 10
    d. 10 < 15
    e. 15 +
4. Would you consider yourself to have a specialty (e.g. housing provision, clinical support, drug and alcohol abuse, etc.)?
    a. Yes
    b. No

If yes, please provide details _____

5. Have you undertaken any relevant training which is focused on managing complex cases?
    c. Yes
    d. No

If yes, please provide name of training _____

Baseline confidence in managing complex cases

6. How would you rate the ease of developing an in-depth understanding of the needs of the individual(s) you support (where 1 is extremely challenging and 10 is very easy)?

1 2 3 4 5 6 7 8 9 10

7. How would you rate your understanding of how to deal with individuals who are not deemed to be 'treatment-ready' (where 1 is not at all and 10 is a complete and comprehensive understanding)?

1 2 3 4 5 6 7 8 9 10

8. How would you rate your understanding of the process for managing complex cases (where 1 is not at all and 10 is a complete and comprehensive understanding)?

1 2 3 4 5 6 7 8 9 10

9. How would you rate your overall confidence as relates to managing individuals facing complex disadvantage?

1 2 3 4 5 6 7 8 9 10

Questionnaire – to accompany subsequent interviews with service practitioners

Current confidence in managing complex cases

1. How would you rate the ease of developing an in-depth understanding of the needs of the individual(s) you support (where 1 is extremely challenging and 10 is very easy)?

1 2 3 4 5 6 7 8 9 10

2. How would you rate your understanding of how to deal with individuals who are not deemed to be 'treatment-ready' (where 1 is not at all and 10 is a complete and comprehensive understanding)?

1 2 3 4 5 6 7 8 9 10

3. How would you rate your understanding of the process for managing complex cases (where 1 is not at all and 10 is a complete and comprehensive understanding)?

1 2 3 4 5 6 7 8 9 10

4. How would you rate your overall confidence as relates to treating individuals facing complex disadvantage?

1 2 3 4 5 6 7 8 9 10

Changes in confidence in managing complex cases

5. Have you noticed a change in your overall confidence in managing individuals facing complex disadvantage?
    a. Yes
    b. No

Questionnaire – to accompany interview 1 with service users

Details of participant

1. What is your name
2. What is your age
3. What best describes your gender?
    a. Female
    b. Male
    c. Prefer to self-describe
4. How would you describe your ethnicity?

White

    a. English / Welsh / Scottish / Northern Irish / British
    b. Irish
    c. Gypsy or Irish Traveller
    d. Any other White background

Mixed / Multiple ethnic groups

    e. White and Black Caribbean
    f. White and Black African
    g. White and Asian
    h. Any other Mixed / Multiple ethnic background

Asian / Asian British

    i. Indian
    j. Pakistani
    k. Bangladeshi
    l. Chinese

m. Any other Asian background

Black / African / Caribbean / Black British

n. African
o. Caribbean
p. Any other Black / African / Caribbean background

Other ethnic group

q. Arab
r. Any other ethnic group

5. What is your religion?
    a. No religion
    b. Christian (including Church of England, Catholic, Protestant and all other Christian denominations)
    c. Buddhist
    d. Hindu
    e. Jewish
    f. Muslim
    g. Sikh
    h. Any other religion. If yes, details _____
6. For how long have you been accessing local / community services?
    a. < 2
    b. 2 < 5
    c. 5 < 10
    d. 10 < 15
    e. 15 +
7. In the last 12 months, have you spent any time in prison?
    a. Yes
    b. No
8. Have you ever spent time in prison?
    a. Yes
    b. No
9. In the last 12 months, have you spent any time on probation?
    a. Yes
    b. No
10. Have you ever spent time on probation?
    a. Yes
    b. No

Baseline perception of service use

11. What types of community support services have you accessed in the last six months?
    a. Mental health support / counselling
    b. Residential services / housing
    c. Drug and alcohol services
    d. Navigating financial benefits
    e. Other. If so, please specify_____
12. Which of those support services would have been helpful to you in the last six months?
    a. Mental health support / counselling
    b. Residential services / housing
    c. Drug and alcohol services
    d. Navigating financial benefits
    e. Other. If so, please specify_____
13. How relevant have the services which you have accessed been (where 1 is not at all relevant and 10 is very relevant)?

1 2 3 4 5 6 7 8 9 10

14. How quickly were you able to access the services which you required (where 1 is very slowly and 10 is very quickly)?

1 2 3 4 5 6 7 8 9 10

15. How intensive have the services which you have accessed been (where 1 is minimal and 10 is very intensive)?

1 2 3 4 5 6 7 8 9 10

16. How intensive would you have liked the services to be (where 1 is minimal and 10 is very intensive)?

1 2 3 4 5 6 7 8 9 10

17. How would you rate the overall level of support that you have received in the last twelve months (where 1 is completely inadequate and 10 is perfect)?

1 2 3 4 5 6 7 8 9 10

Questionnaire – to accompany subsequent interviews with service users

Details of participant

1. In the last 6 months, have you spent any time in prison?
    a. Yes
    b. No
2. In the last 6 months, have you spent any time on probation?
    a. Yes

b. No

Baseline perception of service use

3. What types of community support services have you accessed in the last six months?
    a. Mental health support / counselling
    b. Residential services / housing
    c. Drug and alcohol services
    d. Navigating financial benefits
    e. Other. If so, please specify_____
4. Which of those support services would have been helpful to you in the last six months?
    a. Mental health support / counselling
    b. Residential services / housing
    c. Drug and alcohol services
    f. Navigating financial benefits
    g. Other. If so, please specify_____
5. How relevant have the services which you have accessed been (where 1 is not at all relevant and 10 is very relevant)?

1 2 3 4 5 6 7 8 9 10

6. How quickly were you able to access the services which you required (where 1 is very slowly and 10 is very quickly)?

1 2 3 4 5 6 7 8 9 10

7. How intensive have the services which you have accessed been (where 1 is minimal and 10 is very intensive)?

1 2 3 4 5 6 7 8 9 10

8. How intensive would you have liked the services to be (where 1 is minimal and 10 is very intensive)?

1 2 3 4 5 6 7 8 9 10

9. How would you rate the overall level of support that you have received in the last twelve months (where 1 is completely inadequate and 10 is perfect)?

1 2 3 4 5 6 7 8 9 10

Changes in accessing services

10. Have you noticed a change in your access to relevant services?
    d. Yes
    e. No
11. Have you noticed a change in how quickly you are able to access services?
    f. Yes

g. No

12. Have you noticed a change in the overall level of support that you have received in the last six months?

    h. Yes

    i. No

Appendix F Consent forms and information sheets

Participant Information Sheet for Service Users

UCL Research Ethics Committee Approval ID Number: 16793/002 (pending)

YOU WILL BE GIVEN A COPY OF THIS INFORMATION SHEET

Title of Study: How do mental health interventions impact the incarceration and outcomes of women?

Department: Institute for Global Health

[redacted]

[redacted] r.burgess@ucl.ac.uk

1. **Invitation Paragraph**
   You are being invited to take part in a two-year research project which will form part of an MPhil / PhD study. Before you decided it is important for you to understand why the research us being done and what this will involve. Please take time to read this paper carefully and discuss it with others if you wish. Ask us if there is anything that is not clear or if you would like more information. Take time to decide whether or not you wish to take part. Thank you for reading this.

2. **What is the project's purpose?**
   This research will focus on if, how and why community mental health projects change the lives of women who use them. We will try to understand what makes these programmes most effective and who they best work for. We want this research to benefit the women who use these services, through gaining an understanding of what works, which can then be used to improve the programmes.

3. **Why have I been chosen?**
   You have been chosen as you are an adult (>18 years old), female user of a service (the passport) which is designed to improve the lives of women.

4. **Do I have to take part?**
   Taking part is entirely voluntary and you can decide to leave the study at any time. If you decide to leave the study, you will be asked what you wish to happen to the data you have provided up to that point. You will be able to ask for your data to be removed up to four weeks following interview.

5. **What will happen to me if I take part?**
   If you decide to take part, you will be asked to participate in up to 3 interviews over the space of 24 months. Each will last approximately 30-45 minutes and you will be asked to complete a questionnaire in the session.

   We will use this time to understand the value you get from the Passport. A number of other service users will be contacted for this also, to better understand who most benefits from the services that are offered.

   These interviews can be done in person in London, or remotely over a videocall. On occasion, you be contacted after the interview with follow-up questions, though this is rare and you can decide not to take part if you wish.

   We will record your consent through the signature of the consent form which comes with this document.

6. **Will I be recorded and how will the recorded media be used?**

I will record your interview but this will only be used to write up the points that you make. Recordings will be destroyed once transcribed. You may decide not to be recorded if you are not comfortable with this.

7. **What are the possible disadvantages and risks of taking part?**
   If you participate in the interview, you will be asked to discuss your experience of using these services, which might bring up distressing thoughts around previous or current experiences. All questions are optional, so you do not need to answer any question which you are uncomfortable with. You are able to end the interview at any time.

   If it would help you, you are welcome to bring or invite a trusted person with you for support, if you are happy for them to hear what you say.

8. **What are the possible benefits of taking part?**
   You will be compensated for your time to the value of £10.50 per session in food vouchers, which you will receive immediately when you finish each interview.
   Outside of immediate benefits, we hope that this work will help to improve these services in the future.

9. **What if something goes wrong?**
   If you wish to raise a complaint, please contact [redacted]. If you don't feel like your complaint has been handled appropriately, you can contact the Chair of the UCL Research Ethics Committee – ethics@ucl.ac.uk

10. **Will my taking part in this project be kept confidential?**
    In order to be able to really know if the services are effective, this research project is wanting to speak to women 5 times over a course of 2 years, so that you can tell me if things have changed for you or not. I know that phone numbers can change over time, so if I can't reach you for the next interview, I am asking if you will agree to me contacting the agency who referred you for this project, to ask them to speak to you to see if you still want to be involved, and to then agree with you how best to reconnect us. This means that the service would then know that you were participating in the research project.

    However, all information that you share with me will remain completely anonymous and be kept strictly confidential. I will not share the details of what you have said to me with the agency. I will be speaking to people referred by different agencies, You will not be able to be identified in any reports or publications.

11. **Limits to confidentiality**
    Confidentiality will be maintained as far as possible, unless during our conversation I hear anything which makes me worried that someone might be in danger of harm. In this case, I might have to inform relevant agencies of this.

12. **What will happen to the results of the research project?**
    The results of this research will be presented within a PhD thesis and may also be published in an article. Results will also be presented to the service so that they can make improvements. The first publication would likely be made available three years after the study begins, but the final PhD thesis will unlikely be available before July 2024.

    If you would like a copy of the research, I will send a copy to you.

13. **Local Data Protection Privacy Notice**

    Notice:
    The controller for this project will be University College London (UCL). The UCL Data Protection Officer provides oversight of UCL activities involving the processing of personal data, and can be contacted at data-protection@ucl.ac.uk

This 'local' privacy notice sets out the information that applies to this particular study. Further information on how UCL uses participant information can be found in our 'general' privacy notice:

For participants in research studies, click here

The information that is required to be provided to participants under data protection legislation (GDPR and DPA 2018) is provided across both the 'local' and 'general' privacy notices.

The categories of personal data used will be as follows:

- Age
- Contact details
- Ethnicity
- Recent interactions with prison or probation
- Recent access to mental health services and/or counselling, drug & alcohol services, and housing services
- Interactions with the programme being studied

The lawful basis that will be used to process your personal data are: 'Public task' for personal data and' Research purposes' for special category data.

Your personal data will be processed as long as it is required for the research project and will be securely stored for the duration of the study. It will be destroyed up to five years after the study has completed, or publications are completed, whichever is sooner (other than audio recordings which will be deleted once transcribed). We will remove data which directly identifies you and replace this with an identifier (for example, a key made up of numbers) so that personal data is not directly linked to your name and will make sure we process the data as little as possible. Personal data will not be shared with anyone outside the research team, and I will only access it from the computer in the UK.

If you are concerned about how your personal data is being processed, or if you would like to contact us about your rights, please contact UCL in the first instance at data-protection@ucl.ac.uk.

14. Contact for further information

For further information please contact:

[redacted]

The information sheet and signed consent form can be retained by the participant.

Thank you for reading this information sheet and for considering to take part in this research study.

CONSENT FORM FOR SERVICE USERS IN RESEARCH STUDIES

Please complete this form after you have read the Information Sheet and/or listened to an explanation about the research.

Title of Study: How do mental health interventions impact the incarceration and outcomes of women?
Department: Institute for Global Health
[redacted]
This study has been approved by the UCL Research Ethics Committee: Project ID number: 16793/002

Thank you for considering taking part in this research. The person organising the research must explain the project to you before you agree to take part. If you have any questions arising from the Information Sheet or explanation already given to you, please ask the researcher before you decide whether to join in. You will be given a copy of this Consent Form to keep and refer to at any time.

I confirm that I understand that by ticking each box below I am consenting to this part of the study. I understand that it will be assumed that unticked boxes means that I DO NOT consent to that part. I understand that by not giving consent for any one element that I may not be able to take part.

		Tick Box
1.	*I confirm that I have read and understood the Information Sheet for this study. I have thought about the information and what is asked of me. I have also had chance to ask questions which have been answered and I would like to take part in the study. I understand that the researcher will try to speak with me up to 3 times, over the next two years.	
2.	I agree that if the researcher cannot get hold of me for the next interview, that they can ask the agency who referred me to get in touch with me, to see if I still want to be involved, and how best to reconnect us. (you do not have to agree to this, and you can still take part)	
3.	*I understand that I will be able to ask for my data to be removed up to four weeks following each interview.	
4.	*I consent to take part in the study. I understand that my personal information listed in the Information Sheet will be used for the reasons explained to me. I understand that according to data protection legislation, 'public task' will be the lawful basis for processing and 'research purposes' will be the lawful basis for processing special category data.	
5.	**Use of the information for this project only** *I understand that all personal information will remain confidential, unless in the course of the work I discuss something with my interviewer which makes them worried that someone might be in danger of harm. If this happened, I would be told of any decision that might limit my confidentiality. I understand that my data will be stored securely and it will not be possible to identify me in any publications.	
6.	*I understand that my information may be reviewed by responsible individuals from the University for monitoring and audit purposes.	

7.	*I understand that my participation is voluntary and I am free to leave the study at any time without giving a reason, without the support I receive or my legal rights being affected. I understand that if I decide to leave the study, I will be asked what I want to happen to the data I have provided up to that point. I can ask for my data to be removed up to four weeks following interview.	
8.	I understand the potential risk of taking part and the support that will be available to me should I become distressed during the course of the research.	
9.	I understand the benefits of taking part, specifically that I will be compensated for my time, as well as potential improvements to services in the future.	
10	I understand that the data will not be made available to any commercial organisations but is the responsibility of the researcher undertaking this study.	
11	I understand that I will receive compensation for my participation in this research.	
12	I understand that the information I have submitted will be published as a report and I wish to receive a copy of it. (Please tick the box and also circle: Yes/No)	
13	I consent to my interview being audio recorded and understand that these recordings will be destroyed immediately after they are written up. To note: If you do not want your participation recorded you can still take part in the study.	
14	I confirm that I understand the reason I have been asked to take part in this study, as detailed in the Information Sheet and explained to me by the researcher.	
15	I confirm that: (a) I understand the criteria for being included in this study as written within the Information Sheet and explained to me by the researcher; and (b) I fall within this criteria for being included within the study.	
16	I am aware of who I should contact if I want to make a complaint.	
17	I voluntarily agree to take part in this study.	

_____	_____	_____
Name of participant	Date	Signature
_____	_____	_____
Name of witness (if required)	Date	Signature

Participant Information Sheet for Programme Practitioners

UCL Research Ethics Committee Approval ID Number: 16793/002 (pending)

YOU WILL BE GIVEN A COPY OF THIS INFORMATION SHEET

Title of Study: How do mental health interventions impact the incarceration and outcomes of women?
Department: Institute for Global Health

[redacted]

1. **Invitation Paragraph**
   You are being invited to take part in a research project which will form part of a PhD study. Before you decide, it is important for you to understand why the research is being done and what participation will involve. Please take time to read the following information carefully and discuss it with others if you wish. Ask us if there is anything that is not clear or if you would like more information. Thank you for reading this.

2. **What is the project's purpose?**
   This research will focus on how and why community mental health interventions affect rates of detainment and outcomes, such as quality of life, in women in settings where they are available. It will look to understand within which contexts the programmes are most effective and for whom. This research aims to benefit the recipients of related programmes by improving our understanding of what works.

3. **Why have I been chosen?**
   You have been chosen as someone who works within a programme aiming to improve outcomes in the population I'm focusing on (i.e. a woman who benefits from the provision of services which aim to improve her outcomes and quality of life.

4. **Do I have to take part?**
   Taking part in this study is entirely voluntary and you may discontinue participation at any time without having to provide a reason. If you decide to withdraw, you will not be contacted further and you will be asked what you wish to happen to the data you have provided up to that point and can withdraw your data up to four weeks following interview. If you do not withdraw within four weeks, your data will be used.

5. **What will happen to me if I take part?**
   Should you decide to take part, you will be contacted to participate in 5 interviews over 24 months. Each interview will last 30-45 minutes and will consist of a series of questions with open answers. You will also be asked to complete a questionnaire in the session.

   The interviews will be used to understand where practitioners see the most significant value in the Passport intervention. I will also utilise these interviews in developing the theory for when and why these elements of the initiative are valuable.

   The interviews can be done in person in London or remotely (preferably via Microsoft Teams). In exceptional circumstances, you be contacted with follow-up questions relating, though you can opt out of this at any point during the interview process.

   Your agreement will be recorded through the signature of the consent form which accompanies this document. Contact details and specialism will be collected for the purposes of contacting you and undertaking the interviews, but will not be used after this.

6. **Will I be recorded and how will the recorded media be used?**
   The audio recordings of your interview(s) will be used only for written analysis. Recordings will be destroyed once transcribed. You may decide not to be recorded if you are not comfortable with this.

7. **What are the possible disadvantages and risks of taking part?**
   There is a small risk that programme leads may be able to identify you from comments included within the written analysis. I will reduce this risk so far as possible through grouping participants and themes within the analysis.

   If you participate in the interview, you will be asked to discuss your experience of using these services, which might bring up distressing thoughts around previous or current experiences. All questions are optional, so you do not need to answer any question which you are uncomfortable with. You are able to end the interview at any time

8. **What are the possible benefits of taking part?**
   Whilst there are no immediate benefits for people participating in the project, it is hoped that this work will help to shape the development of this - and similar - support programmes, as well as future research in this field.

9. **What if something goes wrong?**
   Should you wish to raise a complaint, please contact Charlotte Brady in the first instance at charlotte.brady.19@ucl.ac.uk. However should they feel their complaint has not been handled to their satisfaction through this route, then you can contact the Chair of the UCL Research Ethics Committee – ethics@ucl.ac.uk

10. **Will my taking part in this project be kept confidential?**
    All the information that we collect about you during the course of the research will remain anonymous and be kept strictly confidential. You will not be able to be identified in any ensuing reports or publications.

11. **Limits to confidentiality**
    Please note that assurances on confidentiality will be strictly adhered to unless evidence of wrongdoing or potential harm is uncovered. In such cases the University may be obliged to contact relevant statutory bodies/agencies.

12. **What will happen to the results of the research project?**
    The results of this research will be presented within a PhD thesis and may also be published in an open-access article. The first publication would likely be made available three years after the beginning of the study, but the final PhD thesis will be available after July 2024.

    It is likely that I would also present the findings to the staff of the involved services.

    Data will not be transferred or shared outside of this.

13. **Local Data Protection Privacy Notice**

    Notice:
    The controller for this project will be University College London (UCL). The UCL Data Protection Officer provides oversight of UCL activities involving the processing of personal data, and can be contacted at data-protection@ucl.ac.uk

    This 'local' privacy notice sets out the information that applies to this particular study. Further information on how UCL uses participant information can be found in our 'general' privacy notice:

    For participants in research studies, click here

    The information that is required to be provided to participants under data protection legislation (GDPR and DPA 2018) is provided across both the 'local' and 'general' privacy notices.

    The categories of personal data used will be as follows:

    - Name
    - Role
    - Affiliation
    - Age

- Contact details
- Ethnicity
- History of interactions with the criminal justice system
- History of mental illness
- Interactions with the programme being studied

The lawful basis that will be used to process your personal data is 'Public task' for personal data and' Research purposes' for special category data.

Your personal data will be processed so long as it is required for the research project. Data will be securely stored for the duration of the study, and destroyed up to five years after the study is completed, or publications are completed, whichever is sooner. We will pseudonymise the personal data you provide and will endeavour to minimise the processing of personal data wherever possible. Personal data will not be transferred outside of the European Economic Area (EEA).

If you are concerned about how your personal data is being processed, or if you would like to contact us about your rights, please contact UCL in the first instance at data-protection@ucl.ac.uk.

14. Contact for further information

For further information please contact:

[redacted]

The information sheet and signed consent form can be retained by the participant.

Thank you for reading this information sheet and for considering to take part in this research study. ----------

CONSENT FORM FOR PROGRAMME PRACTITIONERS IN RESEARCH STUDIES

Please complete this form after you have read the Information Sheet and/or listened to an explanation about the research.

Title of Study: How do mental health interventions impact the incarceration and outcomes of women?
Department: Institute for Global Health
[redacted]
This study has been approved by the UCL Research Ethics Committee: Project ID number: 16793/002 (pending)

Thank you for considering taking part in this research. The person organising the research must explain the project to you before you agree to take part. If you have any questions arising from the Information Sheet or explanation already given to you, please ask the researcher before you decide whether to join in. You will be given a copy of this Consent Form to keep and refer to at any time.

I confirm that I understand that by ticking/initialling each box below I am consenting to this element of the study. I understand that it will be assumed that unticked/initialled boxes means that I DO NOT consent to that part of the study. I understand that by not giving consent for any one element that I may be deemed ineligible for the study.

		Tick Box
1.	*I confirm that I have read and understood the Information Sheet for the above study. I have had an opportunity to consider the information and what will be expected of me. I have also had the opportunity to ask questions which have been answered to my satisfaction and would like to take part in this research study, which I understand will aim to speak to me 5 times over the next two years.	
2.	"I understand that I will be able to ask for my data to be withdrawn up to four weeks following interview.	
3.	*I consent to participate in the study. I understand that my personal information listed in the Information Sheet will be used for the purposes explained to me. I understand that according to data protection legislation, 'public task' will be the lawful basis for processing, and 'research purposes' will be the lawful basis for processing special category data.	
4.	**Use of the information for this project only** *I understand that all personal information will remain confidential, unless in the course of the work I discuss something with my interviewer which makes them worried that someone might be in danger of harm. If this happened, I would be told of any decision that might limit my confidentiality. I understand that my data will be stored securely and it will not be possible to identify me in any publications.	
5.	*I understand that my information may be subject to review by responsible individuals from the University for monitoring and audit purposes.	
6.	*I understand that my participation is voluntary and that I am free to withdraw at any time without giving a reason, without the support I receive or my legal rights being affected. I understand that if I decide to leave the study, I will be asked what I want to happen to the data I have provided up to that point. I can ask for my data to be removed up to four weeks following interview.	
7.	I understand the potential risks of participating.	

8.	I understand the benefits of participating in relation to future service improvements.	
9.	I understand that the data will not be made available to any commercial organisations but is solely the responsibility of the researcher undertaking this study.	
10	I understand that I will not benefit financially from this study or from any possible outcome it may result in in the future.	
11	I understand that the information I have submitted will be published as a report and I wish to receive a copy of it. (Please tick the box and also circle: Yes/No)	
12	I consent to my interview being audio recorded and understand that the recordings will be destroyed immediately following transcription. To note: If you do not want your participation recorded you can still take part in the study.	
13	I hereby confirm that I understand the inclusion criteria as detailed in the Information Sheet and explained to me by the researcher.	
14	I confirm that: (c) I understand the criteria for being included in this study as written within the Information Sheet and explained to me by the researcher; and (d) I fall within this criteria for being included within the study.	
15	I have informed the researcher of any other research in which I am currently involved or have been involved in during the past 12 months.	
16	I am aware of who I should contact if I wish to lodge a complaint.	
17	I voluntarily agree to take part in this study.	

_____	_____	_____
Name of participant	Date	Signature

Appendix G Initial hypotheses developed for testing through the ITAV intervention

Developed understanding of women with complex needs

Through the analysis, six CMOCs were identified which together formed the above programme theory: i) Building an understanding of the cultural and social differences between individuals and their impact on engaging with services can support the application of new approaches; ii) Services can 'meet women where they are' through outreach activities that encourage engagement, rather than wait for them to be ready to engage (a focus on prevention that can also reduce overall costs of service provision); iii) Community-based care increases flexibility and accessibility of services, enabling attendance around other responsibilities, reducing barriers to engagement and the maintenance of relationships; iv) Increased understanding of women with complex needs enables rapid, appropriate, tailored and integrated support to meet a wide variety of needs; v) Intensity of support could and should be matched to needs at a point in time, to ensure the best use of resources; and vi) Services may be more willing to try new approaches through increasing their understanding women with complex disadvantage and through building partnerships and experience.

Building an understanding of the cultural and social differences between individuals and their impact on engaging with services can support the application of new approaches

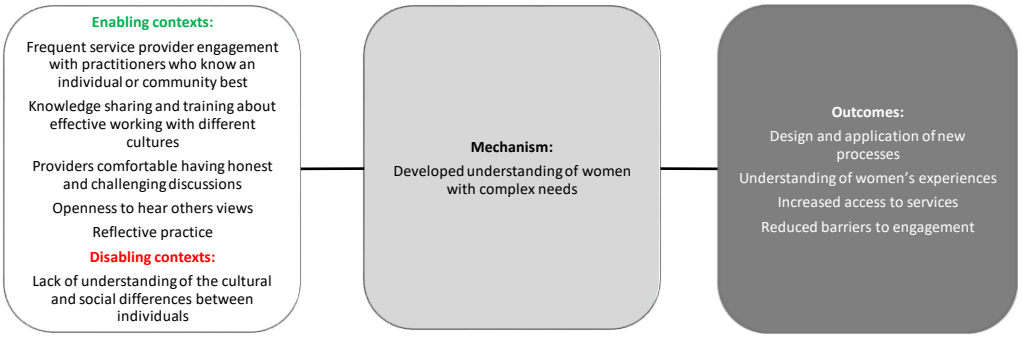
We saw that service providers having a lack of confidence in navigating the complexities of treatment in the context of certain demographics can result in a real or perceived inability to provide appropriate support for women, particularly when they are of a different ethnicity or are part of another culture or community. ITAV is aiming to improve this understanding by having service providers engage more frequently with practitioners and organisations who know an individual or community best (including faith- and community-based organisations), through knowledge sharing and training about effective working with different cultures, and through more reflective practice.

To do this effectively requires service providers to feel comfortable having open discussions with each other on an ongoing basis about how best to support different individuals, being open to hearing different views and learning from others.

This also requires service providers to be able to try new approaches with the space to work flexibly to deliver services with a more human, individualistic focus.

Figure 38 shows the CMOC related to this basic theme.

Figure 38: CMOC related to the hypothesis "Building an understanding of the cultural and social differences between individuals and their impact on engaging with services can support the application of new approaches"



Services can 'meet women where they are' through outreach activities which encourage engagement, rather than wait for them to be ready to engage.

We have seen that women with multiple disadvantage may not actively seek out treatment and may struggle to engage with services (particularly when this involves travel and attending council buildings). The ITAV intervention intends to take a more proactive approach to identifying appropriate services and pathways through outreach and active engagement with women who could benefit from support, rather than waiting for them to actively seek support or be at a point of crisis. This may be through local services and support centres, but could also be through community or religious centres, bringing an additional understanding of cultural relevance, barriers and enablers, which could improve the quality of – and trust in – outreach. This approach is expected to result in earlier intervention by support services and therefore more of a focus on prevention.

Through a more coordinated and integrated approach, service user experience may also be improved, as there should be 'no wrong door' to access support, meaning that

a woman has the option of seeking support from someone she has an existing relationship with. As well as improving care for the women ITAV aims to support, this also has the potential to reduce the overall cost of service delivery through reduced likelihood of criminal justice involvement and the frequency and duration of hospital stays.

Figure 39 shows the CMOC related to this basic theme.

Figure 39: CMOC related to the hypothesis "Services can 'meet women where they are' through outreach activities which encourage engagement, rather than wait for them to be ready to engage"

Community-based care increases flexibility and accessibility of services, enabling attendance around other responsibilities, reducing barriers to engagement and the maintenance of relationships.

ITAV aims to increase accessibility of services by having individual clinical provision take place in comfortable surroundings such as residential spaces and community hubs. Screening and assessments have the potential to be more accurate in the community and home visits can facilitate medication delivery, crisis intervention and network building. This can also mitigate some of the issues caused by imbalanced power dynamics by providing treatment in a setting in which the service user is more comfortable, and by making services more flexible, allowing women to work in partnership with services to schedule appointments and giving them a better chance of being able to attend. A different perspective on their lives and experiences can also improve understanding of the women services are trying to support.

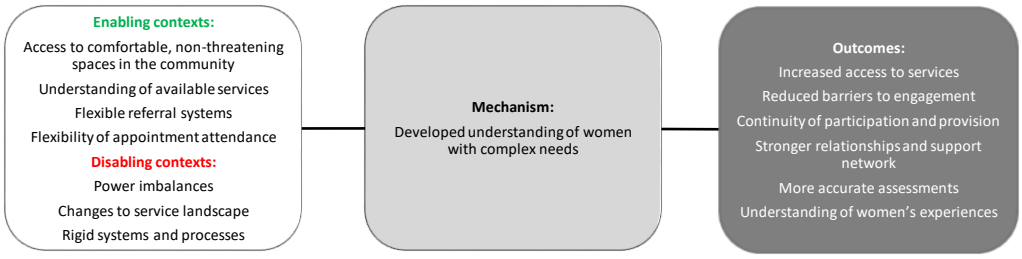
Having a focal point in the community can enable continuity of care and appropriate identification of follow-on services and provide additional benefits to the community within which a programme is based, through knowledge and experience building and subsequent improvements to broader service provision. It can also increase flexibility

in the provision of services by facilitating the building and maintenance of relationships between local services. This aims to reduce both the practical and psychological barriers to engaging with services, and also encourages attendance to be scheduled around other responsibilities, such as familial responsibilities and engaging with other services. It also aims to enable the maintenance of personal relationships by keeping treatment close to home. Having a relationship with her community can increase a woman's belief that she is worthy of, and entitled to, support, increasing the likelihood of ongoing service engagement and participation.

Having a basis of care in the community can further increase the flexibility and accessibility of services, by enabling attendance at appointments. If a base in the community is maintained, services will often have a greater ability to signpost the most relevant services and relationships can be built between teams to facilitate this with more effective communication.

Figure 40 shows the CMOC related to this basic theme.

Figure 40: CMOC related to the hypothesis "Community-based care increases flexibility and accessibility of services, enabling attendance around other responsibilities, reducing barriers to engagement and the maintenance of relationships"



Increased understanding of women with complex needs enables rapid, appropriate, tailored and integrated support to meet a wide variety of needs.

As we saw when considering issues in accessing services, women with multiple needs can struggle to seek comprehensive treatment appropriate to their requirements. As part of this service provision, practical needs such as housing need to be addressed in addition to mental health support if outcomes are going to be improved. This is particularly the case when women have co-morbidities, such as physical health issues, or other characteristics that may result in more specific requirements.

ITAV aims to address this by enabling greater collaboration between services. This is expected to help by increasing more thoughtful and flexible movement between service providers, to allow for more tailored care and the prioritisation of support. It is intended to enable the alignment of treatment plans to needs at any point in time, based on the most up-to-date view of care requirements. ITAV also aims to enable this through building joint-agency understanding of individuals who require support with more regular and open communication between services, allowing treatment to be integrated across providers.

Figure 41 shows the CMOC related to this basic theme.

Figure 41: CMOC related to the hypothesis "Increased understanding of women with complex needs enables rapid, appropriate, tailored and integrated support to meet wide variety of needs"

Intensity of support could and should be matched to needs at a point in time, to ensure the best use of resources.

As well as the flexibility to tailor treatment between services, the duration and intensity of support should be flexible to effectively support women with complex needs. However, we have seen that treatment can be time-limited and lack of resources can restrict the amount of time that providers can spend with individual women in their care. To enable this change requires system restructuring around the needs of the individual, which is not necessarily a linear progression. This has the additional advantage of moving the balance of power towards the woman seeking support, as she is more able to define her own treatment needs and the options are made possible by varying the intensity of support. In the absence of systemic change, this can be facilitated by services working more closely to build a holistic understanding of the needs of the individual seeking to access them. Women with complex needs are often known to local services through previous contacts, and providers can increase their understanding of an individual by sharing this knowledge and experience with each

other, enabling a more holistic approach to service provision. This is expected to ensure the best use of limited resources by aligning treatment with the most urgent needs.

Figure 42 shows the CMOC related to this basic theme.

Figure 42: CMOC related to the hypothesis "Intensity of support could and should be matched to needs at a point in time, to ensure the best use of resources"

Services may be more willing to try new approaches, by increasing their understanding of women with multiple disadvantage and by building partnerships and experience.

Services can be rigid in their processes and approaches and attempt to fit all service users into the same pathways, despite differences in the types and severity of needs. This is exacerbated by having limited time to spend on developing more creative approaches to case management. ITAV aims to increase service providers' understanding of some of the alternative approaches that can be taken to support women with multiple needs in a way that they can rapidly apply. It also aims to increase understanding and develop relationships and partnerships between services, so that the available options are understood.

A better understanding of the approaches and services that are available may give individual service providers the confidence to try new and different ways of supporting women with complex needs. This includes feeling more comfortable in dealing with issues and barriers related to intersectionality, including class, disability, race, sexuality and gender. It could also facilitate increased collaboration and identification of gaps in pathways, leading to the development of more creative approaches to delivery.

Figure 43 shows the CMOC related to this basic theme.

Figure 43: CMOC related to the hypothesis "Services may be more willing to try new approaches, by increasing their understanding of women with multiple disadvantage and through building partnerships and experience"

Service users have trust and understanding in the services supporting them

Through the analysis, six CMOCs were identified which together formed the above programme theory: i) A trauma-informed approach, including providing safe spaces for women who have experienced trauma, should be implemented to enable recovery and build a woman's trust and confidence to access support; ii) Women with complex needs require long-term support, with the understanding that they can access support when needed, to give them confidence in the system and providers; iii) If a woman has a trusting relationship with her service provider and she feels cared for, she is more likely to engage with services and access appropriate treatment; iv) Building self-belief enables behaviour change and empowers women to make decisions for themselves, build their own understanding of their needs and take more ownership over their care; v) Women can be empowered through open and honest discussion around intersectionality to accept and reframe their experiences; and vi) Having a relationship with her community can increase a woman's belief that she is entitled to support, increasing likelihood of service engagement and participation. I'll discuss each in turn here.

A trauma informed approach, including providing safe spaces for women who have experienced trauma, should be implemented to enable recovery and build a woman's trust and confidence to access support.

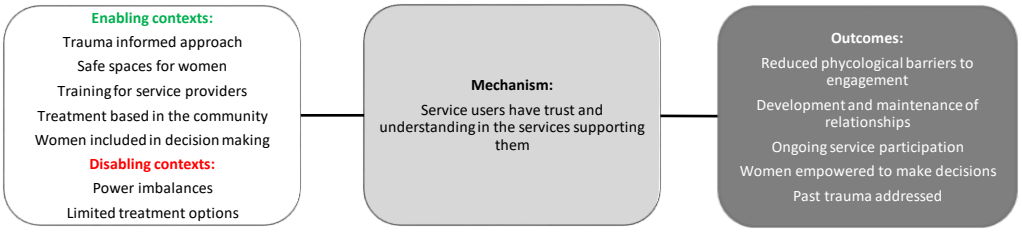
Women with complex needs have almost always experienced trauma and this has often taken place over several years, if not decades. A trauma-informed approach to service use should be implemented to enable recovery and build a woman's confidence to access support. Providing a safe space for women who have experienced trauma enables rebuilding of confidence and provides an opportunity to

address past trauma, while facilitating the building of relationships with others in the community to provide additional two-way support. This approach can also be built through a woman's relationship with her community. If an intervention has a basis in the community, this can reduce psychological barriers to engagement through increased familiarity to those seeking support, which encourages participation.

Including women in decisions can empower them to build their own understanding of their needs and take more ownership over their care, moving the balance of power towards the women seeking support as they feel better equipped to make this assessment and advocate for their preferred pathway. Often women with complex disadvantage who have experienced trauma will be lacking in self-confidence and self-worth, but helping women to develop an understanding of their own needs can improve this. To facilitate this change, services can be structured so that a woman makes her own choices about what her goals are and a plan to meet these can then be co-developed, so that this is led by the individual. Building self-belief can enable positive behaviour change and empowers women to make decisions for herself, better equipping her to navigate the support system.

Figure 44 shows the CMOC related to this basic theme.

Figure 44: CMOC related to the hypothesis "A trauma informed approach, including providing safe spaces for women who have experienced trauma, should be implemented to enable recovery and build a woman's trust and confidence to access support"



Women with complex needs require long-term support, with the understanding that they can access support when needed, to give them confidence in the system and providers.

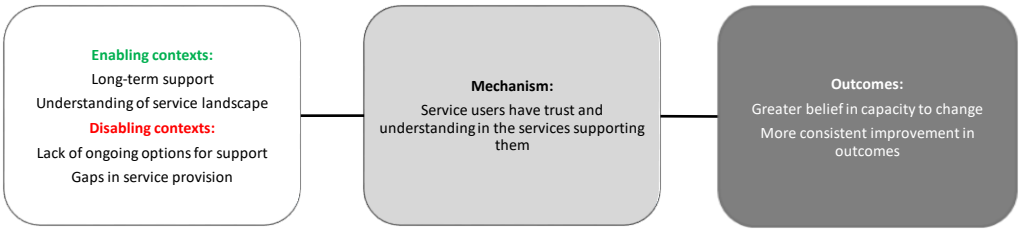
Women with complex needs often require long-term support, so demonstrating that they can access some support when needed can give them confidence in their service

provider and the health and support system more broadly. Women with complex needs may have mental health issues requiring treatment, but layered on top of that are physical health issues and practical concerns (e.g. finances, housing). Therapeutic work takes time, but often treatment programmes are time-limited in nature, such that support can 'drop off' (either partially or completely) once a programme is complete.

It might be the case that a specific type of service of programme is only required or appropriate for a limited amount of time, but what ITAV aims to do is increase service providers' understanding of where service users can go following the completion of these programmes, such that service users understand that they are able to access continued support in some form. This may help to address the cycle of individuals' situations improving while actively receiving treatment, just to deteriorate again once the programme comes to an end, and could also make service users more confident also that continued change is realistic and achievable, while feeling better supported by the system due to an awareness that they have the power to re-engage as / when needed.

Figure 45 shows the CMOC related to this basic theme.

Figure 45: CMOC related to the hypothesis "Women with complex needs require long-term support, with the understanding that they can access support when needed, to give them confidence in the system and providers"



If a woman has a trusting relationship with her service provider and she feels cared for, she is more likely to engage with services and access appropriate treatment.

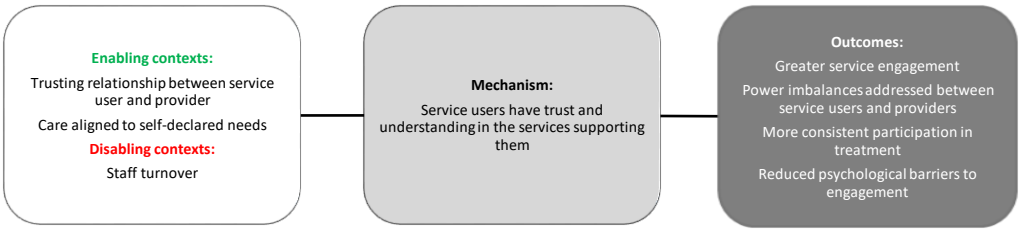
ITAV has a principle of building relationships based on trust and understanding. Trust in interventions can be built through aligning care to perceived needs, as this can enable women to feel heard and supported. If an individual feels that they are

understood by the people they're working with, they may be more willing to open up about their own needs and goals which helps to facilitate appropriate assessment and associated service provision. Improving service providers' understanding of the barriers in place for women with complex needs (including those which relate to intersectionality) can help them to demonstrate this understanding, giving service users more confidence that they're being looked after. This can also improve working relationships, such that power imbalances are actively addressed by service providers.

Building trust can also help to encourage further (and more consistent) engagement, through women seeing value in seeking access to treatment and presenting at appointments. This also lowers the psychological barriers around engaging, as any perceived risks are minimised, and the experience feels more comfortable and safe. This can be undermined through high staff turnover, as this requires the consistent building of new relationships and trust, as discussed earlier.

Figure 46 shows the CMOC related to this basic theme.

Figure 46: CMOC related to the hypothesis "If a woman has a trusting relationship with her service provider and she feels cared for, she is more likely to engage with services and access appropriate treatment."



Building self-belief enables behaviour change and empowers women to make decisions for herself, build their own understanding of their needs and take more ownership over their care.

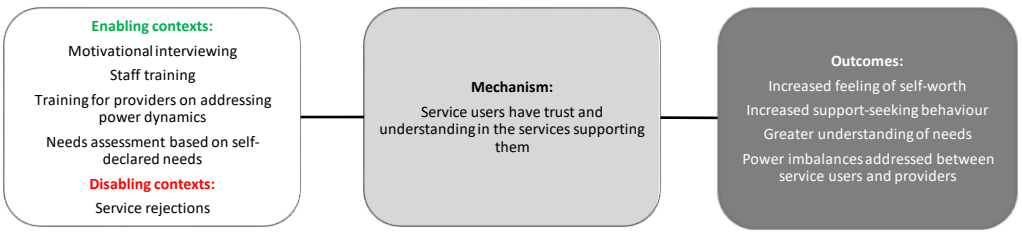
Experiencing trauma can reduce a woman's feeling of self-worth, making her believe that she is not deserving of care and support, and therefore reluctant to seek this or advocate for herself.

Increasing self-belief and self-worth can in turn make women more likely to see themselves as deserving of support, enhancing the will to seek access to treatment and advocate for themselves in the context of their own care. This can be enabled through providing training to providers on addressing power dynamics and through motivational interviewing and how to utilise this as a tool to encourage behaviour change and increase feelings of self-worth, which may have been damaged through experiences with services to date (e.g. through experiencing service rejections or dismissals).

If women are able to build their self-confidence and become more familiar with their own needs, this can enable more appropriate treatment, as providers can assess treatment requirements related to self-declared goals and requirements. As we saw earlier, structuring treatment around personal goals can help to shift power back towards service users and increase individual agency. This can increase a woman's trust in the system as they can immediately see that their concerns are being validated and acted upon, encouraging them to take more agency over their own care.

Figure 47 shows the CMOC related to this basic theme.

Figure 47: CMOC related to the hypothesis "Building self-belief enables behaviour change and empowers women to make decisions for herself, build their own understanding of their needs and take more ownership over their care"



Women can be empowered through open and honest discussion around intersectionality to accept and reframe their experiences

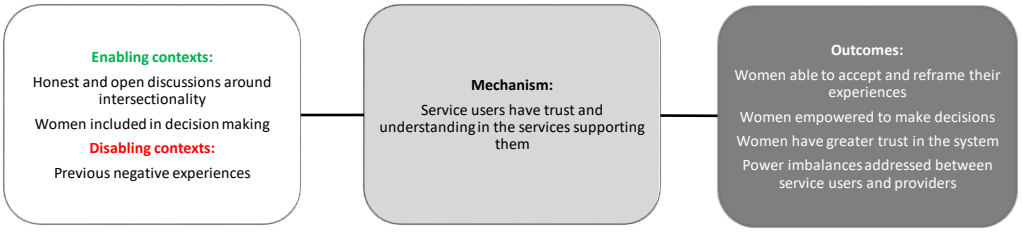
Women may have experienced discrimination on the basis of their sex, race, class or physical disability from services, making them untrusting that the providers who are there to support them will take their concerns seriously. As we saw above, increasing the range and availability of treatment options, then including women in decisions

around their own care can support the development of this trust, as women feel heard and understood.

Service providers can also build trust with service users through incorporating open and honest discussions around intersectionality in therapeutic settings. This can encourage empowerment, and an acceptance of their realities through directly addressing the inequalities they have experienced. Particularly when the practical issues they may be experiencing, e.g. limited access to services, is contextualised within this discussion. This can improve the relationship between service providers and users through open discussion which helps to avoid the reproduction of existing power hierarchies.

Figure 48 shows the CMOC related to this basic theme.

Figure 48: CMOC related to the hypothesis "Women can be empowered through open and honest discussion around intersectionality to accept and reframe their experiences"



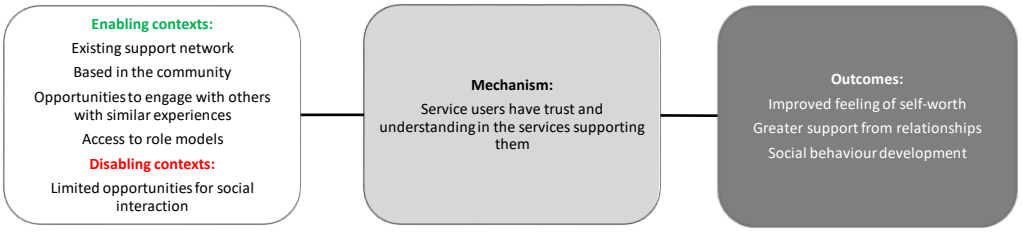
Having a relationship with her community can increase a woman's belief that she is entitled to support, increasing likelihood of service engagement and participation.

Low feelings of self-worth can also be improved when a woman has a support network around her, as building and maintaining relationships with others can result in improved self-perceptions, as well as the benefit of having people around her to support her participation in service use and treatment.

ITAV's basis in the community may facilitate this, through providing services that are based in community spaces, where women seeking support can meet others in similar or relatable positions. These connections can result in role models, social behaviour development and increased self-confidence.

Figure 49 shows the CMOC related to this basic theme.

Figure 49: CMOC related to the hypothesis "Having a relationship with her community can increase a woman's belief that she is entitled to support, increasing likelihood of service engagement and participation"



Flexible service provision and collaboration

Through the analysis, six CMOCs were identified which together formed the above programme theory: i) The dismantling of power structures between services can build a joint understanding of how to deconstruct discriminatory structural barriers in services; ii) Flexibility in services make them less likely to reject women with complex needs or discharge them for lack of engagement; iii) Improving relationships between services increases empathy and understanding of each service's priorities and objectives, enabling more productive conversations and reducing frustration with other providers; iv) Boundary spanning roles and approaches enable effective communication through wraparound support, for a more integrated service provision; v) Services each have a unique view to bring to the table based upon their specialism, which can be shared through a multi-agency approach to enable a more tailored approach to service provision; and vi) Women with complex needs require services to be coordinated to ensure all needs are appropriately assessed, prioritised and addressed, including parallel treatment of co-morbidities and practical needs. I'll discuss each in turn here.

The dismantling of power structures between services can build a joint understanding of how to deconstruct discriminatory structural barriers in services

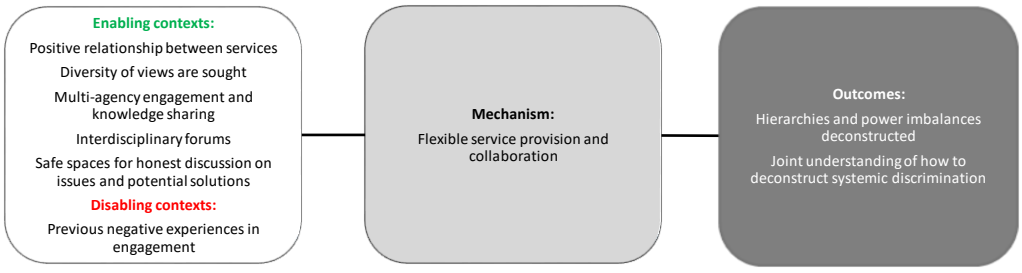
We have seen that there can be mutual frustration between services and that as a result they become disjointed and siloed. This can come from a lack of clarity around the 'offer' of each service and from negative experiences of working together in the

past, making engagement between services more challenging. In turn this highlights power differentials (particularly between voluntary and non-voluntary sector organisations) and reduces the diversity of expertise, experience and views around a table when discussing individual cases and designing systems. ITAV is aiming to improve these relationships between services through increasing engagement and knowledge sharing between agencies, and through the creation of specific forums for providers to share their expertise with each other and take a multi-agency approach to case management, through which it's aiming to reduce power differentials between services and ensure that diverse views are heard.

Building these positive relationships can make it easier to have more constructive discussions around systems change, as individuals feel more comfortable sharing the issues that they are identifying and suggesting potential solutions to those problems. ITAV has a strong focus on inclusion through bringing different agencies in to these discussions, including local community and faith-based organisations. This could support the dismantling of power hierarchies between services, bringing in organisations that may be less resourced, but have a greater understanding of the local community and its residents.

Figure 50 shows the CMOC related to this basic theme.

Figure 50: CMOC related to the hypothesis "The dismantling of power structures between services can build a joint understanding of how to deconstruct racist, ablest and classist structural barriers in services"



Flexibility in services make them less likely to reject women with complex needs or discharge them for lack of engagement.

We have seen some of the challenges in service provision stemming from strict eligibility criteria and rules related to discharge from programmes for lack of

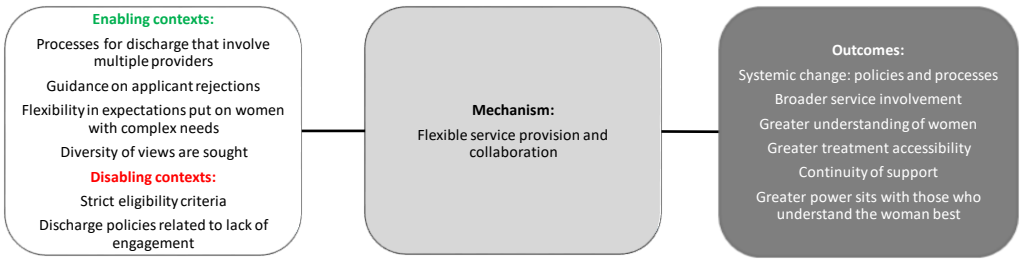
engagement. Being more flexible in these policies would facilitate greater accessibility and continuity of treatment.

ITAV aims to support this increase in flexibility through guidelines that services engage with each other – including those who have the best knowledge and understanding of the woman in question – before rejecting an application for access to support or discharging an individual from their programme. This has the additional benefit that it ensures different viewpoints are sought, which is especially relevant when working with clients from different cultures or backgrounds to the service provider managing their case. This is expected to encourage services to be more flexible and in turn, reduce rejections and provide more consistent support for those who need it, putting more power in the hands of the person with the greatest understanding of the individual woman.

In addition, ITAV is aiming to achieve systemic change to enable broader improvements in these policies, through increasing understanding of reasonable expectations around engagement for women with complex needs, as described earlier.

Figure 51 shows the CMOC related to this basic theme.

Figure 51: CMOC related to the hypothesis "Flexibility in services make them less likely to reject women with complex needs or discharge them for lack of engagement"



Improving relationships between services increases empathy and understanding of each service's priorities and objectives, enabling more productive conversations and reducing frustration with other providers.

Improving relationships between services can provide benefits to service users directly, through enabling integrated support, and indirectly through increasing the confidence of service providers in helping service users to navigate the treatment

landscape. ITAV is aiming to do this through facilitating discussions at senior stakeholder level to share understanding of strategic objectives and priorities; and at delivery stakeholder level to facilitate case management, application and delivery.

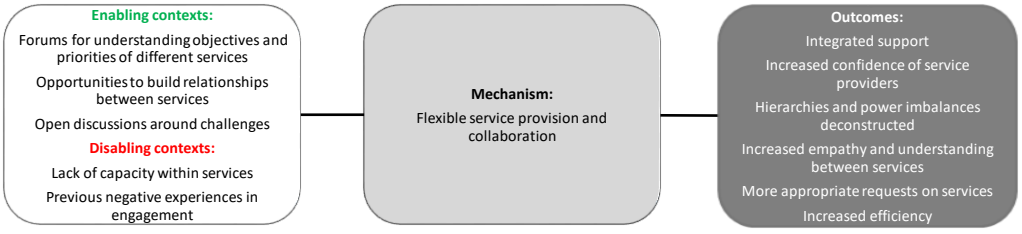
Building this understanding between stakeholders can increase empathy between services, as it can build an appreciation for the challenges that each service is facing and the reasons why they are sometimes unable to support the requests coming from other professionals. This is also improved by building understanding of each service's priorities and objectives, as this can reduce the number of requests that are outside of scope or infeasible for a service to deliver, and therefore saves time and reduces frustration from services being misaligned with their expectations of others.

Services can often hold frustration with other specialisms where they don't step in to a role which they believe they should fill, or aren't very reactive or responsive to requests. Building this understanding and empathy between services can mitigate the risk of ongoing negative impact from these experiences when trying to collaborate.

This may also allow for more constructive conversations between providers around areas of discrimination, building the confidence of individual providers in discussing these issues while sharing knowledge and experience. Improving relationships can support in deconstructing hierarchies and the associated power balance between colleagues, helping to have more constructive discussions and calling out issues that they see related to discrimination or barriers that impact specific populations through "challenging with compassion".

Figure 52 shows the CMOC related to this basic theme.

Figure 52: CMOC related to the hypothesis "Improving relationships between services increases empathy and understanding of each service's priorities and objectives, enabling more productive conversations and reducing frustration with other providers"



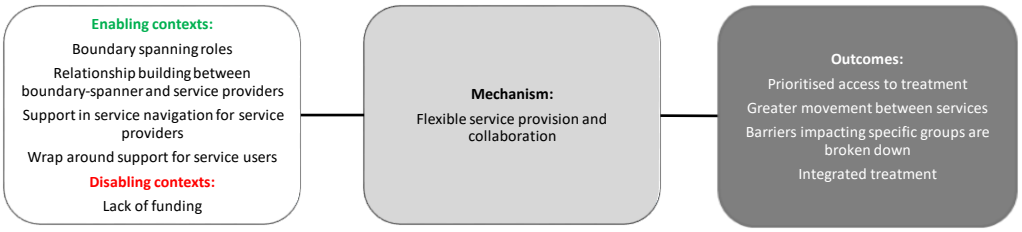
Boundary spanning roles and approaches enable effective communication through wraparound support, for a more integrated service provision.

To facilitate cross-service working, boundary spanning roles can be established. The purpose of these roles is to: maintain an understanding of the service landscape, hold relationships with professionals within these services, and use this understanding to navigate appropriate treatment pathways. This allows them to help service users to access their own care and support service providers to advise their clients on these available pathways.

These boundary spanning roles can spend time focused on building relationships with different services and service users, to improve communication on both sides and provide wraparound support to those seeking treatment. This can also enable the design and prioritisation of services to the needs of the individual through applying their understanding and experience to individual cases, and making enquiries on behalf of both the users and providers and breaking down barriers that impact specific groups, which boundary spanners are well placed to identify.

Figure 53 shows the CMOC related to this basic theme.

Figure 53: CMOC related to the hypothesis "Boundary spanning roles and approaches enable effective communication through wraparound support, for a more integrated service provision"



Services each have a unique view to bring to the table based upon their specialism, which can be shared through a multi-agency approach to enable a more tailored approach to service provision.

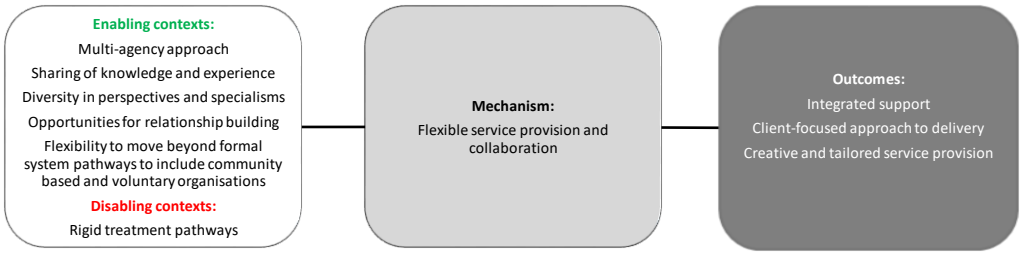
ITAV is built on a principle that services each have a unique view, and that they can learn from each other to build a more integrated and client-centred approach to service delivery, whilst incorporating the variety of specialisms around the table. This

is enabled through stronger relationships between services, to create a multi-agency approach where knowledge and experience is shared between teams.

Creating a multi-agency approach also has the potential to enable tailored service provision, as teams can take a holistic approach to understanding needs, identify the most effective pathways for individual cases and support each other to make these transitions between service providers happen smoothly and effectively. This can also allow for more creativity in service provision, as a diversity of views can come together to problem-solve in relation to individual cases and bringing in the voluntary sector or community based practices can extend care and support beyond formal system pathways whilst benefitting from greater cultural understanding of the community and / or population being supported.

Figure 54 shows the CMOC related to this basic theme.

Figure 54: CMOC related to the hypothesis "Services each have a unique view to bring to the table based upon their specialism, which can be shared through a multi-agency approach to enable a more tailored approach to service provision"



Women with complex needs require services to be coordinated to ensure all needs are appropriately assessed, prioritised and addressed, including parallel treatment of co-morbidities and practical needs.

The ITAV intervention creates forums and mechanisms to discuss individual cases bringing in a range of specialisms to help to coordinate care and ensure that treatment gaps are filled. This could also facilitate taking a more holistic view of the assessment of treatment needs and subsequent planning of care, including helping to structure parallel treatment pathways. This is particularly relevant when considering comorbidities which we know is a common issue for women in this group.

Figure 55 shows the CMOC related to this basic theme.

Figure 55: CMOC related to the hypothesis "Women with complex needs require services to be coordinated to ensure all needs are appropriately assessed, prioritised and addressed, including parallel treatment of co-morbidities and practical needs"