Skills for Justice

Ministry of Justice

Out of Court Disposals Training Guide

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Contents

Overview

This training guide is an output from a research study commissioned by the Ministry of Justice on how police in England and Wales use Out of Court Disposals (OOCDs; or Out of Court Resolutions[1]) to support adults (aged 18 or over) with health-related vulnerabilities, such as mental health problems, substance abuse, or neurodiversity.

It is intended to be used by police forces in England and Wales to support their use of OOCDs for adult offenders with health vulnerabilities.

This guide is structured into three sections and an Annex:

- Section 1 covers the background, rationale and intended target audience of the guide, as well as signposting to additional OOCD resources produced by the study team.
- Section 2 presents the suggested content for the training of operational decision makers.
- Section 3 presents the suggested content for the training of OOCD leads, subject matter experts and dedicated OOCD team members.

A 'Train the Trainer' guide is included in the Annex.

[1] The National Police Chiefs' Council commissioned research on the terminology police use to describe an outcome for lower-level offending without going to court, formerly known as Out of Court Disposals, including at the time of the OOCD study and when its outputs were produced. The survey found that the majority of respondents preferred the term 'resolution' as opposed to 'disposals'. Consequently, policing has rebranded away from disposals to resolutions. The MoJ are also happy to support the transition and have now adopted the term Out of Court Resolutions.

1. Background, rationale, and audience

1.1. Background

In 2021, the Ministry of Justice commissioned RAND Europe, Get the Data and Skills for Justice to conduct a study funded by the Shared Outcomes Fund on how police in England and Wales use OOCDs to support adults (aged 18 or over) with healthrelated vulnerabilities, such as mental health, drug use, or neurodiversity.

The aims of the study were: to provide an overview of how different police forces use OOCDs; to improve the use of OOCDs with conditions attached that address mental health and other health-related vulnerabilities; to provide a basis for practice change; and to improve data collection methods to monitor their use and enable potential further research to explore their effectiveness.

The study was composed of three phases:

- **Phase 1:** The research team captured the current use of OOCD conditions to support adults with health vulnerabilities, and relevant services available locally for each of the 37 police force areas in England and Wales participating in this study, including identifying any local gaps in service provision.
- **Phase 2:** Researchers explored in greater depth how health vulnerabilities were identified and addressed through OOCDs, relevant conditions set, and progress monitored, as well as perceptions of the effectiveness of the available conditions set in a sample of seven police forces.
- **Phase 3:** The research team worked with seven police forces to develop a basis for practice change and improve data collection methods used to monitor the use of OOCDs and enable future research on their effectiveness.

This training guide sits alongside several other outputs of **Phase 3** of the research – each of which are outlined below in Section 1.

If you would like to access the full study report, please click here.

1.2. Rationale and the need for a training guide

The Police, Crime, Sentencing and Courts Act 2022 will consolidate the current disposals into a two-tier OOCD framework consisting of two statutory options: Diversionary Caution and Community Caution,[2] and one non-statutory option, the community resolution.

The existing evidence[3] suggests that OOCDs can help to address health vulnerabilities and reduce reoffending (please refer to the research report's Annex 3 for a detailed review of the evidence base for OOCDs).[4] Further evidence suggests that when OOCD interventions are delivered well and targeted at appropriate individuals, they can be beneficial to both victim satisfaction[5] and reduced reoffending.[6] [7] [8] They therefore have potential as an integral aspect of a rehabilitative approach to criminal justice disposals for lower-level offending.

The research study that informed this training guide found a wide range of approaches to the use of OOCDs across forces in England and Wales in cases that were eligible for these disposals.[9] Furthermore, it found that training of police officers and staff on OOCDs is generally conducted on an ad-hoc basis and not available as a structured programme for most police forces. High staff turnover and inexperienced officers were identified as key challenges for the effective use of OOCDs. Therefore, one of study's key suggestions was the development of a training guide encapsulating the study's key findings, which forces can use to inform their approach to training on the use of OOCDs to address health vulnerabilities.

[2] Home Office (2022), 'Reforms to the Adult Out of Court Disposals Framework in the Police, Crime, Sentencing and Courts Bill: Equalities Impact Assessment', https://www.gov.uk/government/publications/police-crime-sentencing-and-courts-bill-2021equality-statements/reforms-to-the-adult-out-of-court-disposals-framework-in-the-police-crime-sentencing-courts-bill-equalitiesimpact-assessment.

[3] Neyroud, P. (2018). Out of Court Disposals managed by the Police: a review of the evidence. https://www.npcc.police.uk/Publication/NPCC%20Out%20of%20Court%20Disposals%20Evidence%20assessment%20FINAL %20June%202018.pdf.

[4] The available evidence is international and does not always translate to the England and Wales context. The evidence has been interpreted with this in mind.

[5] Allen, R. (2017). Less is more - The case for dealing with offences out of court. London: Transform Justice.

[6] Robin-D'Cruz, C., & Whitehead, S. (2019). Briefing pre-court diversion for adults: An evidence briefing. https://justiceinnovation.org/sites/default/files/media/documents/2019-06/cji_pre-court_diversion_d.pdf.

[7] Broner, N., Mayrl, D. W., Landsberg, G. (2005), Outcomes of mandated and nonmandated New York City jail diversion for offenders with alcohol, drug, and mental disorders. The Prison Journal 85(1), pp. 18-49.

[8] Harvey, E., Shakeshaft, A., Hetherington, K., Sannibale, C., & Mattick, R. P. (2007). The efficacy of diversion and aftercare strategies for adult drug-involved offenders: a summary and methodological review of the outcome literature. Drug and alcohol review, 26(4), 379-387.

[9] For the 31 forces that provided information on the proportion of each outcome given to offenders in 2021, only 8%, on average, of all adult offenders were given an OOCD. The extent that OOCDs were used varied greatly: the Phase 1 aggregate dataset showed that OOCDs made up 4-20% of all outcomes for most forces, and between 7-50% of outcomes in the case of the seven case study forces in Phase 3.

1.3. What is this guide and who is it for?

The study team developed this OOCD training guide, alongside additional resources, to help forces support relevant officers and decision makers in setting OOCD conditions addressing health vulnerabilities, and to support higher-level decision makers in implementing OOCD processes. As a guide, it is intended to be adapted by forces to reflect their local operating context.

The suggested training content in this guide is split between Sections 2 and 3; each directed at one of two target audiences:

1. **Audience 1 - OOCD operational decision makers** (Section 2): the content suggested for this audience focuses on how to handle the practical challenges of using OOCDs to address health vulnerabilities.
   - Targeted training attendees are anticipated to be custody, response or investigative team leads who can cascade knowledge down to frontline officers.
   - Our research indicates that disposal decisions in many forces are made by frontline officers in consultation with their direct superior(s).[10]
   - The training framework outlined here can be adapted to suit the OOCD process within a particular force.

2. **Audience 2 - Dedicated OOCD teams/staff** (Section 3): the content suggested for this audience focuses on supporting higher-level OOCD decision makers.

   Targeted training attendees are anticipated to be custody, response or investigative team leads who can cascade knowledge down to frontline officers.

   - The content is designed to provide a wider understanding of how OOCDs are used to address health vulnerabilities in forces across England and Wales, and how dedicated OOCD teams/staff might incorporate elements of best practice into their local process.
   - This anticipated audience are *OOCD leads, subject matter experts, and dedicated/centralised OOCD team members.*

[10] According to research report (p.69), 13 forces reported that the officer in charge (OIC) was typically responsible for undertaking the vulnerability assessment in the OOCD process, although this is often done in consultation with their supervisor or other colleagues. Custody officers and/or staff were reported to be responsible for the vulnerability assessment in four forces, although again this decision is often made in consultation with the OIC and L&D.

Throughout Sections 1, 2, and 3, 'Key Implications' for forces are highlighted in boxes like the one below:

Key Implications

Each force may want to consider reviewing their current training arrangements to ensure that all those involved in OOCD decision-making are suitably trained in this area. Forces may consider adopting the training structure and content outlined in this guide and tailoring the content to their force's OOCD process and local context.

These implications are collected in the conclusions at the end of both Sections 2 and 3.

The examples provided in this guide may not reflect the practices within all forces. While this new framework aims to enhance consistency between forces, the research found that forces take a variety of approaches to using OOCDs due to local factors including available resources, leadership priorities, locally available intervention/services, gaps in OOCD decision-maker knowledge, experience levels of frontline officers, and attitudes to the use of OOCDs.

Throughout the consultation with forces for this guide, stakeholders noted that providing extensive vulnerability-focused training to frontline officers on the use of OOCDs would be prohibitively resource-intensive, and therefore unlikely to be effective. The training content proposed in this guide is therefore not recommended for frontline officers. Instead, adequate resources (staff, systems, process) should be in place to ensure health vulnerability expertise is available to frontline officers as and when required to support initial OOCD recommendations.

The content of this guide requires input from forces. As noted above, the specific content used in training should be tailored to each force's specific processes and needs. This training guide may be used by anyone responsible for OOCD training – which may imply different roles in different forces: for example, an OOCD lead/team, or force's dedicated training department.

The suggestions in this guide focus on the health vulnerability aspect of OOCD, many are expected to be helpful for OOCD processes in general.

1.3 Signposting to additional resources to help develop and maintain good practice in OOCDs

Alongside this training development guide, the study team has developed the following resource documents as part of Phase 3 of the research:

1. **Health Vulnerability Assessment Guide for OOCDs**: to support forces in developing the health vulnerability assessment process to enable better decision-making. This guide also includes good practice examples for working with Liaison and Diversion (Appendix A).
2. **Quality Assurance Guide for OOCD Health Vulnerability-Related Interventions**: illustrates how forces can ensure they commission/use appropriate and effective services.
3. **Auditing Missed Opportunities Guide**: provides forces with a simple methodology to audit the appropriateness of OOCD decisions.
4. **Data collection tool prototype**: to support forces in gathering and using OOCD data.
5. **Train the Trainer guide:** helps cascade training internally, particularly where responsibility for OOCD training (and associated activities, such as referrals to interventions) is not held by a force's dedicated training department.

The Train the Trainer guide is included as an Annex to this document and details step-by-step good practice on training delivery, covering the following:

1. Why Train the Trainer is important
2. What qualities are essential for a trainer?
3. Common fears and combatting them
4. Understanding the stages of the training cycle
5. Stage one: Identifying needs
6. Stage two: Designing the training
7. Stage three: Delivering the training
8. Stage four: Evaluating the training.

2. Suggested content for operational OOCD decision makers

Section 2 of this guide focuses on suggested content to be directed at operational decision makers – for example, custody sergeants and response and/or investigative team leads. In targeting these groups, the overarching goal is to give them the means to both deliver effective OOCD decisions to support those with health vulnerabilities, and to pass this knowledge on to frontline officers where needed.

2.1. Introduction to OOCDs

The research highlighted that an ideal place to start training on OOCDs may be a quick refresher on the basics of what OOCDs are and why they are used.

What is an OOCD?

OOCDs are used by police in England and Wales as a tool to resolve investigations into lower-level crimes and anti-social behaviour committed by offenders who have little or no previous criminal history and, in most cases, have admitted to committing the offence. OOCDs are intended to prevent escalation to more serious crimes and reduce recidivism rates by enabling police to intervene quickly and divert offenders away from immediate entry into the criminal justice system, as well as from future criminal behaviour.

As noted in Section 1.1, as part of the implementation of the Police, Crime, Sentencing and Courts Act 2022, police forces in England and Wales are expected to consolidate their current disposals into a two-tier plus OOCD framework consisting of two statutory options: Diversionary Caution and Community Caution,[11] and one non-statutory option: Community Resolution. This guide is primarily concerned with the two statutory options.

[11] Home Office (2022). Reforms to the Adult Out of Court Disposals Framework in the Police, Crime, Sentencing and Courts Bill: Equalities Impact Assessment. https://www.gov.uk/government/publications/police-crime-sentencing-and-courts-bill-2021equality-statements/reforms-to-the-adult-out-of-court-disposals-framework-in-the-police-crime-sentencing-courts-bill-equalitiesimpact-assessment.

The new two-tier OOCD framework will consist of:

Diversionary Caution: an 'upper-tier' disposal that allows police to attach rehabilitative, reparative and/or punitive conditions to be carried out within a specified time period. It is considered 'spent' after three months – or sooner if the conditions are met before then. Non-compliance with a Diversionary Caution can result in prosecution for the original offence

Community Caution: a 'lower-tier' disposal that can be used in response to lesser crimes, and which is 'spent' immediately. Non-compliance with a Community Caution can result in a fine being registered with the Magistrates' Court.

Both disposals depend on an admission of guilt by the offender, as there is no recourse to court once the caution is administered.12 Neither caution counts as a criminal conviction, but they can appear on Disclosure and Barring Service (DBS) checks.

Under the national framework, Community Resolutions will remain available for police forces to use in appropriate circumstances. Moreover, it should be noted that alternative options for solving cases out of court, such as Fixed Penalty Notices or deferred prosecution, will also be retained alongside the new statutory two-tier plus OOCD framework.

It is important to acknowledge that although some data on the use of OOCDs is collected nationally, there is no central data available on conditions set by forces or the extent to which offenders comply with them. As such, gaps remain in our understanding of how the use of OOCDs could be improved and which types of referrals are most effective in supporting vulnerable adults. For further information, please refer to the full study report here.

2.2. Defining health vulnerabilities

A common definition of health vulnerabilities is necessary for officers in supervisory roles to consult on disposal decisions/conditions and communicate information about vulnerabilities to frontline officers.

The guide and the accompanying guide documents suggest that health vulnerability definitions from the Liaison and Diversion (L&D) Standard Service Specification[12] would be most appropriate. This document also outlines the aims and objectives of the L&D service and details services that police forces can call on to deliver OOCDs (except in Wales, where available support from L&D will vary from force to force). For more information on health vulnerabilities and the involvement of L&D in an OOCD process, please refer to the dedicated Assessment Guide here, including Appendix A: Working with Liaison and Diversion Services.

[12] NHS England (2019). Liaison and Diversion Standard Service Specification. https://www.england.nhs.uk/publication/liaisonand-diversion-standard-service-specification/

The L&D Standard Service Specification outlines the following health vulnerabilities:

Category of vulnerability	Specific criteria from L&D Standard Service Specification
Mental health	Those with complex emotional/behavioural difficulties requiring mental health and social care support and specialist community intervention as part of an integrated multi-agency package of care Service users in acute crisis with eating disorders, depression, risk of suicide, psychosis, escalating self-harm, personality disorders
Learning disability	Those with learning disabilities
Neurodiversity	Those with autism spectrum disorder
Substance misuse	Those with substance misuse issues
Physical health	Those with acquired brain injury Those with complex, severe, or persistent health needs
Other[13]	Those with multiple sub-threshold needs Repeat offenders Veterans Women Those experiencing homelessness Those at risk – including being at risk of domestic violence – Multi-Agency Public Protection Arrangements (MAPPA),[14] safeguarding issues Service users from a minority ethnic or minority cultural background, including the Traveller community

Table 1. L&D Standard Service Specification

[13] The potential vulnerabilities listed in the 'Other' category may not always constitute health vulnerabilities in themselves but indicate people who may be at higher risk of other types of health vulnerability and instances of multiple overlapping vulnerabilities.

[14] MAPPA is a set of arrangements that provides a common framework for the identification, assessment, and management of certain offenders in the community. For those convicted in England and Wales, the MAPPA Guide sets out a list of the relevant sexual and violent offences: https://www.gov.uk/government/publications/multi-agency-public-protection-arrangements-mappa--3/multi-agency-public-protection-arrangements-mappa-accessibleversion#:~:text=Multi%2Dagency%20public%20protection%20arrangements%20(MAPPA),-UK%20Visas%20and.

Key implication

Forces may wish to consider which vulnerabilities are particularly prevalent in their area, and the interventions available for those offenders. This will depend on the force, but where possible, supervising OOCD decision makers would benefit from understanding the available options, and which vulnerabilities these options are suited to addressing.

2.3. Why do we consider health vulnerabilities in relation to OOCDs?

For those not already engaged in this aspect of police work, the rationale behind using OOCDs to address health vulnerabilities may not be immediately obvious, so it may help to review the reasons why this approach is worthwhile:

- Evidence shows a higher prevalence of (complex) health vulnerabilities among those in contact with the Criminal Justice System.[16,17,18] Rehabilitative conditions attached to OOCDs can point offenders to the support they need to tackle the root causes of their offending behaviour, and so reduce reoffending.
- The evidence base on the effectiveness of OOCDs for adults with health vulnerabilities indicates that providing OOCDs with suitable conditions to appropriate offenders often results in increased compliance rates,[19] improved criminogenic needs and well-being,[15] and reduced reoffending rates.[16]
- OOCDs (whether used in relation to health vulnerabilities or not) can reduce the police resources needed resolve a case, compared to prosecution. During consultation, this was a key insight offered by team leads involved in relatively large volumes of conditional cautions.
- At the same time, effective use of OOCDs could potentially save time and costs across the justice system as a whole, by alleviating the burden on the court system.[17]
- Peer reviewed studies have shown that health intervention diversions can have a strong impact on offending behaviour[18] and wellbeing[24] (depending on the quality of the intervention and how it is targeted).

[15] Codd, H., Doherty, J., Doherty, P., Robertson, L. and Elliott, A. (2016). An Evaluation of the 'Vision', 'Avert', and 'Achieve' Interventions. Preston: University of Central Lancashire.

[16] Harvey, E., Shakeshaft, A., Hetherington, K., Sannibale, C., & Mattick, R. P. (2007). The efficacy of diversion and aftercare strategies for adult drug-involved offenders: a summary and methodological review of the outcome literature. Drug and alcohol review, 26(4), 379-387.

[17] National Police Chiefs' Council (2018), 'Charging and Out of Court Disposals: A national strategy 2017-2021', https://www.npcc.police.uk/Publication/Charging%20and%20Out%20of%20Court%20Disposals%20A%20National%20Strategy.pdf.

[18] Robin-D'Cruz and Whitehead (2019) found that pre-court diversions can be particularly effective for those with health vulnerabilities, despite other research discovering little isolated impact for these groups. This paper supported the notion that providing access to appropriate services is an effective way to overcome drivers of offending, as well as promoting early intervention as essential to tackling substance misuse issues and reducing recidivism. Further support is provided by Harvey et al.'s (2007) review, which found that 74% of the papers reviewed on OOCDs (or the local equivalent) targeted at drug offenders resulted in a reduction in recidivism. For example, Broner, et al. (2005) found that treatment for mental health and substance use issues had significant positive effects on recidivism, with fewer felony, misdemeanour, and violation rearrests at both three and 12 months after diversion. [24] An evaluation of the Vision, Avert, and Achieve programmes available at Lancashire Women's centres by Codd et al. (2016) looked at depression and anxiety data from 77 women and found that 61% of participants reported that involvement in these programmes had a positive impact on their depression, while 63% reported a positive impact on their anxiety levels. In Harvey et al.'s (2007) review paper, most reviewed studies examining the impact of diversionary strategies involving drug interventions on drug use (six out of nine) found a positive impact on drug-use outcomes, with reduced drug-use among participants compared to control groups who went through the usual criminal justice procedures.

2.4. The use of case studies for training

Key implication

Staff with training responsibilities may wish to create tailored case studies for instructive purposes that refer to the force's specific OOCD procedures and processes and demonstrate how OOCDs can be used to address health vulnerabilities.

Case studies can help trainees understand the complexity of the OOCD decision making process and procedure within their force by drawing on real-life examples. The following structure (Table 2) could be used for case studies:

Problem	Input	Output	Outcome
Arrest – signs of mental health and substance misuse vulnerabilities.	Consultation with L&D on best course of action.	In-person vulnerability assessment with an L&D practitioner; referral to a specialist mental health support service.	Offender can access a long-term programme of support; the health vulnerability motivating offending behaviour is reduced.

Table 2. Suggested structure for case studies

Figure 1 offers three further examples illustrating potential differences in OOCD processes and outcomes across different forces, and may be tailored to forces' individual case studies for training purposes.

Figure 1. Examples of OOCD working

As these examples are loosely adapted from research data from real forces, they demonstrate particulars of the process that may vary considerably. It is important to note that process may vary even within a force area, as many steps of the process depend on the knowledge and capability of decision makers and the availability of vulnerability assessment resources and intervention services. A charity that offers an intervention in one region may not offer the same service across an entire force area. This is why it is important for forces to build tailored OOCD case studies following their own OOCD processes and procedures to ensure training examples are true to local practice.

Due to the varying geographic, demographic, and leadership environments forces work within, it is not possible to point to a single example of best practice that is relevant and desirable in all circumstances. However, there are examples of key features of best practice common to forces that use robust processes.

Key features of OOCD best practice

A clear and consistent approach to conducting vulnerability assessments and considering vulnerabilities in disposal decision-making.

Clear responsibilities in the decision-making chain for frontline officers and supervisors, as well as dedicated OOCD staff and the support of L&D if applicable.

Suitable available interventions to attach as conditions for OOCDs, and processes in place to assess quality and effectiveness.

A clear process to set conditions, refer offenders to service providers, and manage service relationships.

Sufficient data recording and information flow to monitor compliance with conditions, audit the use of OOCDs, and evaluate and improve processes.

2.5. Responsibilities in the decision-making chain and vulnerability assessments

All routes to any kind of OOCD outcome involve a vulnerability assessment in some form, however, processes and responsibilities for assessing vulnerability are a major point of divergence between forces.

As such, the suggestions here focus on the information that must be conveyed throughout the OOCD process and taught during OOCD training.

A key element of the decision-making process is ascertaining which vulnerabilities are relevant in a particular case so that an appropriate disposal decision can be made.

Team leads and operational OOCD decision makers must be given information on the vulnerability process within your force. This information may include:

- The disposal decision maker(s) (e.g. supervisor, dedicated OOCD team, OOCD lead, etc.)
- Questions that need to be asked to rapidly screen health vulnerabilities without adding unnecessary burden to frontline officers. The accompanying health vulnerability assessment guide has further information on this stage of the process.
- Available vulnerability assessment tools (checkbox forms, vulnerability information sheets) in place physically or on handheld devices. If vulnerability assessment tools are not yet in place, there are detailed examples in the OOCD health vulnerability assessment guide.
- The information that needs to be recorded and communicated to support the disposal decision and any conditions (e.g. identified mental health issues, learning disability, drug use, neurodiversity, physical illness or disability)
- Available support and advice for officers (officers should have access to expert support from L&D staff; support is also available from supervisors and/or OOCD team).

The following diagram 2 (from the study health vulnerability assessment guide) illustrates an example of the processes involved in a three-gateway model for health vulnerability screening during the OOCD decision-making process:

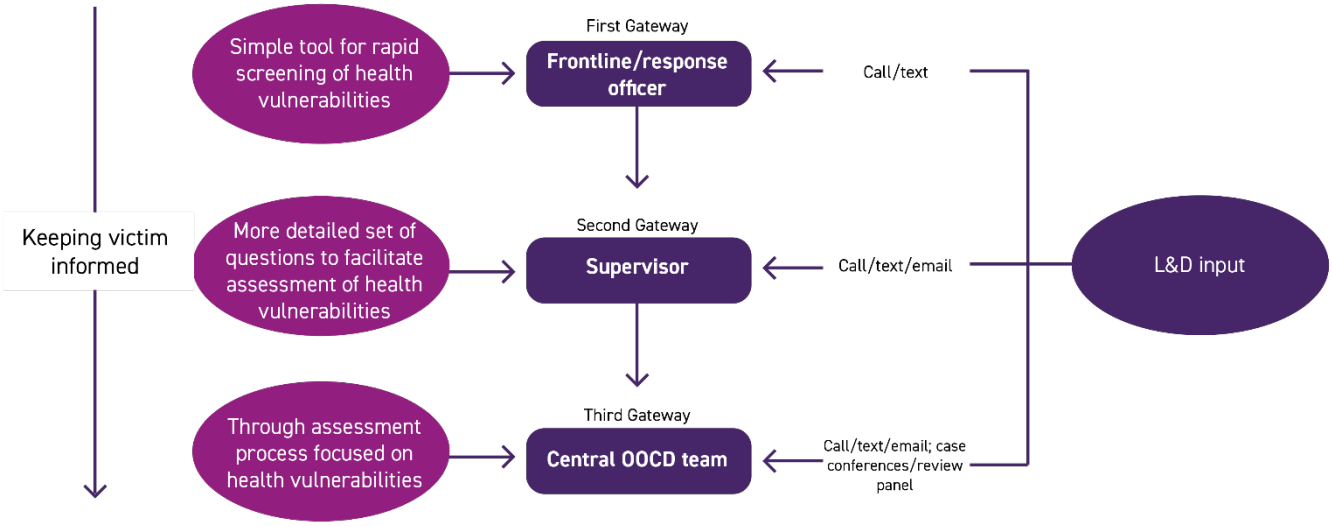


Diagram 2. Illustrating processes involved in three-gateway model for health vulnerability screening during the OOCD decision-making process.

As part of their OOCD processes, forces should ensure:

Disposal conditions are targeted at addressing the causes of offending behaviour (including health vulnerabilities).

The reasons for conditions are recorded to support scrutiny, further decisionmaking and evaluation.

Both the offender and victim(s) should be informed about the purpose of diversion and intervention conditions, and the victim's wishes should be considered in condition-setting.

Compliance with OOCD conditions is monitored.

To support these objectives, it may help to visualise the OOCD decision-making process in a chart, table, or diagram (as per Diagram 2 above), along with the resources available to support decision-making, including the responsibilities of key personnel involved at each stage of the process.

In a situation with an offender where an OOCD is anticipated as a possible outcome, the three-gateway model can include the following responsibilities for each of the three stages in Diagram 2:

- **First Gateway – Frontline officers should:**

  - record any relevant information about the offence
  - give initial consideration to an OOCD and begin screening for health vulnerabilities
  - be able to recognise any immediate risk and suspected/reported health vulnerability/condition based on a simple screening process/tool
  - contact L&D with any questions about potential vulnerabilities.
  - make an initial recommendation for an OOCD decision to their supervisor
  - communicate key information (OOCD recommendation, reasons for diversion, process, timelines, potential outcomes) to decision makers, offenders, and victims as appropriate.

And/or depending on the particular processes and resources available within the force:

- **Second Gateway – Team leads/supervising decision makers/ vulnerability assessors should:**

  - conduct a comprehensive review of all evidence in the case
  - complete a health vulnerability assessment checklist, where needed
  - where applicable, provide further consultation with suitable stakeholders (triage, L&D, etc.) for a more detailed health vulnerability assessment
  - consult with the arresting officer on condition-setting and suitable interventions

- consider making an OOCD decision and assessing the impact of health vulnerabilities on that decision
- communicate with the victim about any decisions regarding the offender's disposal in a timely manner.

- **Third Gateway – Dedicated team /police resource/OOCD leads should:**

- design the overall OOCD process and approach to health vulnerability assessments
- conduct thorough health vulnerability assessments, with support from
- L&D when needed o review cases to determine their suitability for OOCD use
- propose appropriate conditions and relevant interventions to address the offender's criminogenic needs and vulnerability-related risks
- procure suitable interventions to address health vulnerabilities/offending behaviour and liaise with providers
- provide OOCD training
- provide additional support for referrals
- inform victims of the agreed outcome, including receiving their consent if appropriate
- monitor compliance of conditions.

- **Service provider(s) leads should:**

- deliver interventions to address health vulnerabilities and/or offending behaviour
- return information to forces for compliance monitoring purposes.

Many of these steps would occur regardless of whether an OOCD outcome is being considered – so it can help to emphasise to training recipients that these task lists are less burdensome than they might appear on paper.

Additionally, this is not a prescriptive list of responsibilities, as each force's process will differ. This may mean that different responsibilities fall to different roles within the decision-making chain, or it that the process is not yet able to support every step listed here. Conversely, it may be that the process within a force is at a stage where additional features can be included, such as in-depth decision-recording, missed opportunities auditing, quality assurance, etc. (please refer to further guides available). These considerations will be further explored in the second part of this training guide, which is aimed at dedicated OOCD staff members with oversight of a force's process.

Key implications

Roles and responsibilities for each member of the decision-making process in assessing vulnerabilities should be well defined and communicated.

Wherever possible, the burden of conducting vulnerability assessments on frontline officers should be minimised, and the support structures available to help decision- making should be clearly communicated.

Communicating about OOCDs to offenders and victims: Decision makers must be able to provide information about the process to offenders and victims as part of any disposal, such as:

- **Accessible information about the process:**

  - What is an OOCD?
  - Why is one being considered?
  - What might it involve?
  - Possible outcomes if an OOCD is given.
  - Responses to queries such as: 'Do I have to do anything?', 'What will the offender have to do?', 'Will the result form part of a criminal record?', and other details of the process and outcome.
  - Where to get support for OOCD outcome decision-making for the offender if further deliberation is required (e.g. supervisor, OOCD dedicated team, L&D services).

- **Health vulnerability assessment and screening:**

  - What, if any, vulnerabilities have been identified?
  - Any requirements for the disposal being considered:
  - e.g. both Community Caution and Diversionary Caution disposals are dependent on an admission of guilt by the offender, as there is no recourse to court once the caution is administered.
  - available interventions within the force area.

2.6. Improving the vulnerability assessment process

The vulnerability assessment process is vital to the success of any OOCD intervention to support offenders with health vulnerabilities, as this assessment informs decisions over condition-setting. However, thorough vulnerability assessments require expertise in identifying vulnerabilities that many frontline officers do not possess. Therefore, a force's vulnerability assessment process as

part of their OOCD work must leverage the resources of vulnerability experts give frontline officers access to this expertise as required.

Our suggested method of achieving this follows the Three Gateways model introduced in the previous section, which involves three different levels of vulnerability assessment depending on the case:

Assessment stage	Description
First gateway **Frontline/response officer**	Simple screening process composed of a short set of prompts to rapidly identify potential health vulnerabilities in the offender. L&D advice to be available through telephone call or text.
Second gateway **Supervisor**	A longer set of questions, in checklist format, to gain a more in-depth understanding of the offender's health vulnerability, with more detail regarding their criminogenic need, to help provide an appropriate OOCD. L&D advice to be available by telephone call, text, email, or in person.
Third gateway **Dedicated OOCD team**	A thorough set of detailed questions – both checklist and open-ended – to ensure full understanding of the offender's needs and health vulnerabilities, so that appropriate rehabilitative conditions and intervention can be provided to meet their criminogenic needs. L&D advice to be available by telephone call, text, email, or in person. In some complex cases, a multiagency case conference may be needed.

Table 3. Descriptions of screening and assessment questions to be used at each gateway in the three-stage model, as well as specific information that will be collected from the offenders at each gateway.

2.7. Key implications from this section:

- Where possible, forces should identify which vulnerabilities are particularly prevalent in their area and identify the interventions available for relevant offenders. This will depend on the force, but where possible, supervising OOCD decision makers should understand the options available and which vulnerabilities those options are suited to addressing.
- The roles and responsibilities of each member of the decision-making process in assessing vulnerabilities should be well defined and communicated.
- Wherever possible, the burden on frontline officers of conducting vulnerability assessments should be minimised and the support structures available to help decision-making should be clearly communicated.
- The research team suggests that staff with training responsibilities create tailored case studies for instructive purposes, which can refer to the force's specific OOCD procedures and processes and demonstrate how OOCDs can be used to address health vulnerabilities.

3. Suggested content for OOCD Leads, Subject Matter Experts, Dedicated Team Members

This section is directed at individuals who oversee the OOCD process within their force area. The research team identified these individuals as including OOCD leads, specialists, subject matter experts and/or dedicated teams tasked with supporting the OOCD process.

Not all forces have the same structure in place for planning and managing the process. However, most forces engaged in a significant number of OOCDs do have at least one person to support frontline decision makers, provide training on the use of OOCDs, review condition-setting, liaise with other stakeholders (such as L&D) and/or commission or enlist the help of third-party services to deliver interventions to offenders.

The content of this section serves as an introduction for individuals who are new to the role of managing the OOCD process, but familiar with OOCD working – or as a refresher for individuals looking to broaden their expertise and/or improve practice.

3.1. Planning ideal roles and responsibilities

The research found significant differences between forces regarding the roles and responsibilities involved in conducting vulnerability assessments, condition-setting, and compliance monitoring. Some differences may be unavoidable given differences in available resources, offending behaviour, and attitudes towards OOCDs as an approach to criminal justice, both within policing and wider society across the police force areas.

A table detailing suggested responsibilities for frontline officers, supervisors, dedicated OOCD teams, and L&D is also included within the associated health vulnerability assessment guide, and reproduced here:

Stage	Frontline	Supervisor	OOCD team	L&D
First gateway	Record relevant information about the offence, using screening process to identify any suspected vulnerabilities. Contact L&D for support with any queries regarding the offender's health vulnerability. Propose an initial recommendation to supervisor and inform victim of this decision.	–	Advise frontline officer of OOCD options where needed.	Be accessible through digital communication to support frontline officer with any queries.
Second gateway	–	Review all available evidence for the case. Complete the health vulnerability assessment checklist – this can either be done by the supervisor, delegated to another officer, or requested from L&D where needed. Consult L&D on a more detailed professional health vulnerability assessment where needed. Speak with victim about any decisions regarding the offender's disposal, allowing for feedback.	Support supervisor to conduct health vulnerability assessment where needed and relay information regarding OOCD options and conditions. Inform supervisor of any inappropriate decision-making regarding OOCD provision.	Be accessible through digital communication to support the provision of professional health vulnerability assessments. Be available to provide health vulnerability assessments as part of a vulnerability assessment.
Third gateway	–	Provide any additional supporting evidence requested by the dedicated team.	Conduct a thorough health vulnerability assessment, with help from L&D where needed. Review cases to determine their appropriateness for an OOCD. Propose appropriate conditions and relevant interventions to address the offender's criminogenic need and inform the victim of the agreed outcome, receiving their consent where necessary. Ask for the victim's feedback on how the case was dealt with.	Support the dedicated team in conducting thorough health vulnerability assessments. Support review of suitability of cases referred to OOCDs through review panels and case conferences. Support with the identification of suitable interventions to use for conditions.

Table 4. Outline of key roles and responsibilities of the frontline officer, supervisor, dedicated team, and L&D at each gateway of the three-stage model proposed for health assessments.

3.2. Improving the vulnerability assessment process

The vulnerability assessment process is vital to the success of any OOCD intervention to support offenders with health vulnerabilities, as this assessment informs decisions over condition-setting. However, thorough vulnerability assessments require expertise in identifying vulnerabilities that many frontline officers do not possess. Therefore, a force's vulnerability assessment process as part of their OOCD work must leverage the resources of vulnerability experts give frontline officers access to this expertise as required.

Our suggested method of achieving this involves three different levels of vulnerability assessment depending on the case – conducted by:

Gateway 1 – frontline officers

Gateway 2 – supervisors/team leads

Gateway 3 – dedicated OOCD team, where available.

Assessment Stage	Description
First gateway **Frontline/response officer**	Simple screening process composed of a short set of prompts to rapidly identify potential health vulnerabilities in the offender. L&D advice to be available by telephone call or text.
Second gateway **Supervisor**	Longer set of questions, in checklist format, to gain a more in-depth understanding of the offender's health vulnerability, with more detail regarding their criminogenic need, to help provide an appropriate OOCD. L&D advice to be available by telephone call, text, email, or in person.
Third gateway **Dedicated OOCD team**	A thorough set of detailed questions – both checklist and open-ended – to ensure full understanding of the offender's needs and health vulnerabilities, so that appropriate rehabilitative conditions and intervention can be provided to meet their criminogenic needs. L&D advice to be available by telephone call, text, email, or in person. In some complex cases, a multiagency case conference may be needed.

Table 5. Descriptions of screening and assessment questions to be used at each gateway in the three-stage model, as well as specific information that will be collected from the offenders at each gateway.

This process is illustrated in the Diagram 3 – a three-gateway model for health vulnerability screening during the OOCD decision-making process.

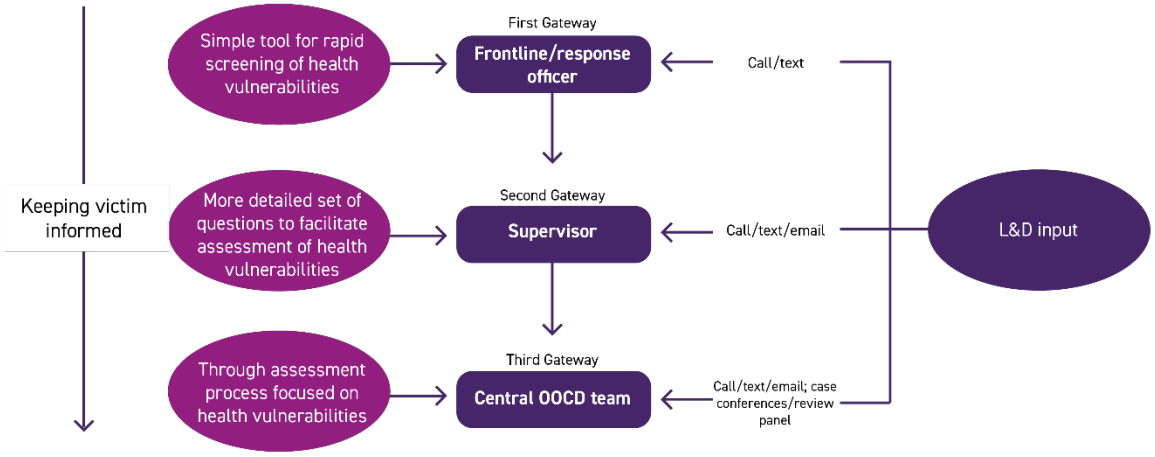


Diagram 3. illustrating processes involved in three-gateway model for health vulnerability screening during the OOCD decision-making process.

General principles for dedicated OOCD staff/process managers to improve vulnerability assessments may include:

- Minimise the burden on frontline officers and encourage consideration of vulnerabilities in relation to the disposal process.
- Involve L&D in vulnerability assessments, either as an advice resource, or as a service to conduct Gateway 2 and 3 assessments.

L&D have a mandate to provide information concerning OOCDs,[19] and utilising this resource can also help ease the burden on frontline officers. The extent of L&D involvement in the vulnerability assessment and/or condition-setting process is up to forces to negotiate with L&D services locally. While L&D services all have the same mandate (except in Wales, where L&D support varies force to force), resources and availability will vary, and this should be accounted for in planning their inclusion. An OOCD health assessment guide focused on how forces can better involve L&D in their OOCD process, produced as part of this study, should be read alongside this document (please follow the link)

[19] NHS England (2019). Liaison and Diversion Standard Service Specification. https://www.england.nhs.uk/publication/liaison-and-diversion-standard-service-specification/

3.3. Referrals to interventions as conditions

OOCDs may be given with a condition attached that requires the offender to access support for their vulnerabilities. For example, they may have to attend an in-depth health vulnerability assessment with a suitable healthcare professional, such as an L&D caseworker, a dedicated police staff member trained to provide assessments, or a GP. Other examples of available services include counselling, and advice tailored to address specific vulnerabilities or types of offence – such as attending an emotion (anger) management course, or a Cautioning and Relationship Abuse (CARA) workshop.[20]

Forces can cultivate new relationships with service providers can be cultivated through different channels. Those most often encountered in the research were:

1. Informal **outreach**, whereby the force contacts a service provider to ask if they can refer offenders to their services as part of OOCDs.
2. **Formal commissioning**, whereby forces or local authorities prepare an invitation to tender for the provision of support services to offenders.
3. Service providers reaching out to forces to **offer their services**.

Key Implication

As part of the training, information regarding service provision available in the force's area could be provided to OOCD dedicated teams and leads – as well as to OOCD operational decision makers who can pass this information on where needed.

Quality is a key consideration when seeking out service providers. The research found that many interventions had not been independently evaluated. The study team has produced a Quality Assurance Guide that aims to help forces assess the effectiveness of available interventions in their force area using three-tier bronze, silver, and gold classification based on established quality factors:

- Evidence base
- Theory of change
- Addressing complexity
- Staff training
- Staff supervision and support
- Management support

[20] Hampton Trust (2023) CARA – What is CARA? https://hamptontrust.org.uk/program/cara/

Forces should strongly consider consulting the associated guidance document for more information on assuring the quality of interventions.

3.4. Missed opportunities and data collection

OOCD leads have a key role in reviewing processes, promoting OOCDs and sharing learning, as well as a role in identifying local needs and what services are available to meet those needs. All these objectives require up-to-date information on the nature and performance of OOCD working within the force area, meaning datacollection is vital to this decision-making.

This training guide does not offer comprehensive content on data collection, but highly recommends consulting the associated guide on Auditing Missed Opportunities, which details different methods to identify where OOCDs could have been used but were not, indicating opportunities to improve to local processes.

Additionally, a data collection tool to help improve the data collection process around OOCDs for health vulnerabilities is also available.

Annex: Train the Trainer guide

This annex is designed to support those tasked with cascading their knowledge of using OOCDs to force colleagues. 'Things to consider' boxes are used to prompt trainers/trainees, and/or introduce situations where each are invited to contribute ideas (interactively) as they relate to individual forces. This annex is designed to be delivered by a trainer/subject expert and includes the following content:

1. Why Train the Trainer is important
2. What qualities are essential for a trainer?
3. Common fears and combatting them
4. Understanding the stages of the training cycle
5. Stage 1: Identifying need
6. Stage 2: Designing the training
7. Stage 3: Delivering the training
8. Stage 4: Evaluating the training

1. Why Train the Trainer is important

- It presents an opportunity for individuals within a force to cascade their experience, skills, and knowledge to colleagues.
- Being able to train staff internally is highly effective, providing shared learning experiences.
- It reduces external training costs and travel expenses.
- It can be shaped to a force's specific needs.
- It can help forces develop an effective training culture, ensuring that staff feel empowered to develop and succeed.
- It helps to provide consistent messaging: individuals who receive training in OOCDs can pass their knowledge on to colleagues, ensuring consistency across the force.
- It is highly responsive to need: training individuals who can pass on their knowledge and skills to colleagues ensures that this internal resource can be mobilised far more quickly than bringing in external trainers.
- Internal trainers have the advantage of knowing their force, its processes, its people, and its culture. This means they can understand needs, identify issues, and tailor their approach accordingly.

2. What qualities are essential for a trainer?

Trainers must develop skills and attributes to work effectively and with legitimacy. Trainers and trainees attending previous training sessions most frequently cited the following qualities and approaches:

3. Common fears and combatting them

Regardless of how long you have been delivering training, you are likely to face fears and reservations. Column one represents some of the concerns most trainers will recognise. Column two offers some simple tools to overcome them.

Common fears	Combatting fears
Lack of confidence	Prepare well
Poor knowledge	Practice the delivery
Forgetting things	Arrive early
Being challenged	Know your material
Mixed abilities	Have a checklist
Disinterest	Manage your energy
Losing the class	Research the audience
Controlling the class	Get help to deliver
Timings	Establish rapport
Expectations	Reflect and improve

4. Understanding the stages of the training cycle

The training cycle consists of the following four stages, each of which is covered in more detail in subsequent sections. In brief, these stages are:

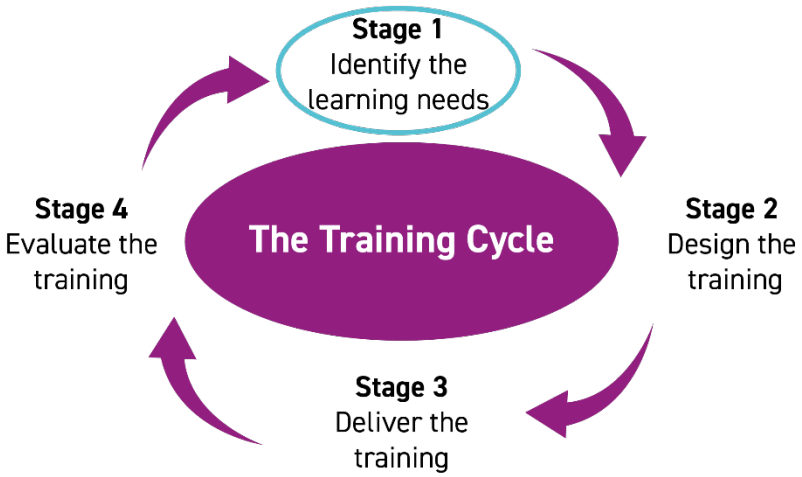
Stage 1 – Identify the learning needs of trainees

Stage 2 – Design a training programme to cater to these needs

Stage 3 – Organise and deliver the training

Stage 4 – Reflect (with trainees) on the training to evaluate the process, delivery, and learning

5. Stage 1: Identify learning needs



Things to consider

It is important not to assume that trainees will be fully aware of the focus of a training session. It is helpful to contextualise the training in terms of how it relates to the needs of both individuals and the force.

The trainer should invite trainees to consider what these needs might be in within their own force. Some examples are provided below, but needs will differ from force to force and trainers/trainees should add their own ideas.

Force need	Individual need
Upskilling (e.g. OOCD expertise)	Knowledge (e.g. OOCD decision-making, health vulnerability assessment, local service provision)
Changing practice – OOCDs	Skills (e.g. knowledge transfer)
External drivers of change (e.g. legislative reforms to the OOCD framework	Internal training (e.g. OOCD two-tier framework, OOCD force procedure)
Internal **drivers**	New roles/responsibilities (e.g. dedicated OOCD team, OOCD subject matter experts, role of L&D)

Key questions

Things to consider

It is essential that trainers understand their audience. To target your training effectively, you must account for factors such as: why trainees are attending; their subject knowledge (often mixed); their expectations and personal objectives; and how they learn (the style they prefer). The following are key questions to consider, but trainer and trainees should work interactively to reflect on the context of their specific force and generate their own ideas.

Why are trainees there?

- Voluntarily
- Mandated
- To upskill
- To get a promotion
- To acquire knowledge
- New job role/new team
- Necessary accreditation

What are their levels of understanding?

- What do they know? (e.g. OOCD framework, procedure)
- What don't they know? (e.g. health vulnerability assessment)
- How will they use new knowledge?
- What are trainees' different roles? (e.g. frontline officers, dedicated OOCD teams, subject matter experts)
- Are there mixed abilities among attendees?

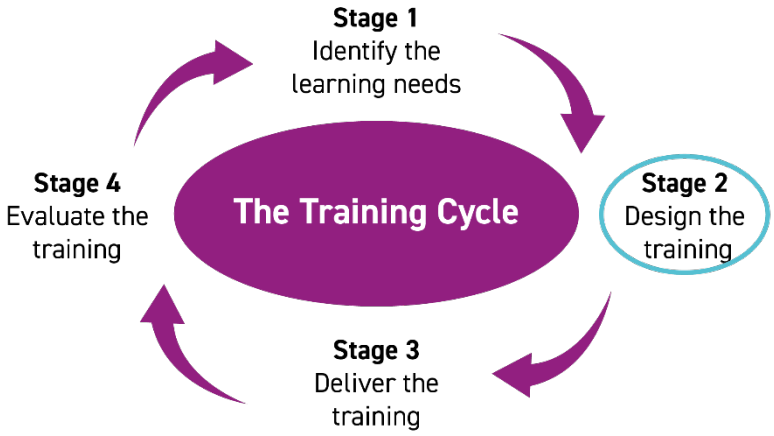
What do they want to achieve?

- Knowledge/awareness
- Learning that they can apply
- Qualifications/accreditation
- To cascade/share learning

How do they learn best?

- Listening
- Watching
- Doing/interacting (e.g. case studies)
- Teaching
- Online
- Face-to-face
- Hybrid

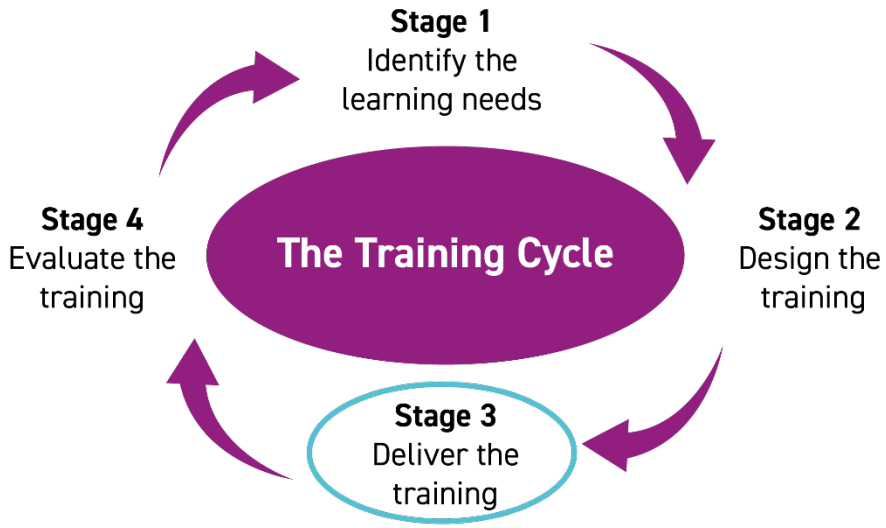
6. Stage 2: Design the training



Determining the learning objective is the first critical step to achieving that objective, which may require a variety of approaches. The example below refers to OOCDs. Trainers should add to them by drawing on their subject knowledge and/or awareness of their force might require. What other learning objectives might there be? Are these better communicated theoretically, practically or both? Learning styles might inform a trainer's approach – but what other factor might also need consideration?

Determine the learning objectives	Achieve learning objectives
Knowledge of OOCDs	Theorical approach
OOCD decision-making process	Practical approach
Understanding roles (e.g. practical decision makers, OOCD subject matter experts)	Mix of both approaches
How to communicate the above	Learning styles

7. Stage 3: Deliver the training



What do you need get right when delivering training? Can you think of anything to add to the following list of key considerations?

Getting it right – key considerations
Who to train (e.g. practical decision makers, subject matter experts)
Structure
Style
Timing
Interaction (e.g. level of interaction)

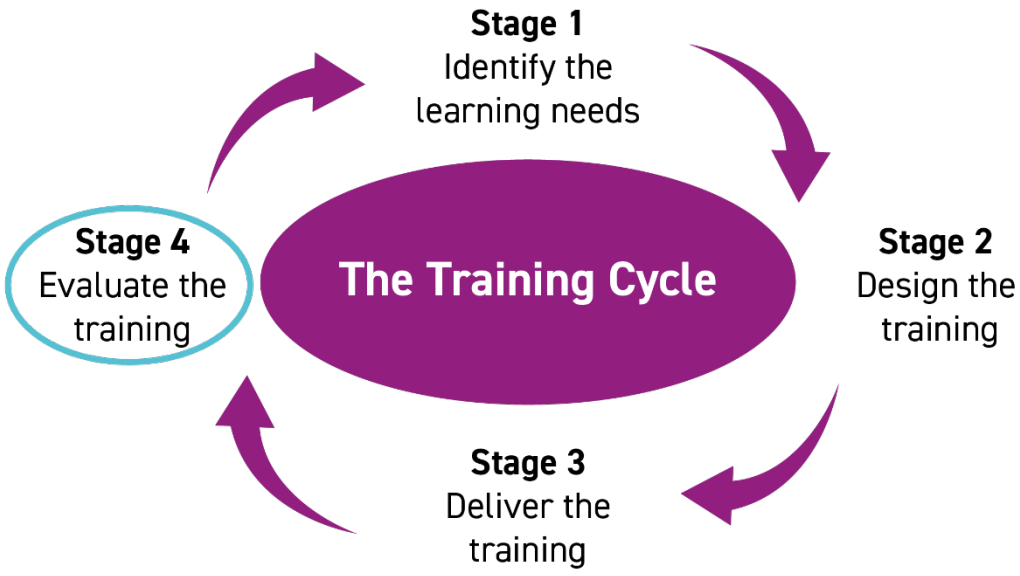
Delivery is the step that some trainers can find daunting – particularly if you must present to different groups of learners. Remembering following approaches can help things go smoothly. Reflecting on your experience as a trainee, can you think of any others?

- Speak clearly and make sure that all trainees understand what you are saying.
- Ensure that trainee expectations are addressed early in the training.
- Explain the structure of the training at the start.
- Review material regularly to ensure it has been understood and updated.
- Try to deal with questions as they arise – but if you don't know the answer, don't be afraid to say you will get back to the trainee later.
- Provide trainees with useful and constructive feedback.
- Keep an eye on time and have a contingency plan in case some parts of the training take longer than expected.
- Deliver the training consistently so that all learners receive the same training.

Barriers to learning	
Poor delivery	Terminology
Boring	Too much
Don't want to be there	Lack of focus
Already know	Learning style
Physical barriers	Disruption

Solutions	
Relate to the trainees	Challenge the trainees
Relevant examples	Break into small groups
Use the trainees	Tasks/exercises
Get feedback	Co-create the training

8. Stage 4: Evaluating the training



Review and improve	How to evaluate
Is it working?	Types of evaluation (e.g. formative, summative, process, outcomes,
Can it work better?	Continuous evaluation
Can it be done differently?	Timing, structure
Did it meet expectations?	Responding (e.g. feedback)

Evaluation is about embedding continuous improvement by understanding what worked well and what could be improved. This should be part of every activity – whether as an exercise in self-reflection and/or a gathering of views from participants.

The evaluation should aim to capture information before the training that can be subsequently used to measure its success against. For example, trainees could be asked to assess their OOCD subject knowledge at the start of the training and then again at the end, providing a picture of their self-reported increase in OOCD knowledge.

An evaluation exercise can be light-touch, or it can be a more focused, intensive review following a tried and trusted methodology (e.g. the Kirkpatrick model of evaluating training). Countless questions can be asked of trainers and trainees in order to evaluate and improve – please follow this link for an extensive list.

Things to consider

Once you have gone to the trouble of designing and delivering training, you will want to be sure that it is working.

The opinions of trainees, colleagues, and managers may be canvassed to obtain a balanced view of how well the training has worked.

A common way to evaluate training is to have learners complete a form at the end of the training where they provide feedback on whether they thought it was useful, what they thought of the trainer and facilities, etc.

This information is very useful for improving future training, but does not measure what was actually learned by participants – for this, some type of assessment is usually administered. This may be a written test, or the learner may be asked to use the knowledge they have gained through training to analyse a case study or sample.

It is up to the trainer to decide what kind of assessment is most appropriate the training. Assessing long-term implementation of learning is more difficult.

4. References

- Allen, R. (2017). Less is more - The case for dealing with offences out of court. London: Transform Justice.
- Bradley, K. (2009). The Bradley Report: Lord Bradley's Review of People with Mental Health Problems or Learning Disabilities in the Criminal Justice System. Department of Health.
- Broner, N., Mayrl, D. W., Landsberg, G. (2005). Outcomes of mandated and nonmandated New York City jail diversion for offenders with alcohol, drug, and mental disorders. The Prison Journal 85(1), pp. 18-49.
- Forrester, A., Samele, C., Slade, K., Craig, T., Valmaggia, L. (2016). Demographic and clinical characteristics of 1092 consecutive police custody mental health referrals. Journal of Forensic Psychiatry & Psychology, 28(3), 295–312.
- Harvey, E., Shakeshaft, A., Hetherington, K., Sannibale, C., & Mattick, R. P. (2007). The efficacy of diversion and aftercare strategies for adult druginvolved offenders: a summary and methodological review of the outcome literature. Drug and alcohol review, 26(4), 379-387.
- Home Office. (2023). Reforms to the adult out of court disposals framework in the Police, Crime, Sentencing and Courts Bill: Equalities Impact Assessment. https://www.gov.uk/government/publications/police-crime-sentencing-andcourts-bill-2021-equality-statements/reforms-to-the-adult-out-of-courtdisposals-framework-in-the-police-crime-sentencing-courts-bill-equalitiesimpact-assessment.
- Kane, E., Evans, E., Shokraneh, F. (2017). Effectiveness of current policingrelated mental health interventions in England and Wales and Crisis Intervention Teams as a future potential model: a systematic review. Systematic Reviews, 6:85, 108-119.
- National Police Chiefs' Council. (2018). Charging and Out of Court Disposals: A national strategy 2017-2021.
- https://www.npcc.police.uk/Publication/Charging%20and%20Out%20of%20Court%20Disposals%20A%20National%20Strategy.pdf.
- Neyroud, P. (2018). Out of Court Disposals managed by the Police: a review of the evidence.
- https://www.npcc.police.uk/Publication/NPCC%20Out%20of%20Court%20Disposals%20Evidence%20assessment%20FINAL%20June%202018.pdf.
- Robin-D'Cruz, C., & Whitehead, S. (2019). Briefing pre-court diversion for adults: An evidence briefing. https://justiceinnovation.org/sites/default/files/media/documents/201906/cji_pre-court_diversion_d.pdf.
- NHS England. (2019). Liaison and Diversion Standard Service Specification.
- https://www.england.nhs.uk/publication/liaison-and-diversion-standardservice-specification/

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