Ministry of Justice

Police use of Out of Court Disposals to support adults with health vulnerabilities

Final report

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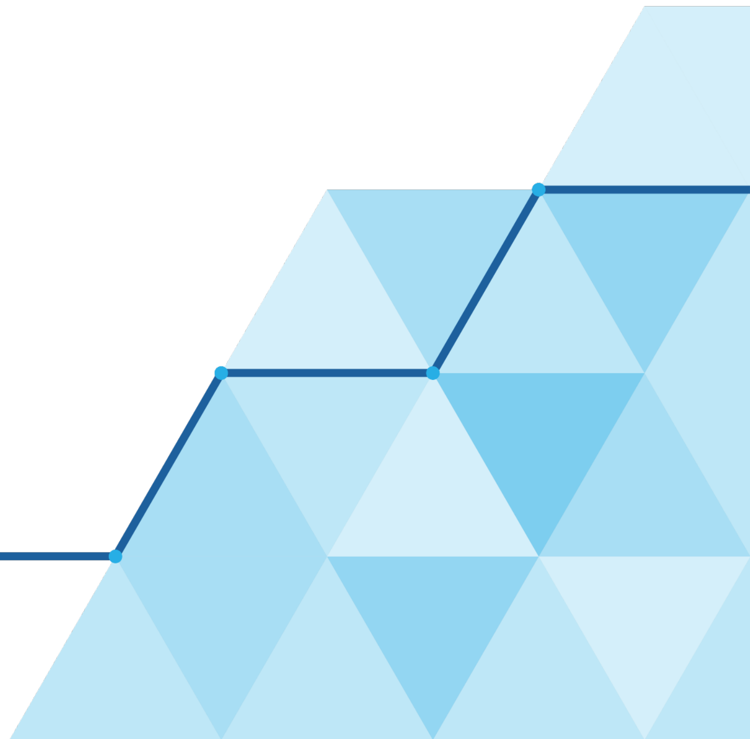

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Report structure

This Report commences with an Executive Summary (Section 1) and an Introduction (Section 2), which provides background to the study and an overview of the methodological approach. The main body of the Report structures findings from across the three phases of the study on the use of Out of Court Disposals (OOCDs) at the force level (Section 3), the frontline operational level (Section 4) and of the data held and collected by forces on the use of OOCDs (Section 5).

- **Section 3** describes the OOCD models in operation across 37 forces (3.2) and provides a brief overview of findings on how OOCDs are decided as appropriate (3.3). It describes how police engage with service providers and provides an overview of services available to be attached as a condition to OOCDs (3.4). Finally, it discusses force training provision around OOCDs and officer experience with OOCDs (3.5); disproportionality in the use of OOCDs (3.6) and the use of OOCD scrutiny panels to review case decisions (3.7).

- **Section 4** describes how OOCD decision-making responsibilities are structured across these forces (4.2). It describes how forces conduct vulnerability assessments (4.3), how OOCD conditions are set (4.4) and how compliance with conditions and breaches are managed (4.5).

- **Section 5** discusses force practices around evaluation (5.2), the minimum dataset that forces should gather to evaluate the use of OOCDs (5.3) and how those data may be collected (5.4). Finally, it describes potential approaches to the design of impact evaluations on the use of OOCDs (5.5).

Each of these findings sections conclude with key reflections and implications for practitioners with reference to the relevant practice guides and tools developed to support police forces. Annex 1 presents a case study of the Support Help Engagement (SHE) Project for women who have been given an OOCD by the Avon and Somerset Constabulary. A more detailed description of the methodological approach to the study is

set out in Annex 2. Finally, a short overview of the evidence base on the effectiveness of OOCDs is presented in Annex 3. It is hoped that this structure enables readers to focus on the sections most relevant to them.

1. Executive summary

1.1 Background to the Report

RAND Europe, in partnership with Get the Data and Skills for Justice, was commissioned by the Ministry of Justice in 2021 to conduct a study funded by the Shared Outcomes Fund on how police in England and Wales use options to resolve cases out of court to support adults (aged 18 or over) with health-related vulnerabilities.[1]

Following legislative reforms, a 'two-tier plus' framework for Out of Court Disposals (OOCDs; or Out of Court Resolutions[2]) is due to come into force nationally. This new framework consolidates the current statutory disposals into two primary options: Diversionary Caution and Community Caution. In advance of the implementation of the framework, this study aimed 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; and to produce the foundations of practice change and improve the data collection methods to monitor their use and enable potential further research to explore their effectiveness.

The study took place in three phases:

- In **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.
- In **Phase 2**, the research team explored in greater depth how health vulnerabilities are identified, relevant conditions set, and progress is monitored,

1 Health vulnerabilities are defined in Section 2.3.

2 The National Police Chiefs' Council commissioned research focused on the terminology used to describe how police describe an outcome for lower-level offending without going to court, formerly known as Out of Court Disposals, including at the time 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 have 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'.

as well as perceptions of the effectiveness of the conditions set in a sample of seven police forces.

- In **Phase 3**, the research team worked with seven[3] police forces on a more detailed follow-up to co-produce the foundations of practice change, developing improved operational practice around the use of OOCDs, and creating supportive guidance, tools and training to enable effective application of OOCDs with health-related conditions. In addition, the research team worked with these forces to improve data collection on the use of OOCDs with conditions attached to enable potential longer-term analytical work to isolate the short, medium- and long-term impacts of individual interventions on reoffending.

This Report presents findings from all three Phases of this study. It is intended to be useful and relevant for frontline and operational police officers, service providers and policy stakeholders.

1.2 Key findings from this study

Force-level approaches to OOCDs

- **Just over half (19) of the participating forces were using a two-tier OOCD model** in March 2022, with a further 13 forces reported to be introducing two-tier in 2022 or working towards introducing it in 2023.
- **The OOCD processes and protocols used varied a great deal between forces** and work with the case study forces identified significant missed OOCD opportunities, even in forces which had high levels of OOCD usage.
- Across 37 forces, **189 services were identified that could be attached as conditions to OOCDs**, with substance misuse and mental health services the most commonly available to be attached to OOCDs.
- Nevertheless, **most force areas reported that the local provision of mental health-related services generally was not sufficient** for the needs of vulnerable offenders with OOCDs.

[3] Six of the seven forces that participated in Phase 3 of the study also participated in Phase 2.

- **A range of funding models for available services were identified**, the most common of which were police-funded, externally funded (for example, by local authorities) and offender-funded.
- Of the forces that reported engaging with service providers as part of their OOCD process, **relationships with service providers were generally maintained through some form of regular contact.**
- **The training of police officers and staff on OOCDs, particularly in relation to conducting vulnerability assessments, was generally conducted on an ad-hoc basis** and was not available as a structured programme for most police forces, with staff turnover and inexperienced officers identified as key challenges.
- **Disproportionality in who received OOCDs was identified as a concern by some OOCD stakeholders.**
- **Force use of OOCD scrutiny panels, which independently review anonymised cases, varied greatly across forces.**

Frontline approaches to OOCDs

- **Three levels of decision-makers at key OOCD decision gateways** – the officer in charge (OIC), their supervisor and the force OOCD management and support functions – **were identified**.
- **Most police forces did not have a force-wide policy requiring a health vulnerability screening and assessment** during the OOCD decision-making process and the use of a tool to assess health vulnerabilities was a well-established process in only a minority of forces, usually those with a dedicated OOCD team.
- **The majority of forces were still reliant on frontline officers and their supervisors to make decisions** regarding OOCD condition setting and deciding on any supportive interventions.
- **The most effective OOCD management processes and outcomes were found in those with a dedicated team.**
- **The responsibility for monitoring compliance varied significantly between forces**, with some assigning it, for example, to a dedicated OOCD team, and others to the OIC or an OOCD caseworker.

- **Definitions of what constitutes 'compliance' with conditions varied across and even within police force areas**, making it difficult to understand data on compliance.
- **A wide range of approaches to dealing with breaches of conditions were identified**, but only two forces reported that a breach always resulted in prosecution.

OOCD data collection and evaluation

- **The existing evidence suggests OOCDs can help to address health vulnerabilities and reduce reoffending.** From this evidence, the study team articulated a high level, simple theory of change for OOCDs, which supported their use in policing to reduce crime.
- From this evidence base and feedback from forces in developing the theory of change, the **study team derived a minimum dataset that can help police forces check or provide evidence that OOCDs are implemented correctly and have an impact.**
- **Forces generally collect all these data, though there are some notable exceptions** – including victim satisfaction and offender experience and before and after criminogenic needs.
- **Despite collecting much of the required data, only some of it is used for reporting.** The data are often located on different information systems or collected in such a way that data analysis is complex, or both.
- **As such, the research team has developed a demonstration tool to collate data in one place so that management, monitoring, and evaluation are possible from the data collected.**
- **First, however, forces need to set up a flow of data from frontline and supervisor officers to OOCD teams** that describe health vulnerabilities and provide leadership that uses data to communicate the completed OOCDs and their value to the officers involved.
- **Once these data start to be collected, an impact evaluation of the changes to OOCDs may be considered.** A mixed-method approach involving a quasi-

experiment and process evaluation would offer the most rigorous findings in the current context.

1.3 Reflections and implications

Overall, findings from the study indicate that there is significant variation across forces in England and Wales in their OOCD processes and in how well-developed and well-established these processes are.

At the force level, it appeared that OOCDs were underused in many forces; across the 31 forces that shared information on outcomes given to offenders in 2021, on average only 8% of all offenders were given an OOCD, but this varied substantially between forces. Furthermore, significant gaps were identified across most force areas in the availability of interventions to meet the needs of vulnerable offenders. Furthermore, limited provision of training on OOCD use, staff turnover, high proportions of inexperienced officers, and the disproportionality in who receives OOCDs were identified as significant force-level challenges to making the best use of OOCDs to support adults with health vulnerabilities.

At the frontline operational level, limited use of vulnerability assessments in the OOCD process and limited input from Liaison and Diversion (L&D) services were also widely reported. In relation to offender engagement and compliance with conditions, there is a lack of meaningful data available which creates challenges in understanding the effectiveness of their use. Overall, the existence of a dedicated OOCD team or independent entity was associated with strong and consistently applied OOCD processes.

While most interventions identified in this study have not been rigorously evaluated, broader evidence from the UK and abroad suggests that OOCDs can address health vulnerabilities and reduce reoffending. In Section 5, we discuss how relevant data can be collated to facilitate the management, monitoring, and evaluation of OOCDs.

Based on these reflections, our Phase 3 work produced a series of practice guides and tools to support forces to develop and maintain good practice in using OOCDs to support adults with health vulnerabilities. These guides and tools, listed below, are referred and linked to where appropriate throughout this report.

- **Health Vulnerability Assessment Guide:** to support forces in identifying the health vulnerability assessment process and enabling better decision-making throughout. This guide also includes good practice examples for working with Liaison and Diversion.
- **Quality Assurance Guide:** discussing how forces can procure in a way that facilitates a good evidence base.
- **Auditing Missed Opportunities Guide:** provides forces with a simple methodology for auditing OOCD decisions to identify learning.
- **Data collection tool prototype:** to support forces in gathering and using OOCD data.

In addition, the study team developed OOCD training resources for forces to support relevant officers and decision makers on setting conditions to OOCDs to address health vulnerabilities, and to support higher level decision makers on implementing OOCD processes.

Implications

Sections 3, 4 and 5 conclude with a series of implications for OOCD practitioners and stakeholders in light of the implementation of the statutory two-tier plus framework in 2023.

At the force level (Section 3), these implications are:

- Each force should review their current processes and protocols to ensure significant opportunities to use OOCDs for those with health vulnerabilities are not being missed. This could include offence type audits and more detailed scrutiny of cases given OOCD and equivalent cases where they were not. A guide developed as part of this study is available (see the Rand website).
- **Forces should analyse data on local needs to identify any gaps in service provision**, and work with service providers to address these gaps.
- **Forces should build service provision for OOCDs and their relationships with service providers by piloting and scaling up services in response to identified local need** (and informed by robust evidence of effectiveness – see Section 5 below (see the Rand website).

- Where possible, forces should seek to **identify and utilise service providers with stable sources of funding to help ensure resilience in service provision**. This may mean that some services are funded by the police to provide this stability. Furthermore, **reducing offender-pays services** can remove some barriers to compliance.
- **Forces should establish consistent and standardised modes of communication with service providers**, including on compliance with and breaches of conditions. This may be easier with a dedicated OOCD team.
- **Forces should facilitate good information sharing by integrating service providers into police IT systems** (in compliance with relevant data protection regulations.)
- Each force should review their current training arrangements to ensure all those involved in OOCD decision-making are suitably trained in this area. Forces can consider adopting/adapting the training model outlined in this guidance (see the Rand website).
- Each force should review its current use of OOCD attached services aimed at those with health vulnerabilities to ensure that their current practice is not resulting in disproportionality in the use of OOCDs or discriminating against some individuals, groups or communities.
- **Each force should review their current adult OOCD scrutiny arrangements** to ensure that their overall oversight and accountability mechanisms for OOCDs are more consistent and comprehensive, as well as able to address wider issues of disproportionality.

At the frontline operational level (Section 4)**,** these implications are:

- Each force (where not already in place) should review its position on having a dedicated OOCD team and develop options to put one in place.
- Each force should review their current approach to screening for and assessing health vulnerabilities as part of the OOCD decision making process including links to L&D or equivalent services in all relevant settings including for Voluntary Attendance. The research team has developed a guide on working with L&D for OOCDs (see the Rand website).

- Where possible, **services attached as a condition should be appropriate for and ideally tailored to the offenders' needs and should be feasible as a condition** – for example, the service is accessible, available without cost to the offender, and can be utilised within the timescales of the OOCD. Increased awareness of local service availability among force OOCD decision makers, through training and easily accessible, up-to-date information resources, would help support this process.
- **Compliance with conditions should be defined consistently** across all OOCD stakeholders in each force area, and relevant data should be monitored consistently and used to better understand the effectiveness of the conditions. National guidance on defining compliance may be helpful in ensuring consistency across force areas.
- **In dealing with breaches of conditions, good practice may include making case-by-case decisions on the most appropriate next step**, informed by an understanding of the offender's issues with complying. This may mean revising the terms of the condition, such as giving the offender more time to complete it, offering a different condition, or assessing the condition as essentially completed, where these approaches are in the public interest or appropriate given the circumstances.

In relation to OOCD data collection and evaluation (Section 5), implications are:

- **Forces should collect the OOCD minimum dataset to manage cases, monitor delivery and evaluate impact.** They can use the suggested methods to fill data gaps.
- **Forces should use or copy the demonstration tool within their own systems to collect the right data and report analyses to various audiences** – the OOCD team, frontline officers, senior leadership, victims, and offenders (see the Rand website).
- **Forces should set up a "virtuous cycle" of data collection and communication**, where the results of OOCDs are communicated to frontline officers routinely to demonstrate their value and improve officers' data supply.

- **OOCDs should be evaluated using a mixed-method design, process evaluation, and quasi-experiment** if enough forces improve their data collection.
- **Proportionate evaluation should become standard practice for OOCD interventions** and RCTs should be encouraged for either large or complex interventions or both.

2. Introduction

2.1 Study aims

This Report presents findings from a study commissioned by the Ministry of Justice (MoJ) on how Police in England and Wales use OOCDs to support adults with health-related vulnerabilities. The Report is intended to be useful and relevant for frontline and operational police officers, service providers and policy stakeholders to support the development and implementation of force-level approaches and frontline operational approaches to the use of OOCDs. The goals 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; and to produce the foundations of practice change and to improve the data collection methods to monitor their use and enable potential further research in the future to explore their effectiveness. The study aims were informed by the findings from the literature review described in Section 2.4 below; as the evidence was limited, the study team took a largely exploratory approach to the research.

There were six key aims for this study:

1. **Give a better understanding of the current scale and use of OOCDs** with relevant conditions for adults with mental health and other health vulnerabilities, and the specific content of the conditions attached to these.
2. **Identify relevant intervention services currently used by police forces as OOCD conditions for adults with health vulnerabilities**, including any specialist services for particular cohorts, such as female offenders, young adult offenders or those with neurodiverse needs.
3. **Identify gaps in local intervention services.** This will help prioritise what services are needed but are not currently available.
4. **Enable evidence-informed decision making** by sharing findings on approaches to identify health vulnerabilities and deploy health-related OOCD conditions.

5. **Provide guidance for police forces** on effective practice for accessing existing services. This will facilitate police practice, making it easier to identify which services are relevant for OOCDs.
6. **Enable police to improve data capture** for this group of offenders, including on specific conditions attached to OOCDs. This will enable monitoring of the impact of individual interventions, help to improve commissioning of relevant services based on identified local need and support potential further research on this cohort to inform future policy and practice.

2.2 Background to the study

Out-of-court disposals (OOCDs; or Out of Court Resolutions) are used by police in England and Wales as a means of resolving 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 individuals away from immediate access to the criminal justice system as well as future criminal behaviour.

Currently, there are six types of OOCDs available for lower-level offending behaviour perpetrated by adults:[4]

- **Cannabis warnings:** Cannabis warnings may be given to first-time offenders or those possessing small amounts of cannabis. They are not disclosed on a standard DBS check but may appear on an enhanced DBS check if the information is reasonably believed to be relevant.
- **Khat warnings:** Khat warnings may be given to first-time offenders or those possessing small amounts of khat. They are not disclosed on a standard DBS check but may appear on an enhanced DBS check if the information is reasonably believed to be relevant.
- **Penalty Notices for Disorder (PND):** PNDs are administered in response to disorderly behaviours, such as public intoxication in no-drinking areas. Unlike

[4] Note that some police forces include Fixed Penalty Notices as OOCDs, although they are technically not within the OOCD range.

other OOCDs, an offender can receive a PND without admitting the offence. PNDs are not disclosed on a standard DBS check but may appear on an enhanced DBS check if the information is reasonably believed to be relevant.

- **Simple Caution:** A Simple Caution is an alternative to prosecution intended for lower-level crimes and first-time offenders who have admitted responsibility for the offence. If accepted by the offender and administered by the police, this formal warning will appear on the offender's criminal record but is considered 'spent' immediately for disclosure purposes. Simple Cautions are disclosed on standard and enhanced DBS checks but not on basic DBS checks.
- **Conditional Caution:** Conditional Cautions are given when it is in the public interest for the offender to carry out specific conditions attached to the disposal rather than to be prosecuted. These conditions can serve to provide reparations for the victim, rehabilitate the offender or, in some cases, punish the offender. If the offender does not comply with the conditions set, they may be liable for prosecution for the original offence and for breach of the conditions of the caution. Conditional Cautions will appear on the offender's criminal record and are considered 'spent' after three months. They are disclosed on standard and enhanced DBS checks but not on basic DBS checks.
- **Community Resolution:** Community Resolution is a police-led disposal that focuses on restorative and reparative justice outcomes. This disposal is used to facilitate reparation of the harm done, for instance, by means of an apology to the victim. Community Resolutions are a non-statutory disposal and so the conditions attached are informal and legally unenforceable in the event of non-compliance.

Over the past decade, the existing OOCD framework has been under review by the MoJ and the National Police Chiefs' Council (NPCC). A public consultation was conducted between 2013 and 2014 to gather views from the public and practitioners within the criminal justice system, such as the police and the Judiciary. These different stakeholders confirmed that the existing options needed reform. They felt that the current disposals did not deter offenders sufficiently, as forces were too reliant on Simple Cautions, which have no follow-up or requirements aimed at diversion and rehabilitation. Furthermore, the options were seen as unnecessarily complicated and suffering from a lack of transparency,

largely as a result of their piecemeal development in response to different needs and at different times. Finally, respondents felt that the current system did not place enough focus on reparations to victims.[5]

In response to the findings from the consultations, three police forces across England and Wales (Staffordshire, Leicestershire and West Yorkshire) piloted a new two-tier system in 2014-15, which saw forces using only two of the current OOCD options: Conditional Cautions and Community Resolutions.[6] In 2017, the NPCC recommended that police forces voluntarily move towards a two-tier system to simplify the framework, ensure greater consistency in how OOCDs are used, and guarantee greater transparency.[7]

There are 43 territorial police force areas across England and Wales. Although some forces have already moved towards a two-tier model voluntarily,[8] by opting to primarily use Conditional Cautions and Community Resolutions, others continue to use most or all of the six different OOCD options that are currently available. Following legislative reforms, the MoJ is aiming to implement a national, consistent two-tier plus framework.[9] In this new framework, there will be two primary statutory options: Diversionary Caution and Community Caution. The former is 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 will be considered 'spent' after three months, or sooner if the conditions are met before. The Community Caution is a 'lower-tier' disposal which can be used in response to lesser crimes, and which will be 'spent' immediately. Both disposals are dependent on an

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5 National Police Chiefs' Council (2018), 'Charging and Out of Court Disposals: A national strategy 2017-2021', Charging and Out of Court Disposals A National Strategy.pdf (npcc.police.uk).

6 Ames A, Di Antonio E, Hitchcock J, et al. (2018) Adult Out of Court Disposal Pilot Evaluation – Final Report. Ministry of Justice Analytical Series. Available at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/718947/adult-out-of-court-disposal-pilot-evaluation.pdf

7 National Police Chiefs' Council (2018), 'Charging and Out of Court Disposals: A national strategy 2017-2021', Charging and Out of Court Disposals A National Strategy.pdf (npcc.police.uk).

8 Ministry of Justice (2022). Police, Crime, Sentencing and Courts Act: Reform of the Adult Out of Court Disposals Framework. Impact Assessment. Available at: https://assets.publishing.service.gov.uk/media/6273be6b8fa8f57a37b7b363/MOJ_Sentencing_IA_-_OOCD__2022_.pdf.

9 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-2021-equality-statements/reforms-to-the-adult-out-of-court-disposals-framework-in-the-police-crime-sentencing-courts-bill-equalities-impact-assessment.

admission of guilt by the offender, as there is no recourse to court once the caution is administered.[10] Under the national framework, Community Resolutions will also remain available to police forces to use in appropriate circumstances. Moreover, it should be noted that other options for solving cases out of court, such as Fixed Penalty Notices and deferring prosecution under Outcome 22 will be retained alongside the new statutory two-tier plus OOCD framework.

OOCDs with conditions attached can be used by police to address any needs vulnerable offenders may have. As evidence highlights the higher prevalence of (complex) health vulnerabilities amongst those in contact with the Criminal Justice System,[11,12,13] such use of rehabilitative conditions can point offenders to the support they need to tackle the root causes of their offending behaviour and improve their life chances. Indeed, OOCDs with conditions attached may be used to support specific cohorts that may have particular needs to address the vulnerabilities that might have contributed to why they offended and thus improve outcomes. Evidence shows, for example, that many female offenders experience substance misuse issues and mental health problems. Using a conditional caution, the police can refer these women to appropriate interventions tailored to their needs, as government strategies for early interventions, such as the Ministry of Justice's 'Female Offender Strategy,' recommend.[14] Similarly, in order to improve outcomes for neurodivergent offenders within the Criminal Justice System, OOCDs with conditions attached may be used by police to refer these offenders to specific interventions that can provide the nuanced support they require.[15] Such interventions may take the form of socio-

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[10] Ibid.

[11] 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.

[12] Kane, E., Evans, E., Shokraneh, F. (2017), Effectiveness of current policing-related 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.

[13] 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.

[14] Ministry of Justice (2018), 'Female Offender Strategy'. Available at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/719819/female-offender-strategy.pdf

[15] Recent literature has highlighted challenges in recognising neurodiversity for individuals in custody. See, for example, Williams, E., et.al, (2019), Understanding Risks: Practitioner's Perceptions of the Lottery of Mental Healthcare Available for Detainees in Custody. Policing: A Journal of Policy and Practice, 13(4), 441–454.

communicative and/or educational interventions, with attention paid to the sensory needs of neurodivergent individuals, as has also been set out by the Ministry of Justice's Neurodiversity Action Plan.[16] At the same time, effective use of OOCDs could potentially lead to cost and time savings within the justice system as a whole by reducing the burden on the court system.[17]

Although some data on the use of OOCDs is collected nationally, data on conditions set by forces or the extent to which offenders comply with the conditions is not centrally available. As such, significant gaps remain in our understanding of how police use OOCDs with conditions attached to support offenders with mental health or other health vulnerabilities, how the use of OOCDs could be improved, and what types of referrals are most effective in supporting vulnerable adults at the early stages of the criminal justice system.

Phases of the study

The study took place in **three phases** between October 2021 and March 2023:

- In **Phase 1**, the research team captured current use of OOCD conditions to support adults with health vulnerabilities and identified 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. This phase was focused on research aims 1-3.

  The research questions for Phase 1 were:

  1. What processes, if any, are followed within forces in relation to: assessing vulnerability, identifying services, monitoring compliance, and breach of OOCDs?

  2. Which services are currently available to be attached as conditions to OOCDs that address mental health and other health related vulnerabilities? Are any of these services tailored to or targeted towards

[16] Ministry of Justice (2023), Neurodiversity Action Plan. Available at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1131185/MoJ_Neurodiversity_Action_Plan_Six_Month_Final__edit_.pdf

[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.

particular cohorts, such as female offenders, young adult offenders or those with neurodiverse needs?

3. How is each police force currently engaging with the services available to them?
4. Where are there gaps in local services available, in each of the police forces?
5. Where and how are local interventions being underutilised by police forces, if any are?
6. Have any interventions been previously evaluated? If so, what were the results and the assessment of the quality/veracity of findings?

- In **Phase 2**, the research team explored in a sample of seven police forces how health vulnerabilities are identified, relevant conditions set, and progress monitored, as well as perceptions of their effectiveness. This phase was focused on research aim 4.

  The research questions for Phase 2 were:

  1. How do interventions attached to an OOCD work in practice?
     a. How are individuals assessed and identified as having a need for interventions?
     b. How are they signposted or supported to access local services?
     c. What, if any, follow-up from police or other third parties is provided to these offenders?
     d. How is progress against conditions monitored?
  2. What are perceived to be the most effective methods for condition setting and why?
  3. Which interventions attached to an OOCD are perceived to be most relevant and effective to support individuals with mental health and other health related needs and why?
  4. To what extent do local interventions attached to an OOCD work collaboratively with each other, to ensure a holistic and sequenced

response to meet the possibly complex needs of vulnerable offenders? And if so, how?

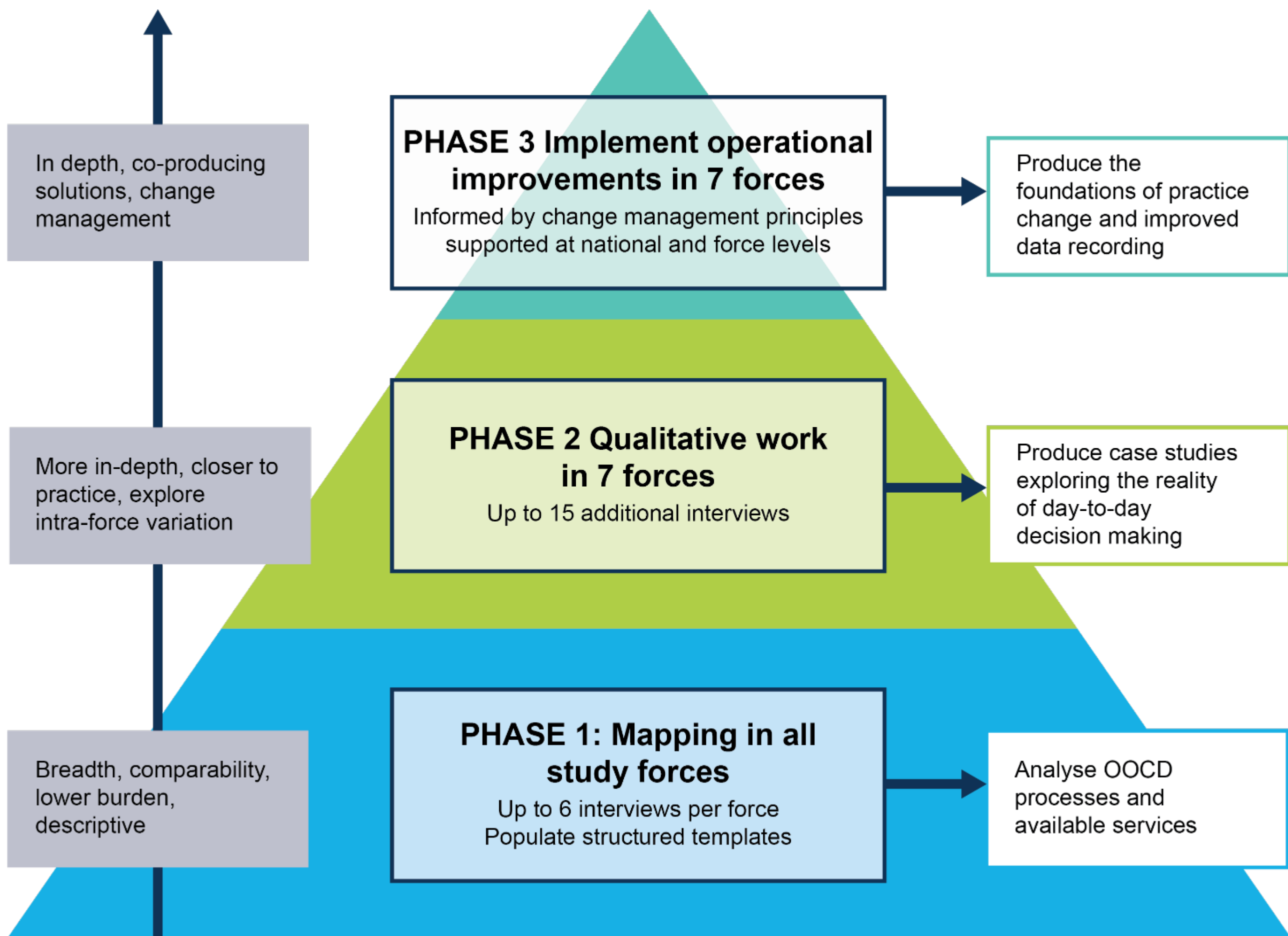
- In **Phase 3**, the research team worked with seven[18] police forces to co-produce the foundations of practice change, and to improve the data collection methods to monitor their use and enable potential further research to explore their effectiveness. This phase focused on research aims 5-6.

  The research aims for Phase 3 were:

  1. Work with a select group of police forces to capture the level of detail needed to enable potential longer-term analytical work to isolate the short, medium- and long-term impacts of individual interventions on reoffending.
  2. Utilise research findings from Phase 1 and 2 to support a sample of police forces in developing improved operational practice around the use of OOCDs to support adults with health vulnerabilities.
  3. Create supportive guidance, tools and/or training to support effective application of OOCDs with health-related conditions.

[18] Six of the seven forces that participated in Phase 3 of the study also participated in Phase 2.

Figure 2.1: Phases of the research



2.3 Scope of the study

The number of police forces

At the start of this study, all 42[19] forces in England and Wales were invited to participate in Phase 1 of the study. Of those, 37 agreed to participate and made staff available for interview. Seven of these forces also agreed to participate as case study forces in Phase 2 of the study. Seven forces (including six of the seven Phase 2 forces) also agreed to participate in Phase 3 of the study.

Types of health vulnerabilities

This study focuses on conditions attached to OOCDs to address six main types of vulnerabilities: drug use, alcohol use, physical health, mental health, neurodiversity, and

[19] Two police forces work together in the OOCD process for their force areas and are therefore referred to as one force for the purposes of this analysis.

learning disabilities. The category 'other' allows the study to capture services addressing vulnerabilities that do not directly map to those six categories.

Types of service users

This study focuses on services for men or women aged 18 or over, including young adults and adults. Services for children (under 18 years old) were not included.

2.4 Data collection

The study was designed to meet the six research aims described above, addressed and divided by study phase. In this section, we briefly outline the methodological approach for each Phase of the study. The research methods are described in further detail in Annex 2: Methodological approach. Before data collection commenced, the study team applied for and received ethics approval from RAND Corporation's Human Subjects Protection Committee. More information on ethics and data protection is provided in Annex 4.

To inform the development of the data collection tools, a targeted literature review was conducted of relevant academic and grey literature published after 2016. Targeted searches were conducted in Google and Google Scholar to identify relevant papers. Once screened for relevance, included papers were subsequently screened in detail to identify key concepts and gain an understanding of the current policy and practice context, as well as the planned shift towards a statutory two-tier plus framework. Furthermore, additional papers were identified by looking at potentially relevant references in previously included papers (snowballing). In total, 12 documents were deemed relevant and included for analysis.

Phase 1 data collection activities

Fieldwork activities

At the start of this study, all 42[20] forces in England and Wales were invited to participate in Phase 1 of the study. Of those, 37 agreed to participate and made staff and local OOCD stakeholders available for interview.

[20] Two police forces work together in the OOCD process for their force areas and are therefore referred to as one force for the purposes of this analysis.

For the Phase 1 data collection, the study team conducted 148 structured interviews (each up to two hours long) between January and May 2022 with up to six interviewees from each participating force area. With the informed consent of the interviewees, interviews were audio recorded and written notes were taken by the fieldworker. The research team sought to speak with the key stakeholders in OOCD policy and implementation from each force area, and those who were most knowledgeable about how OOCDs worked in that force area, in a purposive sampling approach. These interviewees included police force staff and OOCD partners such as L&D leads/practitioners; service providers; persons who commission or manage services that are relevant to an offender with health vulnerabilities; and local authority representatives.

All interviewees were asked to describe, to the best of their knowledge, the services that were available (as of March 2022) to be attached to OOCDs for adult offenders in their force area (covering Phase 1 research questions 2-6). Interviewees were also asked to shed light on four key decision points in the OOCD process in their force area: identifying and assessing the offender's vulnerability; identifying the service to be attached to the OOCD; monitoring compliance with the condition; and managing non-compliance with or withdrawal from the condition attached to the OOCD (covering Phase 1 research question 1).

At the conclusion of the fieldwork, the study team cleaned the data and analysed all interviewee responses to produce a single synthesised entry for each force into a dataset which gathered the data from all participating forces. The data was then analysed by the study team to identify themes across all the interviews. An initial listing of themes was organised manually in a codebook and the research team coded the interview data with amendments to the codebook as needed. Once all data was coded, the team reviewed the coded excerpts and used them to develop a narrative analysis.

Phase 2 data collection activities

Sampling of the seven Phase 2 case study forces

Sampling was undertaken in collaboration with the MoJ and sought to ensure representation, where possible, by: urban/rural area; the OOCD rate; the use of OOCDs;

the type of custody case management system in use; and geographical spread (see Annex 2 for more detail).

Fieldwork interviews in the case study forces

Number and selection of interviewees

The research team conducted an additional 91 interviews in the seven case study forces (up to 21 in total for each of these forces across Phases 1 and 2), again seeking the guidance of each force's OOCD lead on the most appropriate stakeholders to request an interview in a purposive sampling approach. Interviewees included police force staff and OOCD partners, such as L&D leads/practitioners; service providers; persons who commission or manage services that are relevant to an offender with health vulnerabilities; and local authority representatives.

Approach to analysis

The interview questions for the case study forces used more free text responses than the questions posed in the Phase 1 data collection, as we were particularly interested in gathering more in-depth qualitative data around how health vulnerabilities are identified, relevant conditions set, and progress monitored, as well as stakeholder perceptions of the effectiveness of the interventions used for OOCDs. An initial listing of themes was organised in a codebook and the research team coded the interview data with amendments to the codebook as needed. Once all data was coded, the team reviewed the coded excerpts and used them to develop a narrative analysis.

Research activities for Phase 3

The research team used the findings from Phases 1 and 2 to scope the gaps in current police data collection on OOCDs with conditions attached for offenders with health-related vulnerabilities and to work with a sample of seven police forces to produce the foundations of practice change (study aim 5) and improve data collection methods (study aim 6).

As with the Phase 2 data, the qualitative insights gained through engagement and coproduction with the Phase 3 forces have been used to inform analysis on force level approaches to using OOCDs (Section 3), frontline operational approaches (Section 4) and on OOCD data collection and evaluation (Section 5).

Phase 3 data collection activities

In Phase 3 of the study the research team worked with seven police forces to capture the level of detail needed to enable potential longer-term analytical work to isolate the short-, medium- and long-term impacts of individual interventions on reoffending. The findings from Phases 1 and 2 were utilised to support this sample of police forces in developing an improved operational practice around the use of OOCDs. At the same time, supportive guidance documents, tools and training resources were developed to effectively apply OOCDs to support health-related vulnerabilities (listed at 1.3). The study team applied Lewin's unfreeze-change-freeze approach[21] to change management in Phase 3. During the unfreeze phase, the need for change is discussed and agreed with the relevant parties; during the change phase the actions are agreed and implemented; and the changes become everyday practice during the refreeze phase.

This third phase of the study comprised five key stages therefore:

1. A further review of OOCD-related documentation and protocols used in the case study forces to ensure these were updated from the work in earlier phases.
2. Five or six additional interviews with key stakeholders in each force and a sample at national level of six key stakeholders. These interviews were purposive and aimed to gather information on specific issues or approaches in each force or policy area in relation to their use of OOCDs to support adults with health vulnerabilities.
3. From these first two processes we identified the perceived barriers and enablers and their impacts on OOCDs in each force area. These were then presented and discussed in face-to-face workshops with a wide range of local stakeholders from within and without the forces.
4. Following the workshops, a summary note of issues and actions was sent to the force OOCD lead for agreement/amendment. This included the suggested ownership of actions and the support the research team could offer. A first project update meeting was held within one month afterwards. Following this project

[21] Kurt Lewin's model identified three steps to change: 'unfreezing', recognising that a change is needed; 'changing', moving into a new approach; and 'freezing', settling into a new model. For more information: Cummings, S., Bridgman, T., & Brown, K. G. (2016). Unfreezing change as three steps: Rethinking Kurt Lewin's legacy for change management. *Human Relations*, *69*(1), 33–60.

meeting, a revised detailed action and solutions framework was sent to each force. Progress on actions was reviewed in each force at two subsequent project update meetings.

5. The research team facilitated a range of meetings and support activities tailored to each force to assist them in developing and delivering solutions.

The evaluation team also wrote an evaluation framework for OOCDs, described in Chapter 5. This involved a short, targeted literature search on Google Scholar to identify any previous evidence regarding the effectiveness of OOCDs with conditions in supporting adults with health vulnerabilities. The Google Scholar search results were limited to papers published from 2017 onwards, as previous papers were identified through scanning Neyroud's (2018) NPCC literature review paper on OOCDs, as well as obtaining any literature emerging from an MoJ library search using the same search parameters. Twenty-eight papers were read in full following a title and abstract screening, and from this a further nine papers were excluded. Therefore, the evidence emerged from information contained in nineteen peer-reviewed articles and evidence reviews (see Annex 3 for a summary).

2.5 Limitations

Our approach has some limitations. Much of the data analysed in this report comes from interviews with OOCD stakeholders across 37 force areas identified through purposive sampling, and as a result there may be inconsistencies or gaps in knowledge around the use of OOCDs by their force. Moreover, five force areas did not engage with the study. To mitigate against these risks, the team conducted a substantial number of interviews with a variety of stakeholders in each force to triangulate and validate the data (239 across Phases 1 and 2 of the study). Where gaps or inconsistencies remain, these are clearly flagged in this Report. In addition, most interviewees from each force area were proposed to the research team by force OOCD leads. As a result, there was a potential risk of bias towards interviewees with a supportive view of force practices around OOCDs. To minimise this risk, in addition to the number of interviews conducted, we provided guidance to OOCD leads on the types and numbers of OOCD stakeholders (such as officers involved in managing OOCD teams, on the frontline, or responsible for officer

training; service providers; local authority representatives etc.) to approach for an interview.

Furthermore, although Phase 2 aimed to capture a diverse range of force approaches to the use of OOCDs, findings are unlikely to be fully representative due to the diversity of force area practices and are not intended to be generalisable. It should also be noted that the selection of case study forces in Phases 2 and 3 was in part determined by the willingness and capacity of forces to engage with these stages of the study, which required a substantial commitment. Finally, we note that much of the data collection took place around March 2022, providing a snapshot of OOCD policy and practice at that time. In some forces, there may have been changes in their use of OOCDs since that date which have not been captured in this Report, especially in relation to the upcoming implementation of the statutory two-tier plus framework.

3. The Force-level Approach

Table 3.1: Key messages on the Force-level Approach

Key messages

- Just over half (19) of the participating forces were using a two-tier OOCD model in March 2022, with a further 13 forces reported to be introducing two-tier in 2022 or working towards introducing it in 2023.
- The OOCD processes and protocols used varied a great deal between forces and work with the case study forces identified significant missed OOCD opportunities, even in forces which had high levels of OOCD usage.
- Across 37 forces, 189 services were identified that could be attached as conditions to OOCDs to support adults with health vulnerabilities, with substance misuse and mental health services the most commonly available to be attached to OOCDs.
- Nevertheless, most force areas reported that the local provision of mental health-related services generally was not sufficient for the needs of vulnerable offenders with OOCDs.
- A range of funding models for available services were identified, the most common of which were police-funded, externally funded (for example, by local authorities) and offender-funded.
- Of the forces that reported engaging with service providers as part of their OOCD process, relationships with service providers were generally maintained through some form of regular contact.
- The training of police officers and staff on OOCDs was generally conducted on an ad-hoc basis and was not available as a structured programme for most police forces, with staff turnover and inexperienced officers identified as key challenges.
- Disproportionality in who received OOCDs was identified as a concern by some OOCD stakeholders.
- Force use of OOCD scrutiny panels, which independently review anonymised cases, varied greatly across forces.

3.1 Introduction

This Section presents findings on the OOCD models (e.g., two-tier) currently in use; services to support adults with health vulnerabilities that are currently available to be attached as an OOCD condition across forces; how forces engage with service providers; the provision of training for police on the use of OOCDs; disproportionality in OOCD use; and the scrutiny of OOCD decisions. It sets out findings from all phases of the study, providing an overview of approaches across the 37 force areas that participated in Phase 1 (as at March 2022), as well as the more in-depth findings from the case study force areas in Phases 2 and 3.

3.2 Use of OOCDs by forces

As part of Phase 1 of this study, information from participating forces about their current OOCD model was collected and a range of approaches were reported, suggesting that the use of OOCDs and conditions varies across forces.

Forces were asked to characterise their approach to OOCDs as at March 2022 using the following typology:

1. Switched to the NPCC two-tier model in the last year (at least six months ago)
2. Recently switched to the NPCC two-tier model (less than 6 months ago)
3. Working towards introducing a new two-tier policy and process in 2022
4. Introducing a two-tier plus model under the new statutory framework in 2023
5. Currently using a six-tier model
6. The force does not use OOCDs
7. Other
8. Don’t know

Their responses are captured in Table 3.2 below, which shows that 19 forces, or just over half, were using a two-tier model in March 2022. A further nine forces were reported to be introducing two-tier in 2022, whilst four were working towards introducing it in 2023, with two forces reporting that they were currently six-tier with no plans in place at the time to transition to a two-tier model.

Three forces reported ‘other’. One force reported using a four-tier system: community resolution, Penalty Notices for Disorder (PND), simple cautions and conditional cautions. Another force also reported using a four-tier system: community resolution, deferred prosecution (diversionary, educational or intervention),[22] PND and simple caution. Finally, during the study fieldwork, changes were being made to the operation of OOCD processes in one force, and it was unclear what OOCDs would be in use going forward.

Table 3.2: OOCD models in use as of March 2022

OOCD models in use as of March 2022	Forces
Two-tier in the last year (at least six months ago)	17
Recently switched to two-tier (less than 6 months)	2
Introducing statutory two-tier plus in 2023	4
Working towards introducing a new two-tier policy and process in 2022	9
Currently six-tier	2
Other	3
Total	**37**

3.3 Deciding an OOCD is appropriate

Thirty-one forces provided information on the proportion of each outcome given to offenders in 2021 and from the data received, on average, only 8% of all adult offenders were given an OOCD.

The most common outcome across forces was an NFA (‘No further action’) at an average of 61%, followed by a charge at 16%. The remaining 15% of outcomes were classified as ‘Other’, including outcomes such as Summons and Postal Charge and Requisition.

The use of OOCDs varied substantially across forces. For example, the extent that OOCDs were used in the seven case study forces in Phase 3 varied greatly (between 7-50% of outcomes).[23] Several reasons for this disparity were given by OOCD stakeholders from these case study forces, including:

[22] While this force has included deferred prosecution as one of their OOCD options, deferred prosecution is not a statutory OOCD, and eligibility and acceptance criteria differ between the two processes.

[23] The Phase 1 aggregate dataset showed that OOCDs made up 4-20% of all outcomes for most forces.

- The inexperience of frontline officers;
- Negative attitudes in the force around the use of OOCDs;
- No lead from the command team on the importance of OOCDs as a positive disposal;
- Home Office outcome counting rules seen, rightly or wrongly, as a deterrent to using OOCDs;
- Gaps in locally available services to attach to conditions;
- Gaps in OOCD decision-maker knowledge of available interventions;
- OOCDs seen as time-consuming by frontline staff and supervisors;
- Concern that there is no evidence to underpin the impact of interventions; and
- A lack of resources to fund interventions.

All the Phase 3 forces felt that there were missed opportunities to use OOCDs. Missed opportunities were variously identified:

- During case reviews when preparing Scrutiny Panel papers;
- By dedicated support teams;
- During post charge reviews; and
- During detailed audits of all cases dealt with in selected crime types to test the appropriateness of the disposal and whether an OOCD would have been preferable and possible.

For example, one force selected all cases of shoplifting in a six-month period in 2022. Their review highlighted missed opportunities for the use of OOCDs, where a diversionary intervention could have been utilised.

The cases identified by other forces using different audit approaches yielded similar levels of missed opportunities. A novel finding was a concern by one force that while 50% of eligible cases were offered OOCDs, they would like to offer even more but did not feel that they could. This was because they suspected public attitudes to even more cases being disposed of through this route would be negative, and because growing waiting lists for interventions potentially meant that the OOCD timetable could not be met.

3.4 Police engagement with available services

Interviewees in Phase 1 of the study were asked to describe how the 34 police forces were engaging with the services available to them to attach to OOCDs to address health vulnerabilities. These discussions focused on two main elements:

- How relationships between forces and service providers are developed; and
- How these relationships are maintained.

Developing relationships between forces and service providers

Services that could provide conditions attached to OOCDs were reported to be identified by forces via both formal commissioning and informal outreach.

New relationships between police forces and local services were reported to be most commonly established in two ways: commissioning (15 forces), usually through the Office of the Police and Crime Commissioner (OPCC), and informal outreach from OOCD teams or individual leads (13 forces), with three of these forces reporting employing a mix of both methods. Six forces returned no data on developing service provider relationships.

For example, in one force area, new services were selected by an OOCD working group made up of police and diversion practitioners prior to commissioning. In a further two cases, establishing new relationships was left to bespoke, specialised entities such as the Checkpoint team in Durham. One of these three forces stood out as a special case, wherein an entity had been commissioned to manage all diversion activity on behalf of the police force in question.

Relationships developed from informal outreach were reported to involve OOCD leads or dedicated teams contacting known service providers, or providers getting in touch with police forces to offer services.

In 20 forces, services were identified through police personnel either by looking at existing data on the use of OOCDs in their force (offending behaviour, offender vulnerabilities) and identifying a need, or from knowledge of what services were available via word of mouth and community links. In five force areas, service providers were reported to recommend other service providers to the police force.

Where services have been commissioned by forces, it was reported that procurement most commonly involves a process of competitive tendering after a local need has been identified.

However, it was noted in one force that very few providers were positioned to submit bids for OOCD work, given the specialist nature of the work involved, with most districts rarely having more than two overlapping organisations for a particular vulnerability. In this same force, it was also highlighted that some services do not provide interventions to an entire force area; for example, in some districts, substance misuse interventions were provided by one organisation, and in others by another organisation. As a result, provision can vary between forces, and by police district.

It was reported that a potential advantage of establishing relationships through informal contact is the ability to partner with existing independent organisations with their own established practices and funding.

Some interviewees reported that establishing relationships through informal contact helped to accelerate the initial setup of working partnerships. However, non-police sources of funding can be unstable. For example, at the time of interview, one intervention that relies on such non-police support was under threat of losing its funding.

In some force areas, there was evidence that relationships between police and service providers had developed and expanded 'organically.'

For example, pilot projects or working groups were reported to have been built upon existing small-scale work with steady improvements, gradually expanding and developing over time. In five forces, providers had been able to recommend additional appropriate services to police to fill a perceived gap.

In one force, a particular organisation began offering a single intervention to one force area and now offers six interventions (covering offenders who have committed lower level sex offences, domestic abuse, lower level assault, and require support with emotion management) across three force areas with the hope to expand further. Five of the six interventions offered by this organisation were described by a force interviewee as 'being developed in partnership with police forces' that contributed to the 'content and delivery' of

the interventions. This type of organic growth was mentioned by interviewees from another force, who explained much of their OOCD work had been built upon the activity of a collaborative network spanning across multiple force areas. This had arisen in response to an observed need for services providing anger management and anxiety support for offenders in the wider region.

A small number of interviewees reported that an advantage of organically developing relationships with service providers is the ability to scale-up promising activity across a force area.

Such a scale-up is planned for one force's single-district mental health pilot. This process also allows for iterative improvement of practice based on feedback from delivery stakeholders. However, it was reported that this growth depends on the existence of relevant services in the area, adequate funding of those services and buy-in from leadership. Furthermore, it is often based on the motivation and ability of single individuals to forge strong working partnerships with, and between, service providers. Another force described struggling with 'just one to two people managing five districts, for years [with] a lot of work to do' despite being an original pilot force.

Service availability

Across all 37 police forces participating in Phase 1, 189 services were identified that could be attached as conditions to OOCDs to address health vulnerabilities.

The table below sets out the number of services available across all forces, identified for each of the six vulnerabilities focused on in this study. It demonstrates that services to address substance misuse and mental health issues were the most commonly available to be attached to OOCDs.

Table 3.3: Number and percentage of services that address each health vulnerability

Vulnerability	Number of services identified in all participating forces	Percentage of all services identified in all participating forces*
Drug use	132	70%
Alcohol use	125	66%
Physical health	75	40%

Vulnerability	**Number of services identified in all participating forces**	**Percentage of all services identified in all participating forces***
Mental health	109	58%
Neurodiversity	52	28%
Learning disabilities/ intellectual impairment	58	31%
Other	36	19%

* Services may address more than one vulnerability.

Of the 189 services identified across the 37 forces, 31% were reported to be tailored[24] to the needs of the offender receiving the OOCD. This typically meant that they were supported by a case worker who assesses the individual and designs a package of support to their needs that could be delivered by the case worker directly, or through signposting to a relevant service.

In most cases, the services that could be attached as conditions to OOCDs addressed more than one vulnerability as seen in Table 3.4. However, services to address health vulnerabilities in the context of broader complex need experienced by many in contact with the justice system were rarely available.

Table 3.4: Number and percentage of services that address 1, 2, 3, or more health vulnerabilities

Number of health vulnerabilities addressed by the services	**Number of services identified in all participating forces**	**Percentage of all services identified in all participating forces***
1	57	30%
2	40	21%
3	22	12%
4	21	11%
5	3	2%
6	37	20%
7	9	5%

24 Tailored support assesses the individuals' needs and vulnerabilities overall and provides a tailored support package according to those needs. We therefore assumed that the tailored support service would cover every listed health vulnerability in its interventions.

*Percentages do not add to 100% due to rounding to the nearest whole number.

152 services (80%) identified as available to be attached to OOCDs were reported to be available to both men and women. A further 27 services were targeted at women only (14%) and just 10 (5%) were targeted at men only.

Services targeted specifically at women were more likely to address a mental health vulnerability or be individually tailored (i.e., a case worker approach), compared with services available to all. Services targeted specifically at men were more likely to address drug and alcohol use. Sixteen of the identified services were targeted at young adults (8%), two of which were targeted at young men. Half of these services were tailored to the individual, and all had the potential to address mental health vulnerabilities.

Services available by police force

Very few participating forces reported having no services available to attach as conditions to OOCDs that targeted health vulnerabilities.

Out of the 37 forces that participated, only three stated that they had no services to attach to OOCDs that addressed a health vulnerability in March 2022. In the remaining 34 police forces:

- Drug and alcohol services were the most commonly available to attach to an OOCD: all 34 forces had at least one drug use service available and 33 had at least one alcohol use service available.
- Mental health services were also relatively commonly available, in 29 forces.
- Services to support physical health, learning disabilities and neurodiversity were the least commonly available: 23 forces could attach at least one service that could support physical health needs; 21 forces could attach at least one service to an OOCD that could support a learning disability; and 19 forces had at least one service for people with neurodiversity.
- 21 forces had introduced at least one tailored support service that could be attached to an OOCD.

Eighteen forces had at least one service available to attach to an OOCD that was targeted specifically at women only.

Mental health, drug use, alcohol use and learning disabilities were the vulnerabilities that were most commonly the focus of services targeted at women. Thirteen forces reported some level of tailored support for women, indicating a condition could be attached that had the potential to address more than one health vulnerability. One example of specialist support for women given OOCDs identified in this study was Avon and Somerset Constabulary's work with the Nelson Trust's 'Support, Help, Engagement' (SHE) Project. SHE provides managed pathways for women who have been referred to the service by the Constabulary's OOCD team. A case study describing this Project is presented in Annex 1 of this report.

Few forces reported having at least one service to attach to an OOCD that was targeted specifically at men.

Six forces had access to a drug use or alcohol use service targeted at men, five had a service to address mental health vulnerabilities, and four had a service to address physical health. Three of the forces had a tailored support service targeted at men, which were the only available services that could address a neurodiversity or learning difficulty vulnerability specifically for men.

Few forces had services to attach to OOCDs targeted at young adults.

Eight forces had at least one service available to support drug and alcohol use and mental health vulnerabilities in young adults. Six forces had access to a service that could support a physical health vulnerability, five forces could access a service to address learning disability issues, and four forces could access a service to address a neurodiversity vulnerability.

Service funding

A range of funding models for available services were identified, the most common of which were police-funded, externally funded (for example, by local authorities) and offender-funded.

Around a third of identified services that can be attached as conditions to OOCDs to support adults with health vulnerabilities were reported to be directly funded by the police. There is considerable variation between forces in how services are funded. For example, two forces had similar service provision, with 12 and 13 local services respectively, that addressed a range of health vulnerabilities. However, of these two forces, one force had two services funded by the offender and 10 by the police, while the other force had one service funded by the police and nine funded by an external source (funding for the remaining services unknown).

The data also highlights that 21 of all identified services were offender-funded, and were delivered online and in person. Examples were drug awareness-raising and anger management courses.

Modes of service delivery

Of the 189 identified services, 164 (87%) delivered the service in person, 17 (9%) delivered the service online, while seven (4%) services used both delivery methods.[25] Sixty-nine (37%) of the services were delivered by a third sector organisation, closely followed by 61 (32%) being delivered by the police. Other public organisations such as NHS Trusts and local authorities delivered 23 (12%) of the services; 34 (18%) were unclear on the delivery organisation type for the service; and 2 (1%) of the services were delivered by private organisations.

Gaps in local service availability

Qualitative data was gathered from interviewees on any gaps they have identified in the services that were available to be attached as a condition to OOCDs for vulnerable offenders in their force area.

[25] There was a missing response for one service.

Overall, most force areas reported that the provision of mental health-related services generally was not sufficient to meet the needs of those given OOCDs.

These gaps relate not only to the availability of services for specific mental health issues (discussed further below) but also to issues in accessing these services for vulnerable offenders. Interviewees from six force areas reported that waiting times for referrals were a challenge not only in ensuring that vulnerable offenders received timely support, but also in ensuring that they could access the service within the timescales set out in their OOCD.

Interviewees from five force areas also referred specifically to the limitations of attaching conditions to OOCDs for offenders with multiple, complex needs which may be deeply entrenched and require long-term investment to properly address. Similarly, interviewees from three forces reflected that the services provided were not adequately aligned to the needs of offenders, with one police interviewee commenting: 'People aren't always fitting the boxes that we've got to put them in at the minute.'

As noted above, three forces reported not currently attaching any services to OOCDs for vulnerable adult offenders in their area as at March 2022.

Several more specific gaps in mental health-linked service provision were drawn out in the interviews.

Among the most frequently raised gaps was support and treatment for **substance misuse** issues (seven forces), with two forces also reporting that the services that were available in their force area were designed for people with serious misuse issues and were therefore not appropriate for recreational drug users. One force noted that services for offenders with chronic physical pain were not available to be attached as a condition in their force area. They expressed concern that offenders who use illicit substances to manage physical pain may be referred to a substance misuse provider even though the service is not appropriate for their needs.

Services that address the needs of **problem gamblers** were also highlighted as a gap in provision by five forces. Three forces also noted a need for services targeting offenders with issues around **managing debts**. However, one force noted pushback from service providers in their area on attaching such a service as a condition for an OOCD. They

described the prevailing ethos among many in the debt and welfare sector in their area as resting on voluntary engagement from those needing support, and those providers expressed discomfort with the context in which offenders are asked to consent to receiving support.

Services aimed at supporting **anger management and management of emotions** were both identified as missing by seven forces and highlighted as an important driver of offending behaviour for many of those who have received OOCDs. Gaps in service provision for more general mental health issues such as **depression, anxiety, and stress** were also noted by two forces.

Two forces also mentioned a gap in services for offenders considered at **high-risk of harming** themselves and others.

The lack of services that meet the needs of neurodiverse people and/or those with learning disabilities was raised by twelve force areas as a serious concern.

Interviewees in these areas highlighted the difficulties these offenders may experience in engaging with both the force and the relevant service and ultimately complying with the terms of the OOCD. This concern was compounded by the delays that many neurodiverse people experience in receiving a diagnosis for their condition (reported by interviewees in some force areas as up to 24 months). Three forces also highlighted the risk of suicide and self-harm among those with learning disabilities.

The gaps in the availability of services targeted specifically by sex were also noted by many forces.

Five forces identified that the vulnerabilities frequently identified for **female offenders** that drive much of their offending behaviour, such as exposure to trauma and abuse, are not addressed in their force area. By contrast, seven forces reflected on the gaps in services that are specifically tailored for male offenders in their area. Many of the interviewees from these forces drew comparisons with the availability of holistic interventions for women and stressed that similarly targeted services are required to meet the needs of male offenders. One police interviewee commented: ‘Mental health is the key one that needs work on, especially men’s mental health’. The needs of more specific cohorts, such as men

between the ages of 18 to 35 or young fathers, were particularly highlighted by these forces.

Interviewees from one force raised this issue in the context of men who have committed domestic abuse, noting that while services are available for these offenders, they may require much more support beyond the condition of the OOCD:

> We repeatedly see domestic abuse offenders who haven't got a lot of support for mental health, and this, for them, is the first opportunity to talk about some of these issues… they really open up. So, we signpost them to… male-oriented services we know, give them contact details – but then they're on their own, their life is falling apart, and there's all these issues that they aren't equipped to face.

Gaps were also reported by a small number of forces in services to meet the needs of armed services veterans and non-English speaking offenders.

Three forces reported a lack of services to meet the needs of **armed services veterans**, with one force noting that the planned construction of an army camp for the area could increase this need soon.

Two forces also referred to gaps in meeting the needs of **non-English speaking offenders**. They noted that language barriers can pose problems for these offenders in understanding the terms of the condition attached to the OOCD, and in their subsequent interactions with the service provider. This may result in non-compliance with the OOCD and lead to further issues with the criminal justice system as well as create negative impacts on their finances, work, and relationships. One force also noted that offenders who are unable to establish their **immigration status** may not be able to access GPs or other forms of support for their vulnerabilities.

Some forces also referred to gaps in service availability for vulnerable offenders with particular offence types.

Service gaps for **domestic abuse offences** in their areas were noted by four forces. Gaps in services for people who have committed **sexual offences**, such as viewing images of child sexual abuse or extreme pornography, were also identified by two forces. Gaps in

services were also noted for people who had committed a **hate crime** (one force) or who had been involved in **knife crime** (one force).

Key stakeholders in case study forces shared a desire for greater availability of services for offenders with complex vulnerabilities.

In Phase 3, qualitative data from seven forces revealed a common desire from key stakeholders in the OOCD decision making process for a greater availability of services for offenders with complex vulnerabilities such as veterans and those with personality and neurodiversity disorders.

Maintaining relationships between forces and service providers

Of the forces that reported engaging with service providers as part of their OOCD process, relationships with service providers were generally maintained through some form of regular contact.

This reportedly included formal, regularly scheduled meetings (27 forces), more casual emails (24 forces), or telephone updates (20 forces) on an as-needed basis. Eighteen forces reported that they engaged in a combination of regular meetings, email, and telephone contact with service providers.

Seven forces reported that service providers were integrated into police IT systems to facilitate better information sharing, three of these forces noted that this was in addition to other forms of communication (meetings, emails, and telephone).

A small number of forces mentioned communicating in different ways with different service providers.

In some forces, the frequency and nature of the communications were mentioned to be distinct or bespoke with each separate service. The extent of this variation may depend on the size of a force area, the type of offences committed, the force strategy towards OOCDs (for example, dedicated police team, bespoke entity etc.), and their OOCD model. These factors cumulatively resulted in varying needs between forces; for example, within one force, it was reported that their tendency to deliver many interventions 'in-house' via case workers resulted in lower dependence on external services and therefore less communication overall. Likewise, another force reported using a single service provider to

coordinate all interventions offered as part of conditional cautions, reducing the need for variable communication methods, as the police were only engaging with a single partner.

Within another force, it was reported that their extensive network of service providers all differs in their areas of operation, support offerings, and working practices, necessitating a far more complicated process of communication to coordinate interventions. Eight forces reported that they communicated with all services in a consistent way; however, one of these forces had only a single service provider with which to communicate.

Some interviewees from forces with a smaller geographical area highlighted that this characteristic could be an advantage in maintaining relationships between police and service providers.

In one of these forces, it was reported that all key stakeholders involved in the OOCD process can take part in regular review meetings as part of an OOCD working group, aimed at addressing key barriers and highlighting good practice across the force. Representatives from new services were often invited to these meetings. Police interviewees from a larger force area reported that this approach to communication would presently be infeasible due to the size of the force area and the larger, more complex network of service providers to maintain. It was reported that district-specific L&D teams in many force areas do not share referral pathways and service providers leading to greater variance in communication between services and the police, and a relative lack of communication between police and providers across the force.

Forces with a dedicated OOCD team were more likely to report consistent communication across service providers.

This consistency was sometimes presented as a desirable goal, notably in two forces where the need for more consolidated and consistent communication practices was highlighted as a key area for improvement. Forces that manage all their OOCDs through a single bespoke team or independent organisation tend towards providing unique 1:1 support, which often involves a specialist from the force who is assigned to an offender working more closely with service providers.

Almost half of the forces noted that some formal reporting formed part of their approach to maintaining relationships with service providers.

Eight forces provided some level of detail on the nature of this reporting. Weekly, monthly, and quarterly reports were common, and tended to focus on referral numbers, completion rates, reoffending statistics, and cases of extraordinary change in individuals referred. There was no mention of reporting as part of relationship maintenance in 18 forces.

Collaborative working on OOCD cases

All interviewees from the Phase 2 forces were asked for their views on how, if at all, local interventions and services attached to an OOCD worked collaboratively to meet the needs of vulnerable offenders.

Across the case study forces, most interviewees commented that they did not feel well positioned to speak about the nature and extent of collaboration in dealing with OOCD cases.

However, a small number of interviewees, who were more directly involved in handling OOCDs shared their views. In four force areas collaborative working was limited to signposting or referring on individuals with OOCDs to other service providers. However, several interviewees noted that where local service provision overlapped significantly, for example in drug and alcohol support, but gaps remained in addressing other needs, opportunities to signpost to other services were limited. One police interviewee spoke of the role that police can perform in creating links between service providers, especially where there is a dedicated OOCD team to maintain those relationships:

> We've very comfortable getting in touch and having informal chats with appropriate services. We have a dual diagnosis meeting process and get multiple services involved to try and come up with a progression of interventions that meet their needs. The organisations tend not to a do a lot of joint working, so have a [case worker] there to connect those organisations and get them thinking about the work that the other organisations are doing.

A small number of barriers to collaborative working were also highlighted. Managing data protection considerations in effective sharing information about offenders with

other service providers was noted as a challenge in two force areas. One police interviewee stated:

> Often, this kind of collaborative process does not occur, because the channels are not there, and cannot be there, given protections around data protection and the difficulty sharing any meaningful correspondence between policing and the NHS. Especially given the four-month window we can act in, most longstanding health vulnerabilities are the result of conditions that go back years and take years of treatment to properly address.

However, one interviewee commented that their force had dealt with these concerns by establishing appropriate information sharing processes:

> We have set up information sharing agreements and effective referral pathways with all main services across the region. They are all aware of what we do. We also have an agreement that they will accept our assessment documents so they are not having to reassess an individual which could have been a big barrier to collaboration. This means that the individual is not feeling like a new client but some way into the treatment process.

3.5 Police Training and Experience

The training of police officers and staff on OOCDs, particularly in relation to conducting vulnerability assessments, was generally reported to be conducted on an ad-hoc basis and not available as a structured programme for most police forces.

For example, in many forces a sergeant in a response team may request for the OOCD lead or a member of the OOCD dedicated team to speak to their team about OOCDs. This inconsistency in training, however, was identified by several force interviewees as a contributing factor to different messages being conveyed across various training sessions. Very few forces were found to have built OOCD training or vulnerability/health needs screening and assessment more broadly into the structure and delivery of their overall formal force training plan.

High staff turnover was also noted as a major issue in almost all forces participating in Phase 1. For example, one force reported that 42% of frontline officers had less than one year of experience, 62% fewer than three years' experience and only 19% had five or more years of experience. As a result, keeping training up to date is resource-intensive. Guidance from the College of Policing[26] highlights the importance of refresher training for officers generally, however this was also not present in most forces.

Given the reported high turnover and inexperience of new officers, developing a training programme that targets every response officer who may initiate an OOCD would be highly challenging, especially for larger forces.

Therefore, as part of our work in Phase 3 we have developed a targeted training curriculum (see the Rand website) at the supervisor and dedicated team or OOCD lead levels to stimulate their frontline teams to use OOCDs effectively. The contents of the training will involve the skills to support relevant officers and decision makers with the challenge of attaching conditions to OOCDs to address health vulnerabilities, involving the identification of health vulnerabilities, effective condition setting, and communicating OOCDs to offenders and victims.

3.6 Disproportionality

In Phases 1 and 2, disproportionality in the use of OOCDs emerged as a potential concern to be explored further.

Using aggregate data on the use of OOCDs gathered from 31 forces between 1st January 2021 and 31st December 2021 in Phase 1 of the study, the research team analysed proportions of OOCDs, Charges, NFAs or other types of outcomes (such as 'offences taken into consideration') according to offenders' age, ethnicity, and sex. This analysis is set out in the tables below.

In evaluating the Management Information (MI) data drawn from large administrative systems, it is crucial to acknowledge its limitations compared to Official Statistics, which

[26] College of Policing. (2013). Custody management and planning. Available at: https://www.college.police.uk/app/detention-and-custody/custody-management-and-planning#refresher-training.

undergo a more rigorous quality assurance process. This data, while indicative, is not exhaustive as it does not include information from all forces and has gaps in the data received. Additionally, the lack of controls for potential differences in cohorts, such as offence types or offending histories, suggests that the figures should be interpreted as raising potential concerns that warrant further investigation, rather than as definitive conclusions.

Table 3.5: Proportion of each type of outcome offenders received according to age group

Outcome	OOCD	Charge	NFA	Other	Total
18-24	34,388 (16%)	40,836 (19%)	109,612 (51%)	27,940 (13%)	212,776 (100%)
25-34	31,841 (9%)	74,298 (21%)	201,665 (57%)	45,994 (13%)	353,798 (100%)
35-44	18,810 (7%)	56,430 (21%)	155,855 (58%)	37,620 (14%)	268,715 (100%)
45-54	10,060 (7%)	25,870 (18%)	89,109 (62%)	18,684 (13%)	143,723 (100%)
55-64	4,740 (8%)	8,295 (14%)	38,516 (65%)	7,703 (13%)	59,254 (100%)
65+	1,943 (7%)	2,221 (8%)	19,717 (71%)	3,887 (14%)	27,768 (100%)
Unknown	2,484 (3%)	1,656 (2%)	74,537 (90%)	4,140 (5%)	82,817 (100%)

* Base numbers for: 1. 18-24 = 214,926; 2. 25-34 = 353,798; 3. 35-44 = 268,717; 4. 45-54 = 143,725; 5. 55-64 = 59,256; 6. 65+ = 27,771; 7. Unknown = 82,819.

This data demonstrates that younger age groups receive a greater proportion of OOCDs: the age group that received the greatest proportion of OOCDs was 18-24-year-olds (16%), followed by 25-34-year-olds (9%). Older groups of offenders tended to receive a greater proportion of NFAs, and a smaller proportion of charges.

Table 3.6: Proportion of each type of outcome offenders received according to ethnicity (self-reported)

Outcome	OOCD	Charge	NFA	Other	Total
Asian British	9,570 (14%)	11,621 (17%)	38,282 (56%)	8,202 (12%)	67,675 (100%)
Black British	10,470 (17%)	17,861 (29%)	22,788 (37%)	10,470 (17%)	61,589 (100%)
White	62,981 (9%)	146,957 (21%)	391,886 (56%)	90,973 (13%)	692,797 (100%)
Multiple ethnicities	2,639 (10%)	5,543 (21%)	14,518 (55%)	3,695 (14%)	26,395 (100%)

Outcome	OOCD	Charge	NFA	Other	Total
Other	1,918 (18%)	2,877 (27%)	3,942 (37%)	1,918 (18%)	10,655 (100%)
Unknown	17,849 (5%)	32,128 (9%)	267,740 (75%)	35,698 (10%)	353,415 (100%)

* Base numbers for: 1. Asian British = 68,361; 2. Black British = 61,590; 3. White = 699,798; 4. Multiple ethnicities = 26,398; 5. Other = 10,656; 6. Unknown = 356,987.

As seen in Table 3.6, Black British offenders received the least amount of NFAs (37%), but the greatest proportion of charges (29%). Offenders in the 'Other' ethnicity group and Black British ethnicity group received the greatest proportion of OOCDs (18% and 17% respectively). Other than those with 'Unknown ethnicity', White and Asian British offenders received the greatest proportion of NFAs (56%).

Table 3.7: Proportion of each type of outcome offenders received according to sex

Outcome	OOCD	Charge	NFA	Other	Total
Male	8,764 (10%)	184,725 (21%)	492,600 (56%)	114,353 (13%)	800,442 (100%)
Female	23,520 (9%)	28,746 (11%)	177,708 (68%)	28,746 (11%)	258,720 (100%)
Other	545 (15%)	109 (3%)	2,580 (71%)	399 (11%)	3,633 (100%)
Unknown	8,386 (10%)	838 (1%)	72,124 (86%)	2,515 (3%)	83,863 (100%)

* Base numbers for: 1. Male = 879,644; 2. Female = 261,336; 3. Other = 3,634;
4. Unknown = 83,866.

According to Table 3.7, male and female offenders received a similar proportion of OOCDs (10% and 9% respectively). However, female offenders were more likely to receive an NFA (68%) compared to male offenders (56%). Furthermore, 21% of male offenders received charges, whereas only 11% of female offenders did.

In effect, some individuals and groups are excluded from OOCDs for a variety of reasons.

Exclusion was identified as a critical problem by many force interviewees. The main reasons given by police force interviewees across the three phases included:

- **Communication barriers that can stop certain individuals and groups being offered OOCDs.**
  For example, most interventions assume:
  - competent level of English language skills;
  - a certain level of cognitive ability;
  - the ability to function in a group;
  - the ability to hear and see; and
  - the ability to get to a venue or have the remote technology required to access the intervention.

  For some individuals, one or more of these issues can result in their exclusion from consideration for an OOCD or leave them unable to take part or complete the intervention programme.

- **Persons from some communities are reluctant to admit guilt.**
  Factors which may contribute to this reluctance were reported to include:
  - perceptions of police by some communities and individuals;
  - previous negative experiences with police in the UK and/or their country of origin; and
  - peer pressure not to cooperate.

- **Police perception of who does or does not 'deserve' an OOCD.**
  For example, in relation to:
  - individuals with previous OOCD failures
  - locally held views about individuals from certain communities or families
  - individuals offering a 'no comment' response interview or not admitting to the offence, which can result in an escalation of the matter by the police resulting in a prosecution
  - individuals with some health vulnerabilities (particularly mental health problems including neurodiversity and learning disabilities).

Issues such as the above relating to disproportionality did not appear to feature in scrutiny panels and in the other OOCD cases that the study team reviewed as part of Phase 3.[27]

Some of the Phase 3 forces were considering or had introduced novel ways to address some of these tacit exclusion criteria.

For example, one force was working with British Sign Language to develop ways of adapting interventions for pre-lingually deaf individuals. Another force had experimented with key interventions being delivered in the most common non-English language groups in their area. In other initiatives, some intervention providers had adapted programmes so that they were tailored to individuals ensuring that they were not excluded by their inability to take part in conventional delivery.

Another promising initiative that has been evaluated through randomised controlled trials (RCTs) in three forces is Operation Turning Point. The RCTs compared the relative effectiveness and cost/benefit of police prosecuting lower harm offenders with an alternative treatment, called a 'Turning Point Contract', that combines a deferred prosecution with a set of conditions agreed with the offender, intended to support desistance. Deferred prosecution is a policing outcome that allows cases to be resolved without going to court but does not fall under the OOCD framework. A feature of Turning Point, as well as other deferred prosecution schemes, is that it does not require guilt to be admitted before participation.

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[27] Wider academic research and commentary appear to confirm these findings. For example, Kane et al 2018, found that:

> Individuals with a MH [mental health] flag have almost identical police dispatch response profiles to those without; they were arrested for and charged with similar offences. Those with a MH flag were significantly more likely to be charged with a criminal offence, less likely to receive a caution and spent longer periods in police custody than people under similar accusations but with no MH flag. MH flagging appeared to disadvantage the people flagged, despite the presence of theoretically appropriate interventions.

and:

> While it is important that OOCDs are applied consistently and offenders are treated equally, it is also important to acknowledge that different groups may require a different approach, with flexibility within the OOCD system to ensure that they can be tailored to need. Equality should not simply mean treating everybody in the same standardised manner, rather it should be grounded in an understanding what the impact of potential change is likely to be on different groups and individuals and developing appropriately tailored responses to ensure equality of outcomes.

Revolving Doors (2017). Under the Spotlight: Review of Police and Crime Plans. Available at: https://revolving-doors.org.uk/under-spotlight-review-police-and-crime-plans/.

3.7 Scrutiny of OOCD decisions

Findings from the case reviews conducted in Phase 3 of this project indicated that the force use of OOCD scrutiny panels, which independently review anonymised cases, varied greatly among the seven case study forces.

Some forces had a system in place for regularly reviewing adult OOCD cases on a monthly or bimonthly basis. Others conducted infrequent reviews and/or reported that their scrutiny panels ceased operating during the COVID-19 pandemic and had not yet restarted. These findings suggest that there is a need for more consistency in the frequency and thoroughness of scrutiny panels across forces to provide effective oversight of OOCDs for adults.

Scrutiny panels tended to be set up to focus more on individual cases, reviewing a small number of cases rather than the overall usage of OOCDs. There was no evidence of reviewers examining the broader issues in their force area, such as data trends on the use of OOCDs, any disproportionality in the use of OOCDs, the experience level of frontline staff involved in the cases, or the impact of having a dedicated team (or not) in the force. Instead, the focus was primarily on whether the individual should have been given an OOCD rather than whether they received a suitable OOCD, for example, an appropriate intervention or recognition of any health vulnerabilities. Including a remit for scrutiny panels to look at trends in the use of OOCDs would give forces and OPCCs a more strategic perspective on the key aspects of deficit and potential improvements to OOCDs highlighted throughout this report.

3.8 Reflections and implications

Overall, there was significant variation across the 37 forces in the OOCD models in operation and the use of OOCDs. It was also found that OOCD processes and protocols that were used varied a great deal between forces, and work with the Phase 3 case study forces identified significant missed opportunities to use OOCDs to support adults with health vulnerabilities.

While substance misuse and mental health services were the most commonly available to be attached to OOCDs, most force areas reported that these services were still insufficient

for the needs of offenders given OOCDs. Specialist services supporting neurodiverse individuals, young adults and veterans were not common and identified as a gap in provision. Gaps in police training and high staff turnover across many forces were identified as major challenges in OOCD use.

Issues identified by Phase 3 interviewees that may lead to the disproportionate application of OOCDs included not having English language proficiency; cognitive ability that did not match the level needed to participate in an intervention; reluctance of offenders to admit guilt; police perceptions of who is 'worthy' of receiving an OOCD; and health vulnerabilities that may require special arrangements for access to an intervention. Finally, the use of scrutiny panels for adult OOCDs and the actions that followed them varied greatly. There was no evidence of reviewers examining broader issues, such as disproportionality in the use of OOCDs, the experience level of frontline staff involved in the case, or the impact of having a dedicated OOCD team in the force (or not).

Implications

- Each force should review their current processes and protocols to ensure significant opportunities to use OOCD for those with health vulnerabilities are not being missed. This could include offence type audits and more detailed scrutiny of cases given OOCD and equivalent cases where they were not. A guide has been developed as part of this study (see the Rand website).

- **Forces should analyse data on local needs to identify any gaps in service provision**, and work with service providers to address these gaps.
- **Forces should build service provision for OOCDs and their relationships with service providers by piloting and scaling up services in response to identified local need** (and informed by robust evidence of effectiveness – see Section 5 below.)
- Where possible, forces should seek to **identify and utilise service providers with stable sources of funding to help ensure resilience in service provision**. This may mean that some services are funded by the police to provide this stability. Furthermore, **reducing offender-pays services** can remove some barriers to compliance.

- **Forces should establish consistent and standardised modes of communication with service providers**, including on compliance with and breaches of conditions. This may be easier with a dedicated OOCD team.
- **Forces should facilitate good information sharing by integrating service providers into police IT systems** (in compliance with relevant data protection regulations.)
- Each force should review their current training arrangements to ensure all those involved in OOCD decision-making are suitably trained in this area. Forces can consider adopting/adapting the training model outlined in this guidance (see the Rand website).
- Each force should review its current use of OOCD attached services aimed at those with health vulnerabilities to ensure that their current practice is not resulting in disproportionality in the use of OOCDs or discriminating against some individuals, groups or communities.
- **Each force should review their current adult OOCD scrutiny arrangements** to ensure that their overall oversight and accountability mechanisms for OOCDs are more consistent and comprehensive, as well as able to address wider issues of disproportionality.

4. Frontline Operational Approach

Table 4.1: Key messages on frontline operational approach

Key messages

- **Three levels of decision-makers at key OOCD decision gateways – the officer in charge (OIC), their supervisor and the force OOCD management and support functions – were identified.**
- **Most police forces did not have a force-wide policy requiring a health vulnerability screening and assessment** during the OOCD decision-making process and the use of a tool to assess health vulnerabilities was a well-established process in only a minority of forces, usually those with a dedicated OOCD team.
- **The majority of forces were still reliant on frontline officers and their supervisors to make decisions** regarding OOCD condition setting and deciding on any supportive interventions.
- **The most effective OOCD management processes and outcomes were found in those with a dedicated team.**
- **The responsibility for monitoring compliance varied significantly between forces**, with some assigning it, for example, to a dedicated OOCD team, and others to the OIC or an OOCD caseworker.
- **Definitions of what constitutes 'compliance' with conditions varied across and even within police force areas**, making it difficult to understand data on compliance.
- **A wide range of approaches to dealing with breaches of conditions were identified**, but only two forces reported that a breach always resulted in prosecution.

4.1 Introduction

This Section presents findings on how frontline decisions to use OOCD to support adults with health vulnerabilities were made, including OOCD decision-making models within forces; conducting vulnerability assessments of offenders as part of the OOCD process; the OOCD condition setting processes; and the monitoring of compliance with and breach of conditions. In all three phases of the research, the research team sought to understand the frontline operational issues at the core of OOCD usage nationally. In Phase 3, there was a more detailed and specific review of these issues.

4.2 OOCD decision-making models

Several different models for decision-making around OOCDs were identified across police forces participating in this study.

Across the 37 force areas participating in phase 1 of the study, four different models were identified on how decisions were made on giving an OOCD and the conditions set, as well as monitoring of compliance with the OOCD.

- The first decision-making model is led by the officer in charge (OIC) and their supervisor. In this model, officers and supervisors are responsible for managing and handling OOCD decision-making and following up on compliance without any additional support from within the force.
- A second model is OIC- and supervisor-led with additional support from an OOCD lead within the force. This model entails officers and supervisors handling OOCDs with the support of an OOCD lead, in some instances with the support of administrative staff. The OOCD lead is responsible for providing guidance and support to the officers and supervisors.
- A third model uses a dedicated OOCD team comprised of trained staff who provide support to officers and supervisors in handling OOCDs. Dedicated OOCD teams vary in size and structure ranging from 1) a support function focused on OOCDs and available to front-line OOCD decision makers; 2) a team that advises decision makers; conducts wide ranging assessments of individuals; finds interventions to attach to conditions; monitors compliance; and manages

breaches, and; 3) a team that offers all of these functions and also delivers interventions to be attached as a condition to the OOCD.

- The fourth model involves central support from a group of Evidence Review Officers (EROs) or their equivalent, who review OOCD cases along with other criminal justice system disposals. EROs liaise with external agencies including Crown Prosecution Service, work with supervisors and the officer in the case to ensure each file is of sufficient quality, adheres to legislation and criminal justice requirements and make decisions in cases for the progress of the offender such as Charge to court, Bail for further evidence, Youth Referral, Summons, Caution etc.

In Phase 2, data from seven forces was collected to provide additional insight into how each force handles each stage of the OOCD decision-making process, from initial recommendations to proposing interventions to be attached as conditions and monitoring compliance with the condition. Table 4.2 below sets out each force's approach and demonstrates the diversity of models in operation.

Table 4.2: Phase 2 forces' OOCD decision-making model

Force	Force 1	Force 2	Force 3	Force 4	Force 5	Force 6	Force 7
Recommends an OOCD	Officer	Shared	Officer	Officer	Officer	Officer	Officer
Monitors appropriateness of OOCD recommendations	Central	Central	Shared	Not in place	Officer	Central	Central
Identifies potential services to use in OOCDS	Central	Central	Shared	Central	Officer	Central	Shared
Shares service information with OOCD decision makers	Central	Central	Shared	Central	Central	Central	Central
Assesses the person's health vulnerabilities / needs	Central	Central	Shared	Not in place	Officer	Shared	Not in place
Sets OOCD conditions	Officer	Central	Officer	Officer	Officer	Officer	Central
Refers offenders to services listed in conditions	Central	Central	Central	Central	Officer	Central	Central
Monitors compliance with conditions	Central	Central	Shared	Central	Officer	Not in place	Central
Recommends a breach decision	Officer	Central	Shared	Officer	Officer	Shared	Central
Police staff support offenders?	No	Don't know	Don't know	No	Yes	No	No

* Shared responsibility means the OOCD team provides support to officers

Phase 3 data from stakeholder interviews and solution-focused workshops revealed that stakeholders from most forces agreed on the importance of having a dedicated team to manage much of the OOCD decision-making process. The stated benefits of a such a team included: reducing frontline officers' workload; making more appropriate decisions on OOCDs and attaching conditions when compared to frontline officers and their supervisors; identifying missed opportunities where OOCDs could have been used rather than alternative disposals; providing and maintaining links and performance monitoring of intervention providers; and providing a repository of expertise and advice for frontline staff and supervisors.

Forces that made less use of such a team, or had a very small team, saw the benefits of expanding the team and giving them more responsibilities in terms of health assessments and service recommendations. Phase 2 qualitative data also reflected this advocacy for a dedicated team, with one force OOCD lead commenting:

> "I cannot see how forces with no central team and standard operating framework are or can deliver [OOCDs] effectively."

4.3 Identifying and assessing health vulnerabilities

Conducting vulnerability assessments

Based on data collected in Phase 1, most police forces did not have a force-wide policy requiring that a health vulnerability assessment be conducted during the OOCD decision making process.

Police officers with responsibilities around OOCDs were asked whether there was a force-wide policy that a vulnerability assessment should be undertaken when the decision is made to give an OOCD to an offender. Of the 37 forces, only five reported that such a policy was in place with an additional two forces reporting that such a policy would be introduced shortly. Of the forces with a policy in place, four had been two-tier for at least six months. Twenty-nine forces were reported to not have a force-wide policy around conducting vulnerability assessments in place, while one did not know.

Just over half of forces without formal policies requiring vulnerability assessment (16) reported that this was, informally, standard practice – however, what this practice entailed varied significantly between forces.

Of those forces that reported that there was not currently a force-wide policy, or that did not know whether such a policy was in place, sixteen forces reported that it was nonetheless standard practice to conduct a vulnerability assessment, while it was reported not to be standard practice in thirteen forces and three forces did not know.

Of those forces where a standard practice was reported, the qualitative data indicates that there was significant variation in the understanding of the meaning of 'standard practice' in this context. For example, several forces, particularly those with dedicated OOCD teams, reported that such assessments were integrated into their OOCD processes and typically undertaken by an assigned case worker. By contrast, in other forces it was reported to be standard practice to use a vulnerability assessment framework for any individual that an officer deals with, rather than being specific to those offenders who are given OOCDs. Table 4.3 below sets out the responses:

Table 4.3: Existence of a vulnerability assessment policy or standard practice by OOCD model

OOCD model in use	Force-wide policy	Introducing force-wide policy	No policy, standard practice
Two-tier in the last year (at least six months ago)	Four forces	One force	Eight forces
Recently switched to two-tier (less than 6 months)			One force
Introducing two-tier plus in 2023			Two forces
Working towards introducing a new tier-two policy and process in 2022	One force		Four forces
Currently six-tier		One force	
Other			One force
Total	**5**	**2**	**16**

N=23

Twelve forces reported using a tool to assess vulnerability, although this was a well-established process in only a minority of forces.

For those forces who reported having a force-wide policy or standard practice for conducting a vulnerability assessment after a decision to give an offender an OOCD, interviewees were asked to explain the process by which the assessment was undertaken. Twelve forces reported using a tool to assess vulnerability, although most of these tools had not been validated for reliability.

In one force it was reported that a risk assessment, required as part of the custody process, may involve the L&D team. Once a decision to give an OOCD had been made, their dedicated team would also undertake an assessment. It was reported that this team have developed their own tool for this assessment. In another force, a needs assessment was conducted by the OIC or via telephone by the L&D team, and then reviewed by the dedicated OOCD team.

In a third force, it was reported that a new needs assessment tool had been rolled out, with one version for offenders being given a community resolution, and another more detailed version for those given a conditional caution. A face-to-face assessment was undertaken for all OOCD referrals by the OIC and covered life events such as bereavement, housing, finance, physical health, mental health, disabilities, and alcohol and drug use. In another force, it was standard policy that two assessments were conducted: a bespoke needs assessment that covered some health vulnerabilities, and the Justice Star assessment,[28] which covered ten areas including mental health, drugs, and alcohol.

In another force, it was reported that each case was dealt with individually, but that while there was a policy in place, a vulnerability assessment tool was not used. Officers could check the offender's custody records on the force's Athena information technology system, including on any previously identified vulnerabilities, and could use a basic tool to assess criminogenic risks.[29] The OOCD team then spoke to the OIC about the individual and their vulnerabilities to make a full assessment using a tool created by the force's OOCD lead. It

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[28] For more information: https://www.outcomesstar.org.uk/using-the-star/see-the-stars/justice-star/, accessed 8 March 2023.

[29] Criminogenic risks relate to factors that may cause criminal behaviour.

was noted that the force also used an assessment for controlling and coercive behaviour for domestic abuse offenders.

Forces with a dedicated OOCD team, which reported that conducting vulnerability assessments was standard practice, also had a relatively well-developed process for the assessment.

In one force for example, a case worker would use a needs assessment as well as a ‘Wheel assessment’, which covered all the key pathways to support including housing, employment, and mental and physical health. In a second force, assigned case workers completed the needs assessment, which covered health vulnerabilities, including physical and mental health. In a third force, a risk assessment was conducted before the offender was diverted to a service, where an in-depth vulnerability assessment was carried out.

In five forces, it was reported that vulnerability assessments were conducted by the OIC, often relying on their personal judgement rather than on an established framework or tool. However, in one of those forces there was a pilot of a new tool underway in two areas.

Some forces mentioned vulnerability assessment processes not specific to OOCDs.

Two forces reported that their forces conducted vulnerability assessments for any individuals that an officer is dealing with, rather than only those who have been given OOCDs. Furthermore, a small number of forces (five) that reported not having a force-wide policy or standard practice on conducting vulnerability assessments, typically reported having some process available, if not necessarily well-developed or widely used, to conduct vulnerability assessments. These were typically not specific to OOCDs but rather used for any individuals that an officer is engaging with. Additionally, for a small number of forces, interviewees gave conflicting responses to questions about practices around vulnerability assessments. This indicated that such a process, should one exist in these forces, was not widely understood even by key police OOCD stakeholders.

Responsibility for conducting the assessment

There is considerable variation between forces with regards to conducting vulnerability assessments, with OICs, custody officers and staff and L&D teams all playing a role to a greater or lesser extent.

Thirteen forces reported that the OIC is 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 was often not made alone but rather in consultation with the OIC and L&D. In one force, a case review officer would conduct the assessment with input from the OIC and, if the offender had been through custody, the custody supervisor, and the L&D team. In a second force, the OIC may conduct a formal assessment on the street, and the L&D team conducted a needs-based screening with the offender in custody. Primary responsibility of the L&D team to conduct vulnerability assessments was reported in five forces.

Where dedicated OOCD teams exist, their role in vulnerability assessment differed between force areas.

Seven forces reported that vulnerability assessment was the responsibility of their dedicated OOCD team or OOCD case workers, although there was significant variation in approach for these forces. For example, in one force it was reported that mental health staff and/or the L&D team conducted a vulnerability assessment as part of the custody process. Once it had been decided to give an OOCD, their dedicated team would undertake a vulnerability assessment of the offender. In a second force, a case worker completed the assessments, occasionally asking the L&D team to conduct an assessment for more challenging cases. In a third force, the case worker conducted the assessment with supervision from the OOCD lead. In another force this responsibility depended on the setting: in custody, the OIC and sergeant conducted the assessment, whereas outside of custody, the assessment was made by the relevant case worker. In a third force the OIC flagged any obvious needs for the case worker to follow up with a full assessment, linking in with the L&D team where relevant.

Table 4.4: Phase 2 case study examples of variations in how individuals are assessed and identified as having a need for interventions

Case study force 1 The vulnerability assessment process described involved two stages, before and after an OOCD had been given to an offender. Firstly, a general risk assessment was required as part of the custody process and as part of this, the mental health team and/or the L&D team would assess the offender's vulnerability. Then, once an OOCD decision had been made, the dedicated team would also conduct a face-to-face assessment for all OOCD referrals using a tool that they had developed. It was reported that there were some links to the L&D team for this process, although dedicated team members acknowledged these could be strengthened and they were not generally available for Voluntary Attendance interviews or in investigations. It was reported that the dedicated team received no formal training in conducting vulnerability assessments but rather 'learn on the job.'
Case study force 2 A few years ago, the force set up a trauma-informed approach policy to address mental health issues, substance misuse, poverty, and other issues. Following this policy, each case was dealt with individually, and when a case came through custody, the police IT system would make officers aware if the offender had any existing health vulnerabilities. At this point, the force's dedicated OOCD team would commence a vulnerability assessment and communicate with officers who had dealt with the offender to share relevant information on them. To assess the offender's vulnerabilities, the team used a basic tool for criminogenic risks as well as another vulnerability assessment tool created internally by the OOCD lead. Alongside these tools, a Risk, Frequency and Gravity (RFG) score was also calculated to help assess their behaviour and, for domestic violence offenders, they also used a tool for controlling and coercive behaviour. Based on these assessments, the OOCD team would refer offenders to the appropriate diversion. OOCD team members were given approximately six days in total of in-house training, with inputs from the L&D team and more specialized information on stalking and domestic abuse.
Case study force 6 The approach to conducting vulnerability assessments used by this force was among the least developed of the case study forces. A risk assessment was undertaken when an offender was in custody, which was not specific to the OOCD process. The OIC would also be interviewed by the custody staff about the offender, and information gathered may inform the selection of the condition for an OOCD. An assessment by the L&D team may also be requested, although this was not formally linked to the OOCD process. There was no assessment tool in use, and it was reported that no training was provided to OOCD decision makers about assessing vulnerability.

In Phase 3 the research team focused on:

- Identifying the specific gaps in needs assessment in the seven forces;
- The extent to which key relationships had been developed with L&D and intervention providers that would help fill gaps and make for a more comprehensive and effective approach to the screening and assessment of health vulnerabilities;
- The design and development of a process to embed health vulnerabilities screening and assessment into OOCD processes; and
- Developing a quality assurance approach for forces to use in respect of commissioned interventions.

The Phase 3 forces represented the spectrum of availability of screening and assessment for health vulnerabilities. Some reported having protocols and processes in place at one or more of the decision gateways, while others had none outside custody. Even the most developed systems still had many of the gaps found in Phases 1 and 2, but all were committed to improvement.[30]

The work carried out with the seven case study forces indicated that there were three key stages where health vulnerabilities screening or assessment was needed to inform the OOCD decision-making process, each with an increasing level of sophistication.[31]

These three stages are:

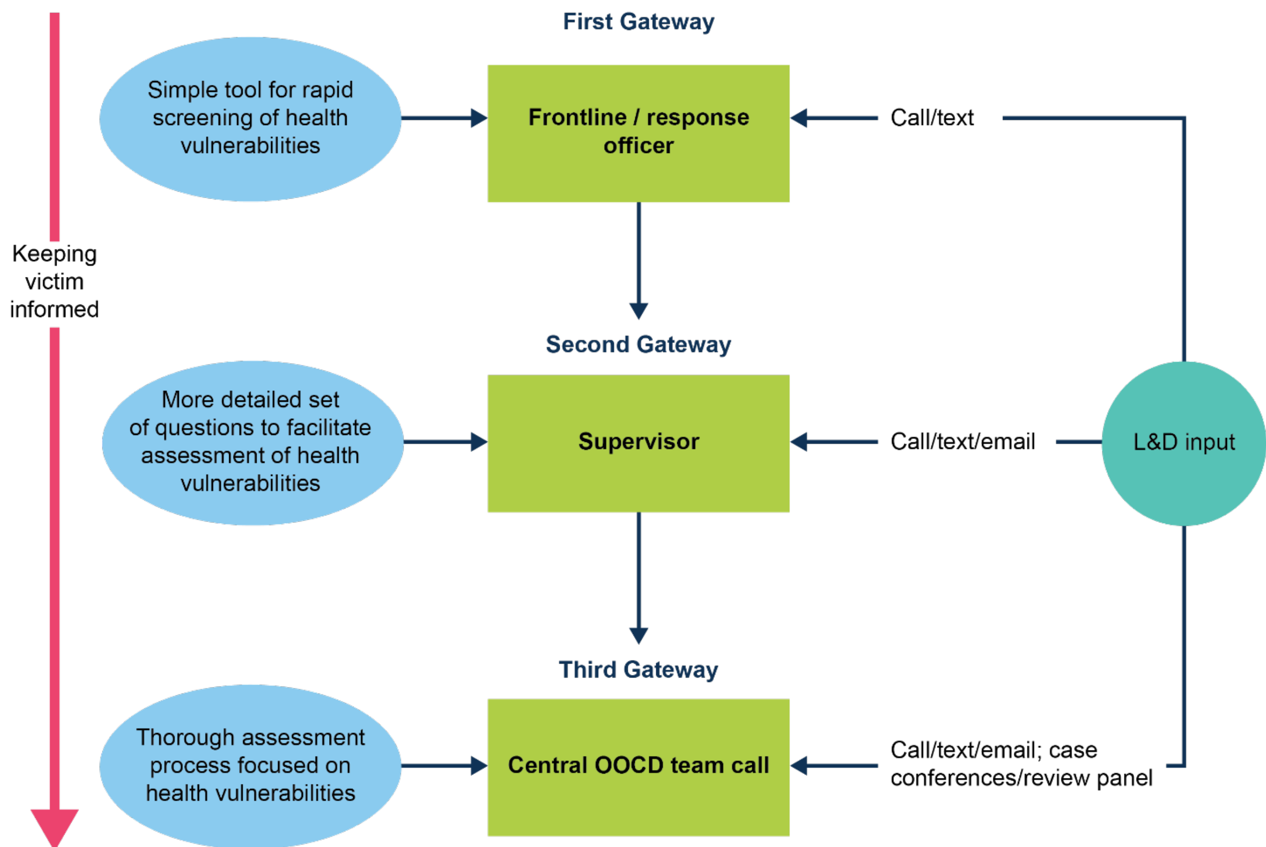
1. OIC's initial encounter with a suspect at which point an initial consideration of an OOCD and screening for health vulnerabilities should happen.
2. Supervisors considering making an OOCD decision and assessing the impact of health vulnerabilities on that decision.
3. Dedicated support/decision review (this may include a fully staffed dedicated team, Evidence Review Officers or a single OOCD lead).

[30] The decision was taken in consultation with the forces, MoJ and the National Steering Group that a normative guide to health vulnerabilities screening and assessment should be developed with the case study forces and other stakeholders (see the Rand website).

[31] Decision-making on health vulnerabilities in control rooms from where dispatch decisions are made was also an issue for some forces but was not within the scope of this work.

Figure 4.1 below outlines these graphically, indicating the key personnel involved in each stage, what they need to make an assessment, and additional inputs which facilitate the process.

Figure 4.1: Key stages where health vulnerabilities screening or assessment is needed



The research team also facilitated local meetings in the Phase 3 force areas with key stakeholders including L&D teams and commissioners. In some areas, relationships were reported to be already well-developed, but the full potential of the relationship had not been explored nor exploited to the fullest extent possible. This was particularly the case in respect of Voluntary Attendance interviews and investigations. In other forces, there was no relationship with L&D beyond the custody setting. Indeed, there is growing anecdotal evidence from NHS England and elsewhere that many individuals admitting summary offences for which an OOCD should be considered were now dealt with through Voluntary Attendance interviews rather than being taken to custody. As a result, these individuals, likely to include those with health vulnerabilities, were often not assessed by L&D. The Rand website sets out a guide to bridging this gap.

4.4 OOCD condition setting

In Phases 1 and 2, the processes used to attach conditions to OOCDs was reviewed by the research team. The picture was varied, but overall, it was found that in many forces there was still reliance on the frontline officer and their supervisor making the decisions without support from either a dedicated team or the L&D team. In Phase 3, the research team worked with the case study forces to look at ways to improve the identification of interventions to attach to conditions related to health vulnerabilities.

How are services attached to an OOCD to address a health vulnerability?

Three forces reported that there were no services currently available to be attached as a condition to an OOCD to support adults with health vulnerabilities. Interviewees from one of these forces reported that they did not currently use services for OOCDs because most offenders were not based locally and it was perceived to be too difficult to expect (and monitor) engagement with local services, and they were sceptical about the value of online services. Interviewees from another force reported that using services was very difficult due to resource constraints and the large and relatively sparsely populated geographic area. Interviewees from the third force reported that there was currently no framework or process around OOCDs in place, which had meant that they have not established any links with relevant service providers for the purposes of OOCDs. There were plans in all these forces to provide services as they transition to the statutory two-tier plus approach. All other forces were asked about the process by which services may be attached to an OOCD.

Twenty-three of the participating forces reported there was either a formal policy or a standard practice guiding the identification of services to attach to an OOCD.

Six police forces said that they have a formal policy for how to identify a service that could be attached as a condition to an OOCD, and a further 17 said they had a standard practice, but no formal policy. Five reported that they would shortly have a policy. Forces that were already using a two-tier approach to OOCDs were more likely to say that they had a standard practice (13 out of 17) than forces that had not yet started the two-tier approach (four out of 13), although interestingly only one force with a formal policy was currently two-tier.

Table 4.5: Existence of policy or standard practice for identifying services by OOCD model

OOCD model in use	Force-wide policy	Introducing a force-wide policy	Standard practice
Two-tier in the last year (at least six months ago)	One force	One force	Eleven forces
Recently switched to two-tier (less than 6 months)			Two forces
Introducing two-tier plus in 2023	Two forces		One force
Working towards introducing a new two-tier policy and process in 2022	Two forces	Three forces	Two forces
Currently six-tier		One force	
Other	One force		One force
Total	**6**	**5**	**17**

N=28

Most participating forces reported that an offender must consent to a condition.

Forces were asked if the offender must agree to the condition for it to be given. Among the 34 forces which reported the availability of services to attach as a condition, only one said the offender did not have to agree and interviewees from another force gave conflicting answers. In a third force interviewees noted that if an offender does not agree to the condition, the matter would progress to prosecution. If this is common practice among forces, there may be uncertainty around the degree and nature of consent required from offenders to the condition.

Awareness of the ability to attach conditions to OOCDs, and of available services, varied among decision makers.

Awareness of the ability to attach conditions to OOCDs varied considerably between and even within forces. OOCD decision-makers in thirty-two forces were reported to be informed about the potential to attach a condition to a OOCD to address a health vulnerability. However, when these forces were asked a follow up question on the level of awareness among decision makers, the picture was very mixed. In six forces, different interviewees gave conflicting answers on the level of awareness in their force.

Twelve forces reported that the level of awareness among their OOCD decision makers was high. These forces most typically had a dedicated OOCD team, although there were no strong associations with having either a two or six-tier approach among these forces. In one of these forces, an interviewee noted that while the level of awareness among the core OOCD decision makers was very high, they found the wider force knowledge level 'frustratingly low' due to the process still being relatively new.

Seven forces reported that there was 'some level' of awareness about the potential to attach a condition to an OOCD, with several interviewees describing varying levels of awareness among their colleagues in the force. Another six forces reported that the level of awareness in their force was low, while two forces did not know.

All 32 forces that reported awareness of the potential to attach a condition to an OOCD also reported that OOCD decision-makers were aware of the available services. However, some qualitative data around this topic indicates that the level of awareness, at least in some forces, may be variable across OOCD decision makers. For example, one interviewee commented:

> "For the general menu of options, it's pretty good. If there's something a little bit more obscure, I would say that there's less awareness."

Interviewees from another force reported that awareness of available services varied between teams and perceived ease of understanding the offender's needs. For example, it was noted that the cannabis service was considered easy to understand and was used frequently, and there was a strong relationship between the Community Investigation Team for drug supply and drug-related harm and the local drug diversion service. By contrast, anger management was considered more difficult to understand as a need and as a result, relevant services were not frequently accessed.

What are perceived to be the most effective methods for condition setting?

All police officer and staff interviewees from the Phase 2 forces were asked for their views on the most effective methods for condition setting in the OOCD process. The degree of insights shared on this topic varied widely between forces, with interviewees from some

forces indicating that they had not reflected on it, while interviewees from other forces, discussed their views extensively and highlighted a range of relevant considerations.

Across and even within the case study forces, there was a range of views on the most effective methods for condition setting. One interviewee felt it was important to understand the relationship between offending and the health vulnerability, and to set conditions that the offender could realistically be able to comply with:

> Making an informed decision: understanding the relationship between offending and health vulnerability, understanding what is appropriate to set as a condition (not setting people up to fail) and being realistic about what is appropriate and achievable.

An interviewee in a different force also noted the importance of understanding the broader needs and vulnerabilities of the offender in effective condition setting, going beyond what is immediately apparent and what appears to be driving their offending behaviour:

> Assessing what their support needs are in the widest sense. For example, domestic abuse may also be affected by alcohol abuse. So, it is important to put in measures for alcohol abuse support to prevent a repeat.

Two interviewees in one force also raised challenges with condition setting. One expressed concern that some conditions, for example attending a course, required the offender to pay. Along the same lines, another interviewee commented that condition setting must take into account whether the offender is in a position to engage with the condition:

> Lots of people we deal with don’t have access to computers, may be homeless, so this needs to be taken into consideration. Also, so many individuals have such chaotic lives and I think a large proportion will not comply as they just forget.

One interviewee described in detail the process in their force, which they felt was effective:

> When we receive a crime report into force CID, we need to assess what the crime is, the level of the crime and the victim’s wishes. So, the conditions are set around

> that, each crime report is assessed differently dependent upon their needs and in line with the needs of the victim as well. If the conditions we set vary from the crime report – for example, if someone has mental health issues, and I believe that referral is going to be more effective – I suggest this to the victim without breaching any data protection and have that conversation about why I feel this is the case. There are many factors taken into consideration when doing an OOCD.

In one force, a dedicated OOCD Toolkit outlining the services, eligibility and referral methods had been established on the force intranet. In addition, several police interviewees positively highlighted a dedicated female-specific course delivered across the whole of the force area by four providers. It was reported that unlike other locally available services, this was a holistic intervention with an individual initial assessment followed by referral to as many interventions as was required to support their needs.

Responsibility for identifying services

In forces without a dedicated OOCD team, the OIC plays an important role in deciding what conditions and services to attach to OOCDs.

When it came to identifying or recommending services to be attached as conditions, fourteen forces reported primarily relying on the OIC for this task, although it was often conducted in consultation with colleagues such as the custody sergeant. This was common in forces with little to no use of OOCDs to address health vulnerabilities, and where condition setting largely depended upon offence type, and rare in forces where a dedicated OOCD team provided oversight. As noted in Section 3.4 above, the training burden for this approach is high and compounded by high levels of staff turnover.

Police-based OOCD teams are used by eight forces to identify and recommend interventions to be attached as conditions to OOCDs.

These dedicated teams were considered by interviewees in some forces to be an effective and even an essential approach to OOCDs as there is one dedicated point of contact for police and services, and engagement between these stakeholders was reported as strong. Interviewees in a force that did not have a dedicated team, expressed the view that while training and internal briefings about available services had been delivered to officers who

are tasked with identifying suitable services, having a dedicated OOCD team would improve the effectiveness of this process.

In the remaining forces responsibility for identifying services and attaching conditions lay with multiple decision makers.

In three forces, it was reported that the responsibility lay with the custody sergeant involved in the case. In one force, it was reported that the responsibility lay with the force Criminal Investigation Department. In a second this was the responsibility of the case review officer, although the decision was sometimes made in consultation with the dedicated OOCD team. In a third force, it was reported that the decision may involve multiple actors including the OIC, custody staff, the L&D team, with the dedicated OOCD team providing oversight. In a fourth force there was a dedicated disposals team run by police, jointly with the Probation Service, while in another force a dedicated team liaised with L&D, the OIC, and local authorities to attach conditions and regularly updated them.

Four forces relied on caseworkers from a dedicated independent entity or commissioned service to select conditions to attach to an OOCD. For these forces, interviewees felt this approach worked effectively for multi-agency working and engagement with services, as keyworkers were provided with the flexibility to find the best intervention needed for the offender incorporating a range of services, including housing, employment, and health vulnerabilities. In addition, one force reported that the responsibility lay with the L&D team, while two forces reported no data.

How individuals were signposted or supported to access local services

A range of approaches to signposting and supporting offenders to access local services was reported across the Phase 2 case study forces. Typically, the process entailed the force facilitating contact between the offender and service provider and sharing relevant information with the provider on the offender and the nature of their OOCD condition. Many service providers reported that they could signpost or refer on offenders who had needs that the provider was not able to address, although some police interviewees had much less knowledge of this stage in the process.

Table 4.6: Phase 2 case study examples on how individuals were signposted or supported to access local services

Case study force 3 After a vulnerability assessment was completed, case workers consulted with offenders on an appropriate strategy of support to address their offending behaviour and help with lifestyle changes where appropriate. It was reported that a core component of the consultation was prompting offenders to reflect on their lives and be able to identify the root causes of their offending behaviour – after which, offenders were offered a tailored, four-month programme, agreed through a contract. This four-month period consisted of focused work with a case worker to address the offenders' needs, whether they be related to drugs, alcohol, mental health, housing, employment, physical health, finances, or other factors. It was reported that most work was performed in-house by case workers who had a diverse array of background specialisms. On occasion, case workers referred into external services for specific issues that fell outside their expertise, such as low prevalence mental health conditions that required the support of a qualified specialist.
Case study force 4 The OOCD team was responsible for identifying services and making the appropriate arrangements for the offender to enter the service, as well as maintaining contact with the service providers. Furthermore, the dedicated OOCD team provided training to all staff, assisting them to recognise services and interventions for health vulnerabilities, and offering an advice helpline to officers who are setting conditions for people. Whilst it was reported that there was a limited number of services available locally, mainly focused on alcohol and substance misuse, one service provider worked with offenders with complex and additional needs and could also make onward referrals and signpost offenders to other appropriate services.
Case study force 7 Once the OOCD team was notified that the OOCD had been given to an offender, that team facilitated contact between the offender and service provider and shared online login details with the provider so they could access relevant information on the offender. It was reported by several police interviewees that service selection was based almost entirely on the availability of an intervention and the offence involved, and that the interventions attached to conditions rarely matched the complexity of vulnerabilities that were experienced by many offenders. Consequently, they were seen by key staff as unlikely to address the offender's needs or offending behaviour. It was reported that OOCDs were used sparingly and are heavily focused towards drug and alcohol provision, with significant gaps around mental health.

In Phase 3, the research team focused on:

- Identifying the specific gaps in condition setting and management in the seven case study forces;
- The extent to which key relationships had been developed with intervention providers that would help fill gaps and make for a more comprehensive and effective suite of interventions to attach as conditions; and
- Developing a quality assurance approach for forces to use in respect of currently commissioned and future commissioning of interventions.

The approach to delivering on the three areas above was partly tailored to each force and partly based on developing a single approach to key issues that could be co-developed with the case study forces and then shared more widely. In each force we held a solution focused workshop to begin to address their identified gaps and issues related to condition setting, partnerships, and quality assurance. The actions and ownership of the actions was agreed and monitored in a series of three follow up project review meetings. To support the forces' programmes of change the research team arranged and facilitated meetings with key stakeholders, that until this project had not been included in the local OOCD processes. These included L&D team leaders and commissioners, intervention providers and local statutory and third sector agencies. The objective of these facilitated meetings was to generate local partnership and co-operative action.

A key area where action was reported as needed by all seven forces (and nationally) was to develop a quality assurance process for interventions used in the OOCD process. The co-produced quality assurance process is set out on the Rand website.

4.5 Monitoring compliance and breach

In Phase 1, the compliance monitoring and breach criteria were reviewed nationally and subsequently in more depth in Phase 2 and Phase 3 forces.

Monitoring compliance was reported to be a matter of formal policy or standard practice in most participating forces.

Of the thirty-seven forces that participated in Phase 1, twelve reported that there was a formal policy in place in their force that compliance with the OOCD condition should be

monitored, with another two forces reporting that there were plans to introduce such a policy when they transition to the two-tier plus framework. Eighteen forces reported that, although there was no policy in place, it was nevertheless standard practice in their force to monitor compliance. For the remaining forces, there was either no formal policy or standard practice in place or it was not known.

Table 4.7: Existence of a formal policy or standard practice for monitoring compliance with conditions by force OOCD model

OOCD model in use	Force-wide policy	Introducing force-wide policy	Standard practice
Two-tier in the last year (at least six months ago)	Five forces		Eleven forces
Recently switched to two-tier (less than 6 months)			One force
Introducing statutory two-tier plus in 2023	Two forces		One force
Working towards introducing a new two-tier policy and process in 2022	Four forces	One force	Three forces
Currently six-tier		One force	One force
Other	One force		One force
Total	**12**	**2**	**18**

N=32

In those forces with a formal policy or standard practice, it was reported that compliance monitoring did in practice occur in almost all cases.

Of the forces reporting that there was a formal policy in place, all but one reported that compliance was monitored in almost all cases, with one reporting that work was currently underway to develop a model for monitoring compliance. In forces where monitoring compliance was reported to be standard practice, 10 reported that compliance was monitored in all or almost all cases, with the remaining forces unsure of the extent of compliance monitoring at their force.

Eighteen forces reported that they were aware of the compliance rate with OOCD conditions in their force. Nine reported that they were not aware while interviewees from the remaining forces did not know if this data was collected. Of the 18 forces that were

aware of the compliance rate, most reported rates of at least 80% and for many forces over 90%. Three forces reported lower compliance rates: at around 65%, 50%, and between 70-80%. Police forces were not asked directly how they defined compliance with OOCD conditions. However, qualitative data from Phase 2 of the study indicated significant variation in definitions and some do not appear to require confirmation that the offender had completed the condition. For example, in some forces it was reported that some intervention programmes were considered completed after first contact whereas others required completion of all elements. This may be an important contextual consideration given the very high reported rates of compliance from these 18 forces.

There was considerable diversity across the forces which monitor compliance in terms of where the responsibility for this task lies.

Fourteen forces reported that their dedicated OOCD team or lead monitored compliance, including six forces for which monitoring was policy and eight for which it was standard practice. In five forces, monitoring compliance was the responsibility of the OIC, with another two forces reporting that it was the responsibility of certain other teams within the force. Five forces reported that OOCD caseworkers monitored compliance, and two forces reported that it was the responsibility of service providers to monitor compliance and share this information with the force. One force reported this responsibility was shared across different OOCD stakeholders including their dedicated team, the OIC and other teams in the force. In a second force, it was reported that monitoring compliance was currently neither a matter of policy nor standard practice, nevertheless reported that the L&D team monitored compliance with OOCD conditions.

Forces most often monitored compliance with conditions using information from service providers on attendance at the service.

Forces that reported monitoring compliance were also asked to describe the information used to do so and how this information was gathered. The most common approach, adopted by 23 forces, primarily relied on information shared by the service provider on the offender’s attendance at the assessment or intervention which was the subject of their condition. These forces also commonly gathered more qualitative information on the offender’s engagement in, and attitude towards, the intervention. One force reported a

similar approach, although the information was shared between the Probation Service and the police and stored on a shared case management system. Another force reported that their information gathering approach varied by service provider. One service was reported to record and share a broad range of information including the offender's health, while another reported that they only monitored attendance, cooperation, and engagement. One police interviewee stated that:

> …compliance information is of some use in terms of judging the value of continuing with the service, and also helps to influence future decisions in relation to the offender.

A small number of forces, particularly those with dedicated OOCD case workers or dedicated teams, reported a relatively intensive approach to gathering and using information on compliance. For example, in one force it was reported that an offender was required to participate in regular meetings with their assigned keyworker to track their progress under the condition; the force also collected feedback from service providers about their engagement with the condition. A second force used a contract agreed upon with each offender which sets out SMART (specific, measurable, achievable, relevant, and time-bound) objectives, tailored to the offender's key three or four needs, which the case worker used to track the offender progress over the course of the condition. In a third force, it was reported that information on the offender's attendance at, and engagement with, the service was gathered along with information on any further calls for service in relation to the offender, with all data on progress against the condition tracked in their case management system.

Breach of conditions

Twelve forces had a formal policy relating to breach of OOCD conditions and fifteen forces had an informal but standard practice approach.

Forces were asked whether there was a formal policy or standard practice that non-compliance with or withdrawal from conditions attached to OOCDs should result in a breach of conditions. Interviewees from 12 forces reported that there was a formal policy in place, of which seven were currently using a two-tier approach. Another force reported that they were planning to introduce a policy in their transition to a two-tier plus approach. A

second force's interviewees reported that they did not know if there was a formal policy for breach of conditions, while the remaining forces reported that there was no such policy in place at their force. Of these latter forces, 15 reported that there was nonetheless a standard practice in their force for breach of conditions.

Table 4.8: Existence of a policy or standard practice for breach of conditions by OOCD model

OOCD model in use	Force-wide policy	Introducing force-wide policy	Standard practice
Two-tier in the last year (at least six months ago)	Seven forces		Seven forces
Recently switched to two-tier (less than 6 months)	One force		One force
Introducing two-tier plus in 2023	One force		
Working towards introducing a new two-tier policy and process in 2022	Three forces		Four forces
Currently six-tier		One force	One force
Other			Two forces
Total	**12**	**1**	**15**

N=28

For many forces where there was a formal policy or standard practice in place, information on what these entailed was limited. A wide range of practices and approaches were identified.

A small number of forces (nine) shared information on their processes. Most typically, it was reported that information on non-compliance would be shared with the OIC. This officer would then decide (often in consultation with colleagues) whether to proceed to charge or summons to court or whether another approach is in the public interest or is appropriate given the circumstances. Such an approach could include, for example, giving the offender more time to complete the condition. Only two forces reported that a breach of the condition always resulted in prosecution.

Several other practices were also identified in the interviews.

For example, in one force it was reported that for instances of non-compliance, the case would go to the Crown Prosecution Service (CPS) for consideration about proceeding to prosecution. In a second force, the OIC and staff in the Diversion Hub had regular discussions about the offender's compliance with the condition and made decisions about appropriate next steps on a case-by-case basis. In a third, it was reported that as conditional cautions were seen as burdensome among some in the force, and compliance monitoring was perceived as a challenge, inspectors were tasked with checking compliance and should there be a breach, the force issued a summons or postal charge. It was noted that when the force transitions to two-tier plus, compliance monitoring would become the responsibility of OICs.

In a fourth force, if the breach occurred prior to a condition being set, the case would be sent to the case worker who would prepare a summons to court. If the breach took place after the condition was set, the case worker analysed the circumstances around the breach and decided whether it is in the public interest to prepare a summons. In a fifth, it was reported that the OOCD team would decide about next steps in consultation with the OIC, supervisors and the L&D team should a breach occur. It was reported that proceeding to charge was not preferable and often not in the public interest; in these cases, the offender may be offered a more appropriate condition. Indeed, 17 other forces also reported that offenders who breached their condition could be offered another OOCD, with one force reporting that another OOCD could not be given but the conditions may be revised.

Table 4.9: Phase 2 findings: What, if any, follow up from police or other third parties is provided to these offenders? How is progress against conditions monitored?

Phase 2 examples on how progress against conditions was monitored.
Case study force 1 Compliance monitoring was the responsibility of the dedicated OOCD team, including breach management, except on the rare occasion that the OIC set the condition; in this case, it was up to that officer to monitor compliance. Data was collected on each intervention's attendance and completion and impact including PNC checks on re-offending. It was reported that other specialist teams within the force also received information on progress against the condition from service providers for offenders to whom they have given OOCDs, and both maintained this information for their own records and shared it with the dedicated team or the OIC, if the officer gave the OOCD themselves. The dedicated team made decisions on whether compliance had been achieved with the service provider. This was identified by police interviewees as an area for future examination as some intervention programmes were considered completed after first contact whereas others required completion of all elements.
Case study force 3 In cases where a diversion was used, it was reported that case workers on the team oversaw compliance over the four-month intervention period. For conditional cautions, the OIC retained oversight, with potential support from their senior officer. The compliance rate was reported as being very high, with ranges reported between 90% and 95%. Police interviewees had a high level of confidence in the compliance monitoring system due to the high compliance rate, and substantial amount of information stored and used to monitor compliance, such as: the initial needs assessment, all work done by case workers, their agreed contract, any breach warnings, or further offences. If non-compliance was detected, offenders were given a verbal disengagement warning, a written warning, and if offenders did not then comply, a non-compliance report was returned to the original OIC on the case for an alternative outcome to be decided.
Case study force 6 Compliance monitoring was identified by several police interviewees as a key area for improvement within the force, with inconsistent reporting practices that differed by service provider, and inconsistent information given by interviewees on the proportion of cases monitored for compliance. OICs were expected to monitor compliance with support from the Criminal Justice Unit, however this monitoring only extended to the initial meetings that offenders attended with L&D – not the external services offenders were then referred into. Some police interviewees stated that engagement with services beyond L&D was entirely voluntary, others said service providers may return updates to L&D about an offenders' progress, which may then be used to inform further decisions, such as prosecution or another alternative outcome.

In Phase 3, the solution focused workshops identified where there were gaps and issues with compliance monitoring and breach criteria in each force and agreed specific actions to address these. In some forces this work was been completed at the time of data collection; in others it remained a work-in-progress. What remained clear was that there was still no shared view of what constitutes compliance across or within forces, although in the seven case-study forces some local protocols had been developed, applied, and monitored with some success. Most of these involved a dedicated team tasked with the job. Where the dedicated support was minimal for OOCDs, the consistency of compliance monitoring and the consistency of breach decisions remained uncertain.

4.6 Reflections and implications

Significant challenges in systematically screening and assessing health vulnerabilities were found at each of the three key OOCD decision gateways identified in this study for most forces.

Most police forces were found not to have a force-wide policy requiring a health vulnerability screening and assessment during the OOCD decision-making process and the use of a tool to assess health vulnerabilities was a well-established process in only a minority of forces, usually those with a dedicated OOCD team. Furthermore, most forces were still reliant on frontline officers and supervisors to make decisions regarding OOCD condition setting and deciding on any supportive interventions. The most effective OOCD management processes and outcomes were found in those with a dedicated team.

Similarly, the responsibility for monitoring compliance varied a great deal between forces, with some assigning it, for example, to a dedicated OOCD team, and others to the OIC or an OOCD caseworker. Across and even within forces, definitions of what constituted compliance with conditions varied widely.

Implications

- Each force (where not already in place) should review its position on having a dedicated OOCD team and develop options to put one in place.
- Each force should review their current approach to screening for and assessing health vulnerabilities as part of the OOCD decision making process including links to L&D or equivalent services in all relevant settings including for Voluntary Attendance. The research team has developed a guide on working with L&D for OOCDs (see the Rand website).
- Where possible, **services attached as a condition should be appropriate for and ideally tailored to the offenders' needs and are feasible as a condition** – for example, the service is accessible, available without cost to the offender, and can be utilised within the timescales of the OOCD. Increased awareness of local service availability among force OOCD decision makers, through training and easily accessible, up-to-date information resources, would help support this process.
- **Compliance with conditions should be defined consistently** across all OOCD stakeholders in each force area, and relevant data should be monitored consistently and used to better understand the effectiveness of the conditions. National guidance on defining compliance may be helpful in ensuring consistency across force areas.
- **In dealing with breaches of conditions, good practice may include making case-by-case decisions on the most appropriate next step**, informed by an understanding of the offender's issues with complying. This may mean revising the terms of the condition, such as giving the offender more time to complete it, offering a different condition, or assessing the condition as essentially completed, where these approaches are in the public interest or appropriate given the circumstances.

5. Improving Data Collection and Evaluation

Table 5.1: Key messages on frontline operational approach

Key messages

- **The existing evidence suggests OOCDs can help to address health vulnerabilities and reduce reoffending.** From this evidence (described below), the study team articulated a high-level, simple theory of change for OOCDs, which means their use in policing is plausible to reduce crime.
- From this evidence base and feedback from forces, **the study team derived a minimum dataset that can provide evidence that OOCDs are implemented correctly and measure their impact.**
- **Forces generally collect all these data, though there are some notable exceptions** – victim satisfaction and offender experience and before and after criminogenic needs.
- **Despite collecting much of the required data, only some of it is used for reporting on OOCD use.** The data are often located on different information systems and/or collected in such a way that data analysis is complex.
- **As such, the research team has developed a demonstration tool to collate data in one place so that management, monitoring, and evaluation are possible from the data collected.**
- **First, however, forces need to set up a flow of data from frontline and supervisor officers to OOCD teams that describe health vulnerabilities (based on the guidance set out in here) and provide leadership that uses data to communicate the completed OOCDs and their value to the officers involved.**
- **Once these data start to be collected, an impact evaluation of the changes to OOCDs may be considered.** A mixed-method approach involving a quasi-experiment and process evaluation would offer the most rigorous findings in the current context.

5.1 Introduction

This section describes what OOCD data forces should collect, how they can collect them, and how the use of OOCDs to address health vulnerabilities can be evaluated. Where appropriate, it links to relevant sections of this report and to the study team's guidance on managing and communicating relevant data, which are both integral to monitoring and evaluating the effectiveness of OOCD processes and services used to support adults with health vulnerabilities. The section starts with a description of the current use of evaluation in police forces.

5.2 Force practices around evaluation

Less than half of the 37 forces (17) involved in Phase 1 were aware of any evaluations or research into the effectiveness of the services they used in terms of improving health-related outcomes.

Furthermore, of the 189 services identified in this study, 166 (88%) were reported to have not been evaluated, with 23 services (12%) reported to have been evaluated. There are some interventions, such as CARA, that have undergone rigorous, independent evaluations and others such as Project ADDER that are currently being independently evaluated. These evaluations are discussed below. In addition, there are other interventions, such as Divert and Gateway in Durham, for which peer reviewed protocols and outcome reports are available. However, these are a very small minority compared to the overwhelming body of interventions being used that have had no such scrutiny. This is not to say that other interventions are without merit beyond those already evaluated independently, but rather, that it is uncertain.

A small number of evaluations were reported to be ongoing or due to commence shortly in some force areas while interviews were being conducted for this study.

These included a six-month evaluation of Cumbria's Pathway programme, which was expected to conclude imminently. In North Wales, a research team from Bangor University was reported to be conducting an evaluation of their Checkpoint programme, while the Police and Crime Commissioner's Office was reported to be evaluating the women's Pathfinder programme. Some interviewees also noted the ongoing evaluation of Project

ADDER (Addiction, Diversion, Disruption, Enforcement, and Recovery), which has sites across England and Wales and seeks to ensure effective treatment and support for people with substance misuse issues, including through expanded diversionary programmes.

In the Metropolitan Police, it was reported that the Mayor's Office for Policing and Crime would be publishing an evaluation of their pilot diversion programme for female offenders . This evaluation looked at outcomes around health and reoffending for pilot participants as well as outcomes for their children. An interviewee from the Metropolitan Police also noted an independent scoping study that they commissioned as part of the force's transition to statutory two-tier plus, which looked at the use of OOCDs in forces including Avon and Somerset, West Yorkshire, Norfolk and Suffolk, Essex, South Yorkshire, Cumbria and Greater Manchester Police.

Staffordshire also noted an evaluation of one of their services being undertaken with Staffordshire University, and in Leicestershire an evaluation was due to start by the University of Southampton; no further information was available about these evaluations.

Feedback from Phase 2 forces suggested mixed feelings about the effectiveness of available services for health vulnerabilities and confusion about how to understand their relative impacts on different offenders.

In Force 1, for example, some interviewees found it difficult to assess the effectiveness of interventions due to a lack of feedback from service providers and offenders. In contrast, others had strong views on effective interventions such as a wrap-around service for women and a drug education programme for first-time offenders. Similarly, in some of the other case study forces certain interventions were viewed as effective, but the criteria this assessment was based on was unclear. Addressing the specific vulnerability for the individual was viewed as essential to interviewees in the forces. In Force 3, one interviewee commented:

> It depends on what the vulnerability is – all the programmes in place are effective as long as the right programme is identified for the individual. It is more about how the individuals interact with the pathways that are effective.

Interviewees across forces repeated a perception that wrap-around / tailored services that could identify and address different vulnerabilities were effective.

In Force 7, most police interviewees did not feel well-informed about effectiveness, while others were negative about available services, particularly offender-pays services and substance misuse interventions.

This feedback is unsurprising given the lack of evaluation of available services, highlighted above. Given this situation, the promotion of intervention evaluation to target limited resources most effectively should have a significant positive impact on forces.

5.3 What data should be collected?

Suitable data measures are based on evidence of what works, and the data should aim to describe the outputs and intermediate outcomes that cause the primary outcomes of interest – in this case, reductions in reoffending and crime, improved victim satisfaction and improved health outcomes for those given OOCDs. A theory of change is a helpful tool for describing this causal process – or simply the story – of how OOCDs can reduce crime which can then be translated into a series of measures. The remainder of this section summarises the current evidence base and the theory of change inferred from this evidence; and a minimum dataset derived from the theory of change and feedback from forces, which can support potential further research to evaluate OOCDs.

The evidence base for OOCDs
The research team conducted a targeted literature search to identify existing evidence regarding the effectiveness of OOCDs with conditions for health vulnerabilities in adult offenders. The full description of the results is set out in Annex 3; a summary is presented below. The evidence suggests that using OOCDs to address health vulnerabilities can reduce crime.

Compliance
Compliance is an essential first step as it determines whether the offender will continue with a programme's entire course, potentially enabling them to benefit from any intervention and reap further positive outcomes. Reviews by both Lange et al. (2011) and

Cordis Bright (2019) found that pre-trial diversion programmes for offenders with mental illness and substance abuse effectively increased the use of appropriate services. Compliance is associated with relationships based on trust and confidence, which are likely to increase a sense of support, encouraging the offender to keep attending the intervention.

Overall, the evidence indicates that when suitable conditions are attached to OOCDs for adults with health vulnerabilities, compliance frequently emerges as an outcome, especially when the service provides a respectful and supportive environment for the offender.

Criminogenic need and well-being
If an offender complies with the order, the evidence further suggests that there will be criminogenic improvements and also improvements in health, well-being and substance misuse (the most evaluated types of OOCD interventions in the literature). For instance, 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 involved in these programmes and found that 61% of participants reported that they had had a positive impact on their depression, while 63% reported a positive impact on their anxiety levels.

Similarly, researchers have discovered improvements in substance misuse related to diversionary strategies. In Harvey et al.'s (2007) review paper, most reviewed studies that examined the impact of diversionary strategies involving drug interventions on drug use (six out of nine) found a positive impact on drug-use outcomes, as drug-use was reduced among participants compared to control groups which went through the usual criminal justice procedures. In particular, cognitive behavioural therapy (CBT) programmes are highly effective in many contexts, such as managing anger or substance misuse.

Victim satisfaction
Previous research has demonstrated that victims tend to primarily focus on the offender's rehabilitation for lower-level offending, with a key concern being the prevention of the offender reoffending in the future (Slothower, 2014). By working on the offender's vulnerabilities and communicating this to the victim, the victim may feel justice has been

served and the offender is on the way to change. Research suggests that in some instances OOCDs may be better overall for victim satisfaction than a court sentence, as victims are not always informed of court outcomes. Thus, demonstrating that an offender has received rehabilitation for their health vulnerability and antisocial behaviours through an OOCD with a condition may bring greater satisfaction to victims.

Reoffending
Better compliance and improved criminogenic needs can develop into a longer-term outcome of reduced recidivism. 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. That paper supported the notion that providing access to appropriate services is an effective way to overcome drivers of offending, also promoting early intervention to be essential for 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 toward drug offenders resulted in a reduction in recidivism. Broner, et al. (2005) found, for example, that treatment for mental health and substance use issues had significant positive effects on recidivism, with fewer felony, misdemeanour and violation rearrests at both 3 and 12 months after diversion.

Overall, the available evidence indicates that early outcomes such as compliance and criminogenic need are linked with future reductions in recidivism. Supportive interventions provided to offenders alongside good accessibility to appropriate services have been particularly connected with a reduction in reoffending.

Theory of Change

The Centre for the Theory of Change defines a Theory of Change as "essentially a comprehensive illustration of how and why a desired change is expected to happen in a particular context."[32] This section uses the evidence described above to propose a simple Theory of Change for OOCDs that can be used to generate a data collection requirement.

[32] Centre for Theory of Change. Available at: https://www.theoryofchange.org/what-is-theory-of-change/. Accessed 4 January 2023.

The evidence described above, suggests that meeting an offender's criminogenic need can help reduce offending.[33,34] Furthermore, the OOCD process assists with avoiding the impact of 'labelling' effects which can arise from attending court.[35] Assisting offenders with their criminogenic needs at their earliest contact with the Criminal Justice System may help them address their underlying issues and behaviours and, with the support of a tailored intervention, prevent future reoffending behaviour.[36] As noted above, CBT can be a mechanism for this process as it helps to identify unhelpful learned behaviours, and then works on unlearning them.[37]

Moreover, these interventions often provide other support, such as housing and assisting offenders in re-entering society with fewer antisocial behaviours.[38,39,40] Collaborating with offenders, and trying to be understanding and build trust, can help improve their compliance, which is an essential first step on the path to improved criminogenic need and reduced reoffending.[41] Early interventions for mental health and drug issues can assist recovery and be provided rapidly through a diversion programme.[42]

Finally, research has shown that victims often focus on offender rehabilitation.[43] The police do not routinely inform victims of court outcomes.[44] Still, they can communicate an OOCD and the attached conditions to the victim, which will likely help them understand the offender's behaviour and what is being done to remediate it. From this, a positive emerging outcome may be the victim's satisfaction that justice has been done. Overall, all the discovered outcomes are often interlinked and can work toward achieving the ultimate impact of crime reduction.

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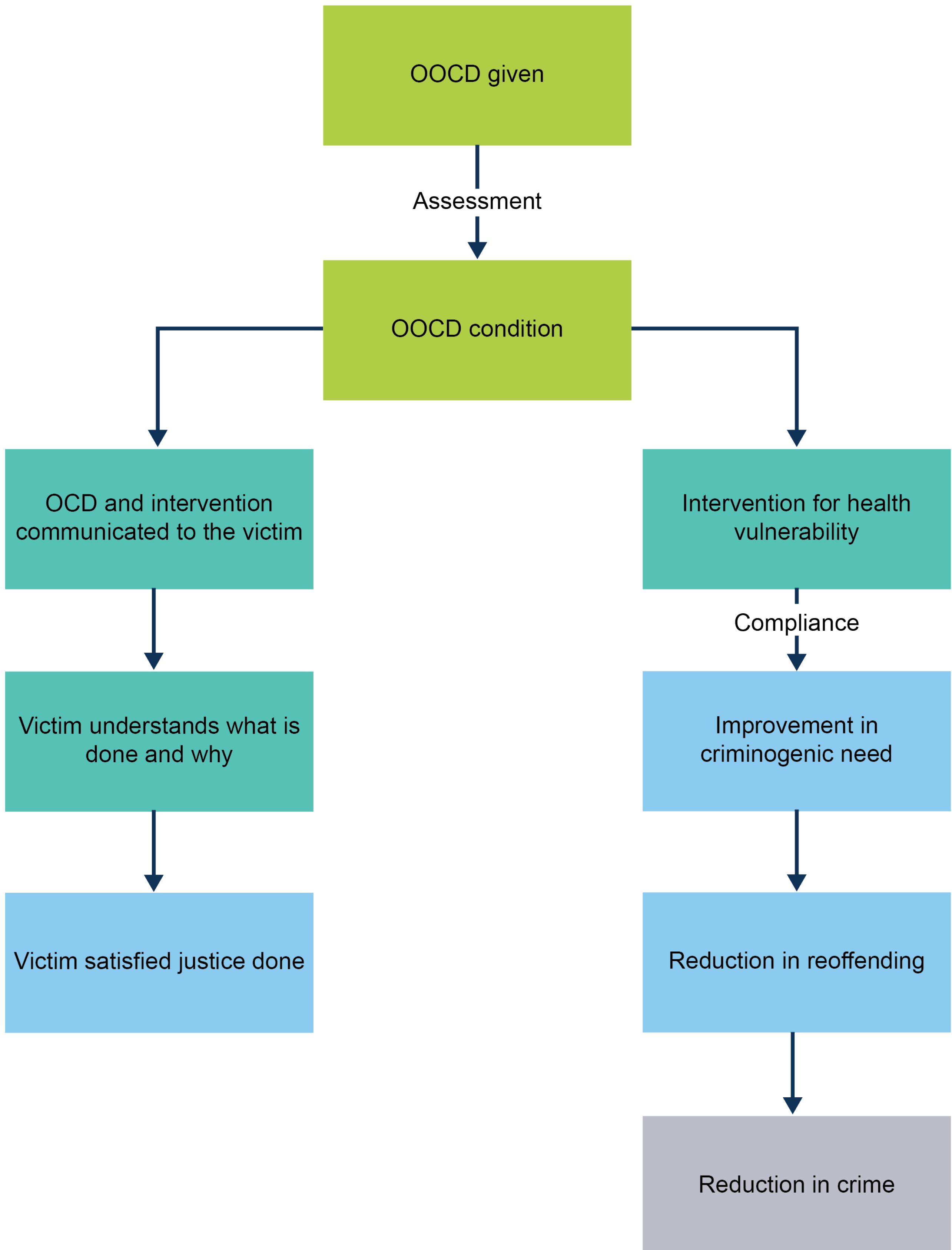
33 Cordis Bright (2019). Op. cit.
34 Ross, S. (2009). Op. cit.
35 Allen (2017). Op. cit.
36 Cordis Bright (2019). Op. cit.
37 Neyroud, P. (2018). Op. cit.
38 Ross, S. (2009), Op. cit.
39 Mooney, S. et al. (2019). Op cit.
40 Department of Justice. (2010). Op. cit.
41 Allen (2017). Op. cit.
42 Cordis Bright (2019). Op. cit.
43 Slothower (2014). Op. cit.
44 Allen (2017). Op. cit.

A visualisation of the activities and process outcomes informed by the Theory of Change are displayed in Figure 5.1 below. A simple text description of this process is also provided below.

Figure 5.1: Diagram illustrating inferred Theory of Change from the literature, identifying the initial activity, outcomes, and final impact[45]



Note: light green boxes are inputs; turquoise are outputs; blue are medium-term outcomes; and grey is long-term outcome.

Assigning an OOCD to an eligible offender first involves the offender committing a crime and subsequently coming into contact with a police force. Officers will weigh up the severity of the offence and use other criteria, such as offending history, risk, and offender vulnerability, to decide whether an OOCD should be given.[46]

For offenders with health vulnerabilities, a condition can be attached to the OOCD requiring them to attend a service that aims to address the vulnerability. It is hoped that tackling the offender's health vulnerability will improve the offender's criminogenic needs, which may translate into a reduction in reoffending. Furthermore, the OOCD and attached conditions are frequently communicated to the victim of the offence, enabling the victim to understand that the offender has recognised their offence and is receiving support for any challenges that led them to commit the crime. Hence, the victim may be satisfied that the offender is addressing their needs and hopefully will not repeat such actions in the future and subsequently come into contact with a police force.

A minimum dataset for monitoring and evaluation

A police force can populate the Theory of Change with data to evidence its short, medium, and long-term impacts.

Table 5.2 below provides an overview of appropriate outputs and outcome measures to evidence the Theory of Change, alongside a brief description of what each measure describes and its potential source of data.

[46] The gravity matrix is often used for these decisions.

Table 5.2: Appropriate outputs and outcomes for evaluating the implementation of OOCDs for health vulnerabilities

Type	Name	Description	Potential Source
Output	Police outcomes	Number (N.) of offenders who receive a charge, OOCD, no further action (NFA) or another outcome. Break down data by offence type, protected characteristics, and vulnerabilities.	Police outcomes data
	Type of OOCD	N. of offenders who received a) Community Caution; b) Diversionary Caution; c) community resolution	Police outcomes data
	Number of OOCDs	N. of OOCDs given to offenders by health vulnerability	Police outcomes data
	Conditions for health vulnerability	N. of conditions set that address a health vulnerability	Police OOCD monitoring data (may not currently collect)
	Additional conditions	Listing of additional conditions provided (e.g., letter to the victim, fine, volunteering) and number of offenders assigned each of these	Police OOCD monitoring data (may not currently collect)
	Number of referrals	N. of referrals to services to address a health vulnerability	Police OOCD monitoring data (may not currently collect)
	Initial compliance	N. of offenders who attended the service initially/ entered the programme	Police OOCD monitoring data (may not currently collect)
	Communication with the victim regarding OOCD & intervention	Number of victims contacted concerning offender's OOCD and attached conditions	Police OOCD monitoring data (may not currently collect)
Short-term Outcomes	Compliance	N. of offenders maintaining compliance through the programme, number of offenders graduating from the programme, number of breaches	Police OOCD monitoring data (may not currently collect)

Type	Name	Description	Potential Source
Medium-term outcomes	Victim satisfaction	Recommended questions (from Crime Survey for England and Wales[47]): • Overall, were you (the victim/the household) satisfied or dissatisfied with the action the police took? (Very satisfied, Fairly satisfied, A bit dissatisfied, Very dissatisfied, Too early to say) • Overall, how satisfied or dissatisfied were you with the outcome? (Very satisfied, Fairly satisfied, A bit dissatisfied, Very dissatisfied, Don't know, Don't wish to answer)	Police victim satisfaction survey (to use recommended questions) [Crime Survey for England and Wales asks relevant questions. However, it cannot determine if the respondent's crime outcome was an OOCD.]
	Improvements in criminogenic need	Percentage (%) of offenders reported to have improved criminogenic need, for example, reduced substance use, improved mental health, improved physical health	Before and after assessment (Police may not collect)
	Offender experience	Overall, how satisfied or dissatisfied were you with the [support received / programme(s) you attended (delete as necessary)]? (Very satisfied, Fairly satisfied, A bit dissatisfied, Very dissatisfied, Don't know, Don't wish to answer)	End of disposal [Adapted from crime survey for England and Wales to be similar to victim question.]

[47] https://www.crimesurvey.co.uk/en/index.html

Type	Name	Description	Potential Source
Long-term Outcomes	Arrest rates	• %. of offenders arrested within 12 months of the OOCD disposal date • Breakdown offence type (new offence by old) • How long to re-arrest (median and mean days)	Police force arrest data / Police national computer
	Reconviction	• % of offenders convicted within 18 months of the OOCD disposal date for an offence committed within 12 months • Breakdown offence type (new offence by old) • How long to re-arrest (median and mean days)	Police National Computer
	Reoffending predictor	Prediction of how likely someone was to re-offend based on previous offending behaviour and demographics	Choose a predictor (e.g. OGRS4) Police National Computer

5.4 How can the data be collected?

In Phase 3, the research team supported seven police forces to identify and collect the data in the minimum dataset. This section describes the data available across the seven forces and how forces can generally fill data gaps and use data.

Available data and filling gaps

By and large, the data in the minimum dataset were available at the seven police forces. Unsurprisingly, the forces had good data on custody and crime outcomes. As such, they could describe the number of outcomes achieved and who had these and explain who started OOCDs. The forces collected data to monitor and manage disposals, such as the conditions attached and initial and final compliance. The forces had the data to monitor reoffending but, except in one of the seven forces, did not do this routinely.

However, three significant gaps were identified in the medium-term outcomes data:

- Victim satisfaction
- Offender experience, and
- Improvement in criminogenic need.[48]

Below we discuss how to fill these gaps so forces can collect consistent data.

Victim satisfaction

Police forces and police and crime commissioners generally commission surveys to monitor victim satisfaction, but our enquiries suggested that these do not isolate victim satisfaction with OOCDs. The study team could not identify if the police forces used consistent questions and methods to measure victim satisfaction. To fill this gap, a dedicated OOCD team can ask victims the two satisfaction questions described in Table 5.2 above. These were sourced from the Crime Survey for England and Wales,[49] so they are of appropriate validity and reliability, and forces can compare their results to a

[48] Criminogenic needs are factors in a person's life that are directly related to their offending. This could be drug and alcohol use and thinking and behaviour.

[49] https://www.ons.gov.uk/peoplepopulationandcommunity/crimeandjustice/bulletins/crimeinenglandandwales/yearendingjune2022

national dataset. The time required to ask these questions is less than one minute and could be completed with any other victim engagement work.

Offender experience

The evidence base suggested that compliance with the disposal can mean more positive longer-term outcomes. If forces understand the overall experience with the OOCD process, they can make changes that could lead to improvements in compliance.

Change in criminogenic need

Criminogenic need, such as health vulnerabilities, is probably the most demanding data gap to correct. A good practice method is to use an accredited tool to measure different criminogenic needs before and after the OOCD. Surrey Police, for example, use the Justice Star[50] to measure the criminogenic need of all offenders before and after the checkpoint programme. Where this cannot be resourced, a force may only be able to measure longer-term outcomes such as re-arrest. Alternatively, if a force is confident in the evidence base for its intervention(s), it could use completion as a proxy for a change in a relevant criminogenic need.

Dispersed data

Though much of the data listed in Table 5.2 were available, the Phase 3 forces collected these data in a way that meant they could not be gathered together for analysis. An OOCD analysis report should describe the full OOCD story, from a crime to reoffending, but this was not presently possible in any of these forces. This finding was also apparent in the data that the forces shared during phase 1 of the study. All forces could share data on the number of outcomes during 2021, but only 10 could describe the number of OOCD interventions/conditions used. Findings from Phase 1 interviews, however, identified that this did not mean that these forces were not monitoring offenders' attendance at interventions and that the teams were not recording information electronically. Instead, they were doing this outside of the force's primary database system – NICHE or Athena, for instance – meaning the data did not link with each other and were recorded in such a

[50] https://www.outcomesstar.org.uk/using-the-star/see-the-stars/justice-star/

way that individual cases could be managed, but aggregate statistics could not be generated routinely.

The study team, therefore, built and implemented a demonstration tool for forces to use or copy that collates and reports the data listed in the minimum data set.

Demonstration tool

The demonstration tool's aims were:

- to allow the management of OOCD cases
- to collate in one place all police data listed in the minimum dataset (Table 5.2 above)
- to fill identified data gaps by providing a data collection and storage method; and
- to produce an automated report with analyses relevant to a range of audiences – OOCD team, senior leadership, frontline officers, victims, and offenders.

A database solution such as Microsoft Access or Office 365 Power Apps would be more appropriate than Excel. Using a database is easier for managing cases and using data for analysis. There are no limits on the amount of data that can be entered and the database can better handle the data that is entered. However, the skills within a force to build and maintain a database solution are scarce and providing such a tool as a first step might prevent implementation if the necessary local skills are unavailable. The study's consultations found that OOCD team members were comfortable manipulating and analysing data in Excel. The study team built, therefore, an Excel tool that demonstrates the necessary data entry, management of cases, and reporting of statistics. This tool can be used in the short term by forces and given to within-force developers to build as a Power Apps or equivalent database solution in the medium to longer term.

Figure 5.2: OOCD Input sheet of Entry and Reporting Tool (populated with dummy data)

OOCD Interventions Input

Case Status | **Surname**
Referral Route | **Year**
Condition

Filter
Reset
Add New

Referral Date	Active	Referral Route	Custody Number	Condition Number	Summary of Condition	Session 1 Date
20/04/2021	Closed	Charge	00/AB9585/29	1	RJ Hub	05/09/2021
14/02/2019	Closed	Exclude	00/AF2162/53	1	Restrictive	22/03/2019
19/01/2019	Closed	Charge	00/AF2268/37	1	Restrictive	21/04/2019
06/03/2022	Closed	Simple Caution	00/AJ3810/70	1	Verbal Apology	17/05/2022
17/07/2018	Closed	Other OOCD	00/AO0931/65	1	Restrictive	03/09/2018
17/07/2018	Closed	Other OOCD	00/AO0931/65	2	RJ Hub	03/09/2018
01/09/2022	Closed	Simple Caution	00/AP1325/28	1	RJ Hub	17/12/2022
05/10/2019	Closed	Charge	00/AP6571/79	1	Restrictive	13/02/2020
02/04/2020	Closed	Simple Caution	00/AP8992/08	1	Verbal Apology	08/07/2020
17/11/2019	Closed	Charge	00/AQ6768/64	1	Forfeit and Destroy	24/12/2019
05/02/2021	Closed	Conditional Caution	00/AR3229/12	1	RJ Hub	12/06/2021
24/04/2022	Closed	Charge	00/AS4491/87	1	Drug Referral	02/08/2022
28/02/2022	Closed	Charge	00/AV7407/42	1	Restrictive	06/04/2022
29/06/2018	Closed	Simple Caution	00/AV7782/64	1	Drug Referral	10/09/2018
29/06/2018	Closed	Simple Caution	00/AV7782/64	2	Forfeit and Destroy	10/09/2018

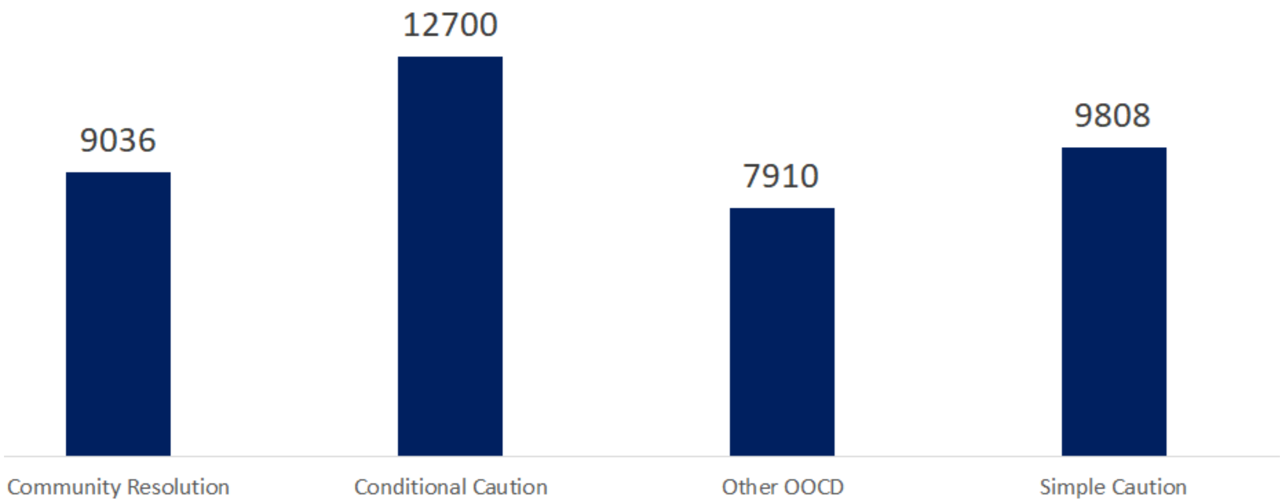
Attended Session 1	Session 2 Date	Attended Session 2	Session 3 Date	Attended Session 3	Outcome
Yes	24/11/2018	Yes			Condition breached
No	09/07/2021	Yes	21/07/2021	Yes	Condition breached
Yes					Condition breached
Yes	19/05/2022	Yes	31/05/2022	Yes	Condition completed
No	04/02/2021	Yes	16/02/2021	Yes	Condition breached
No					Condition breached
Yes					Condition completed
Yes					Condition breached
Yes	15/10/2020	Yes	27/10/2020	No	Condition completed
Yes					Condition breached
No					Condition completed
No	10/10/2019	Yes	22/10/2019	Yes	Condition breached
Yes	05/05/2019	Yes	17/05/2019	Yes	Condition completed
Yes	12/08/2021	No	24/08/2021	No	Condition completed
Yes					Condition completed

Figure 5.3: Headline analysis of main reporting sheet (analysis based on dummy data)

OOCD Delivery

Total charges	Total NFA	Total OOCDS given
32958	5432	39454

Type of OOCDs given



Number of referrals with a health vulnerabillity

18635

Number of OOCD referrals that were put on a pathway addressing flagged vulnerabillity

38225

Number of OOCD referrals that initially attended the service (health vulnerability addressed)

24261 - 100% % of OOCD Referrals receiving an Intervention

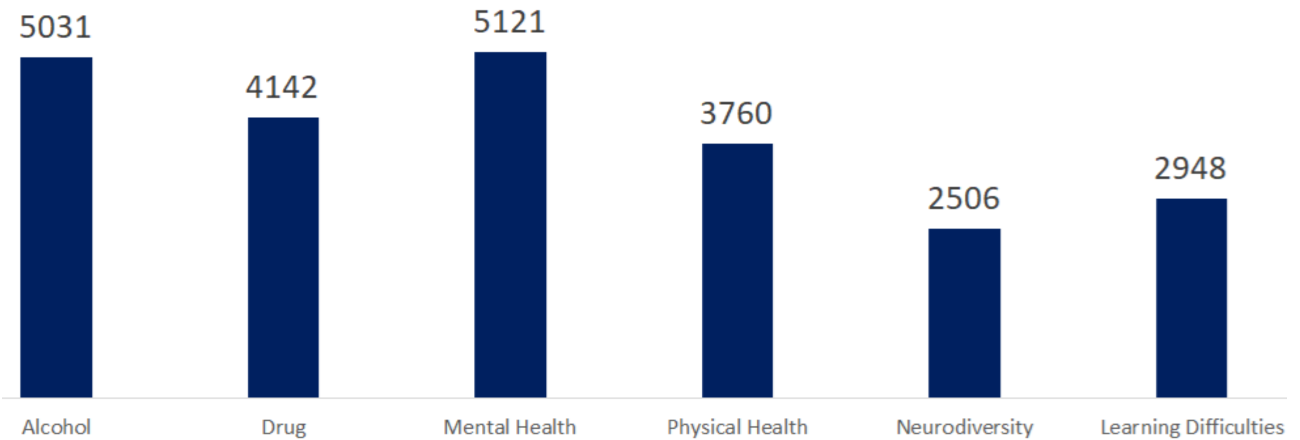
Number of hate crime OOCD referrals

5121 - 12% % of OOCD Referrals receiving an Intervention

Percentage OOCD of all outcomes

51%

Proportion of each vulnerability that was identified after an OOCD referral



Number of OOCD referrals that were put on a pathway addressing a health vulnerability

24262

Number of OOCD referrals that completed their intervention (health vulnerability addressed)

21554 - **26% of OOCD Referrals receiving an Intervention**

Number of domestic abuse OOCD referrals

5627 - **14% of OOCD Referrals receiving an Intervention**

Figure 5.4: Long-term outcome analysis on reoffence offence type from main analysis sheet (analysis based on dummy data)

Format all cells based on their values:

Format Style: 3-Color Scale

	Minimum	Midpoint	Maximum
Type:	Lowest Value	Percentile	Highest Value
Value:	(Lowest value)	50	(Highest value)
Color:			

Preview:

Breakdown of Offence Type of Re-arrest

New Offence (columns) / Old Offence (rows)

Old Offence	Arson and Criminal Damage	Burglary	Drug Offences	Fraud	Miscellaneous Crimes Against Society	Possession of Weapons	Public Order Offences	Robbery	Sexual Offences	Violence Against The Person	Theft Offences	Vehicle Offences
Arson and Criminal Damage	4	24	14		1	20	24	18	9	35	34	38
Burglary	18	48	35		22	34	64	41	28	86	97	97
Drug Offences	12	35	15		9	13	42	38	15	56	75	79
Fraud												
Miscellaneous Crimes Against Society	4	8	11		5	6	16	14	11	24	17	18
Possession of Weapons	9	30	11		11	19	32	29	12	50	46	60
Public Order Offences	24	60	50		25	43	60	58	23	97	118	98
Robbery	18	41	30		18	32	45	33	26	62	78	83
Sexual Offences	20	41	23		10	14	33	17	14	44	35	48
Violence Against The Person	41	71	64		15	46	83	74	50	137	131	145
Theft Offences	42	86	58		26	48	111	76	51	112	152	183
Vehicle Offences	44	112	63		30	65	114	55	43	126	145	142

More information on the demonstration tool can be found on the Rand website. The tool was built in collaboration with the seven case study forces. It can be used with data from each of the main police force data systems – Niche, Athena, Connect, and PoliceWorks. The tool was tested with each case study force and updated to work for each on a day-to-day basis.

Data flow

The successful delivery of OOCDs and collating good data for monitoring and evaluation purposes require establishing a data flow where vital information about offenders and their OOCD disposals reaches the OOCD lead or dedicated team. This study's training materials, health vulnerability assessment guidance, and data tool were all designed with this in mind. From the data perspective, the study encourages forces to create a positive cycle where data describing OOCD delivery and impact are returned to officers in the form of easily accessible data reports, which in turn encourages them to provide data on OOCDs and offender health vulnerabilities. The motivation to complete relevant documents – as described in the health vulnerability assessment guidance – is likely to increase when officers understand the value of the exercise.

The data flow process starts with officers completing basic information in a screening tool completed at the frontline/start of the process. Supervisors and even L&D then provide more detailed factual information on the offender's health status, and finally, the OOCD team can produce detailed health assessments for all or some offenders. Forces can record this information within the demonstration tool – and ultimately build this functionality into their primary systems. The demonstration tool includes data reports that, through visualisation, describe the vulnerabilities of offenders, what is delivered to them, and the impact of OOCDs. These can be routinely returned to officers through a force's general communication methods and presented at relevant interactions.

5.5 Evaluation

Evaluation of OOCDs is currently possible, given the available data. If forces generally collect the data discussed above, then the quality of any potential process and impact evaluation conducted will increase (especially if forces routinely monitor and evaluate OOCDs using the tools shared with them). A series of design decisions are required for

any evaluation. This section discusses the following to inform both national and local evaluation of the new OOCD arrangements: evaluation scope, impact evaluation approaches (national, local and interventions), and the involvement of stakeholders, victims, and offenders.

Evaluation scope

The evaluation scope concerns what OOCD types and offenders to include in the evaluation. It could either include all types and all persons or consider only certain disposals and certain persons– i.e., persons with a mental illness, women repeat offenders – because what can be effective for one cohort may not be effective for another. Given that the design of all OOCDs is changing, the study team suggests including all types in an evaluation. However, national and local evaluation strategies should examine the community and diversionary caution separately and consider the experiences of and impacts upon the different cohorts of offenders receiving OOCDs. Any evaluation would also need to take a holistic view of criminogenic need (and not just look at health vulnerabilities). An offender's education, work prospects, relationships with significant others, and attitudes all interact with health vulnerabilities and must be addressed in OOCDs.

Impact evaluation approach

This section discusses what evaluation approach could be adopted nationally and locally and how interventions can be evaluated.

National evaluation approach

As the introduction of the two-tier approach is a statutory requirement that will be introduced across England and Wales with a single change-over date, it will not be possible to evaluate its impact through a randomised controlled trial (RCT) as a control group cannot be generated. There is, however, the potential for a quasi-experiment where a control group is generated through propensity score matching. There are two designs that could potentially be feasible:

- A **natural experiment** where different implementations of the two-tier model are compared. Our study of police forces has found that forces will vary in how they deliver OOCDs, what conditions will be included, and what impact the services

could potentially have. For a meaningful comparison, forces would need to be similar – i.e., most similar force group – and complete sufficiently different approaches to OOCDs. A feasibility study would need to check whether all these elements come together.

- An **historical control** where the intervention group is matched to a control group that includes persons given an OOCD before the introduction of the two-tier model. Preferably, this matching would be completed within a force, but previous studies have also used national cohorts. This approach would be relatively easy to implement using the Police National Computer. Still, a limitation could be that performance after the implementation of the statutory two-tier framework reflects previous performance because many forces have already updated their approach. A feasibility study should check if there are forces where a considerable change in practice occurred.

These two approaches would best estimate the reoffending impact on persons subject to OOCDs. Estimating an impact on victim satisfaction would require at least two cross-section surveys of victims – at least one before the introduction of the new OOCD arrangements and one afterwards, allowing for a suitable period for the new arrangements to bed in. Estimating the impact on criminogenic need would require before and after surveys with offenders.

Local evaluation approach

Police forces should be encouraged to evaluate their own OOCD processes to understand if they address vulnerabilities, reduce reoffending, and increase victim satisfaction. The minimum dataset and the demonstration tool described above were designed to allow forces to monitor and evaluate their impact on an ongoing basis. The latter also compares local reoffending outcomes to a counterfactual based on a predictor.

Forces can use a before-and-after design to evaluate their OOCD arrangements formally. This design compares the current position to a baseline measured before introducing the new OOCD arrangements. This design could be extended to a quasi-experiment if the force had the internal capacity or could hire an expert team to complete a propensity score matching approach and make the best use of the Police National Computer data.

Interventions
Section 5.2 describes the low number of evaluated interventions currently used for OOCDs. Police forces could best add to the evidence base through the impact evaluation of specific interventions. The study's quality assurance guidance advises forces to ensure interventions are evidence-based and that evaluation is part of the commissioning process. The evaluation of particular interventions also allows using the most rigorous evaluation designs. Researchers used RCTs to evaluate OOCD programmes such as CARA, Checkpoint and Turning Point, and the quality assurance guide encourages their use for complex, resource-intensive interventions.

The Quality Assurance Guide is available on the Rand website.

Involvement of stakeholders, victims, and offenders
The evidence base suggests that OOCDs, when appropriately implemented, have the potential to help reduce offending and crime. There are still many unknowns about what can work best for whom and implementing OOCDs with conditions is complex. As such, there is a strong case for a process evaluation (using realist and theory of change approaches for example) of the new arrangements that involves police officers and staff and partner organisations to share good practice and understand the barriers to exemplary implementation in addition to the findings of this project. The evaluation will also need to include different offender views on how the conditions help them (or not), what victims think of the process, and how their opinions could be improved.

5.6 Reflections and implications

The evidence suggests that OOCDs can address health vulnerabilities and reduce reoffending. Forces generally collect data to evidence the impact of OOCDs. Still, there are some notable exceptions – victim satisfaction and offender experience and before and after criminogenic need – and these need to be filled appropriately. Despite collecting much required data, forces only use some for reporting. The data are often located on different systems or collected in such a way that data analysis is complex, or both.

The study's tool demonstrates how to collate data in one place so that management, monitoring, and evaluation are possible from the data collected. First, however, forces

need to set up a flow of data from frontline and supervisor officers to OOCD teams that describe health vulnerabilities and use data to communicate the value of OOCDs to the officers involved. Once these data start to be collected, thoughts can turn to an impact evaluation of OOCDs. A mixed-method approach involving a quasi-experiment and process evaluation would offer the most rigorous findings in the current context. Proportionate evaluation of OOCDs needs to become standard practice (see quality assurance guide). RCTs can be encouraged for specific interventions that offenders have as conditions.

Implications

- **Forces should collect the OOCD minimum dataset to manage cases, monitor delivery and evaluate impact.** They can use the suggested methods to fill data gaps.
- **Forces should use or copy the demonstration tool within their own systems to collect the right data and report analyses to various audiences** – the OOCD team, frontline officers, senior leadership, victims, and offenders.
- **Forces should set up a "virtuous cycle" of data collection and communication**, where the results of OOCDs are communicated to frontline officers routinely to demonstrate their value and improve officers' data supply.
- **OOCDs should be evaluated using a mixed-method design, process evaluation, and quasi-experiment** if enough forces improve their data collection.
- **Proportionate evaluation should become standard practice for OOCD interventions** and RCTs should be encouraged for either large or complex interventions or both.

Annex 1
Support Help Engagement (SHE) Project Case Study

Acknowledgements

We would like to formally thank the Support Help Engagement (SHE) team, the Nelson Trust, the women who are clients of the SHE project and the ASCEND team, for their time, openness and support that made this good practice case study possible.

Introduction

In the main body of this report, we noted the importance of using tailored interventions and support when offering OOCDs to vulnerable individuals. While there were shortfalls in the processes of screening and assessment being used in many areas, we should also highlight examples of well-integrated approaches to setting and managing OOCD conditions. A number of such examples were identified in the research, and the study team decided to select one which had been in operation for a number of years and which was focused on female offenders. Avon and Somerset Constabulary's ASCEND team have worked with the SHE Project since 2019 to provide specialist support for women given OOCDs and have established a model that could be considered for wider use in the OOCD system.

The Case Study approach

The approach was informed by data from:

- Interviews with Avon and Somerset Constabulary and the SHE team.
- A series of 12 short case vignettes prepared by the SHE keyworkers and focused on their individual clients.
- SHE activity data and descriptive statistics for a 12-month period between January and December 2022.

Background

In 2018, Avon and Somerset Constabulary (ASC) took a recommendation from the National Police Chief's Council (NPCC) that the framework for OOCDs available to use with adults should reduce to two options: Community Resolutions and Conditional

Cautions. Police officers had previously been able to utilise five outcomes in the force: Community Resolution, Simple Caution, Conditional Caution, Penalty Notice for Disorder and Cannabis/Khat warnings.

The Constabulary developed a model in which a team (ASCEND) would be created to assess offenders' critical needs around their offending behaviour and holistic needs such as employment and mental health. Officers can refer the offender to ASCEND, and the case worker meets the offender to assess their needs and agree on a condition plan for that individual. The victim is consulted as part of this decision making through the Community Remedy. Similar models have been implemented in other forces such and Devon and Cornwall.

The ASCEND team is made up of six ASCEND workers and one supervisor. Currently, three are former police officers (one Inspector and two Sergeants), one a former PCSO, two are serving PCs, and the supervisor is a police staff role.

The Nelson Trust

The Nelson Trust (https://nelsontrust.com/) provides a range of services including residential addiction treatment to men and women and support to women in the community who are in, or at risk of, contact with the criminal justice system. The Nelson Trust Women's Centre, where the SHE project is based, is a community-based service created to support women. They aim to support and empower women to make positive changes in their life, providing a safe female-only environment where a wide range of problems and challenges can be addressed.

Project SHE

The SHE service is operated by the Nelson Trust and provides managed pathways for women who have been referred to the service by the ASCEND team. SHE offers an opportunity for women who have been arrested to avoid a charge by agreeing to engage with a SHE keyworker and a range of support interventions offered as part of their conditional caution.

There are agreed conditions for engagement with SHE:

- The woman is required to attend appointments with an allocated SHE keyworker within the agreed compliance date.
- The allocated SHE keyworker will meet with the woman and is required to complete an assessment of needs and create an individual support plan tailored to that woman.
- The support plan will set out achievable goals around the pathways they can support with.
- A wide range of intervention support will be discussed including signposting to the relevant specialist agencies.
- The allocated SHE keyworker will connect with any agencies already involved with the women.
- The SHE keyworker will update the ASCEND workers to advise of their engagement and compliance of attending agreed appointments.

What the SHE project does

The SHE keyworkers have nine supportive pathways available for the women referred to the service, that can be used in any relevant combination:

1. **Housing:** helping and advocating for women to access safe and appropriate housing.
2. **Finances:** Debt, benefits and finance advice, as well as signposting to specialist debt advisory services.
3. **Trauma and abuse:** Domestic abuse support, and support accessing local specialist abuse services.
4. **Drugs and alcohol:** Drug and alcohol awareness and support to access relapse prevention groups and specialist addiction services.
5. **Sexual exploitation and sex work:** Supporting women toward safety and exiting sex working, and support accessing local specialist sex-working services.
6. **Physical, emotional and mental health:** Anxiety and anger management, one-to-one support, craft and art groups, lunch club.
7. **Education and training:** Education, training and employment advice.

8. **Attitudes, thinking and behaviour:** Parenting support, self-esteem and confidence-building groups and one-to-one support.
9. **Families and relationships:** Help with relationship issues, rebuilding bonds with loved ones and being reunited with their children and advocacy around any social services involvement.

After receiving a referral by the ASCEND team, an allocated SHE keyworker will contact the woman to arrange a first appointment. These appointments need to be attended within the agreed compliance date. At the first appointment the woman is required to complete an assessment of needs to help design their support plan and identify what support is needed. The support plan is designed and tailored to set out achievable goals around the pathways listed above. A wide range of other potential intervention support is also discussed, including signposting to any relevant specialist agencies. The allocated SHE keyworker updates the ASCEND team to advise them on the woman's engagement and compliance in attending agreed appointments. If a woman is unable to attend the women's centre, then an alternative option for the appointment, such as a phone call, outreach or home visit is found. The woman is required to attend and fully engage within the agreed compliance date. If they do not engage, this is fed back to the ASCEND team and seen as a breach of the requirements of their caution, which could be charged to court.

Ascend referrals and pathways

The SHE project received 87 ASCEND conditional caution referrals between January and December 2022; this comprised 44 cautions given to women experiencing domestic abuse and 43 cautions for women with multiple and complex needs. Out of the 87 referrals, 78 attended their first appointment and out of the nine that did not; six are still active and were newly referred; the team are awaiting a response from two women; one client passed away. In addition to these 87 conditional cautions, ASCEND sent ten voluntary referrals. In this cohort, 38 women are still actively working with the team.

Table A1.1. Age ranges of the women referred

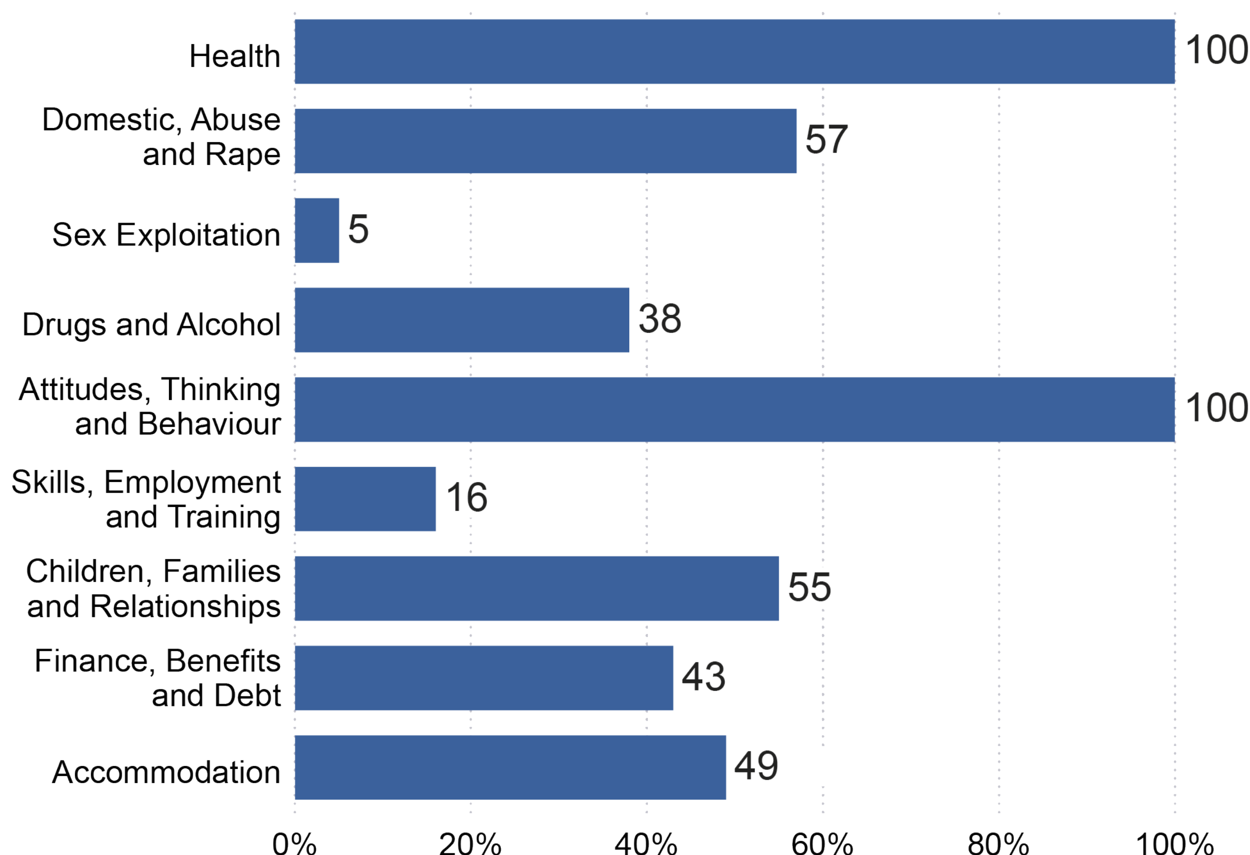
Age ranges	No. of women	% of women
18-24	13	%
25-34	35	%
35-44	21	%
45-54	14	%
55-64	4	%
65+	0	%
Total	**87**	**100%**

Table A1.2 Offence type for the 87 referrals.

Offence type	No. of women	% of women
Criminal damage	6	7%
Drug offences	6	7%
Harassment	6	7%
Public order – nuisance	9	10%
Theft	8	8%
Violence against the person	38	44%
Other	14	16%
Total	**87**	**100%**

In addition, 86% of the women identified as White British or Other White. Figure A1.1 below shows the percentage of referrals that needed support across the nine pathways of need. Referrals were commonly received where women had domestic abuse and children, family and relationship support needs; all women referred had health needs. Out of the 87 referrals, 66 (76%) referrals came through with four or more needs.

Figure A1.1: Percentage of needs across pathways of need



Individual case vignettes

Each of the SHE keyworkers wrote brief case summaries of some of their female clients illustrating the issues that had been worked through and the outcomes of their involvement.[51] These are extracted below:

1. A young mum came to us extremely upset and frustrated at the first meeting for an initial assessment of needs and was very focused on the disagreement with the neighbour which led to her offence. We sat and spoke for 2 hours around the various issues she had going on for her and all these combined were real contributing factors in her emotional outburst with her neighbour. She was suffering quite badly with anxiety and mild depression and had a mountain of debt letters some of which hadn't been even opened in nearly a year. We identified

[51] SHE clients gave their consent for their stories to be shared in this report through their keyworkers.

seven unmet needs of the nine pathways and so we prioritised these issues in which order I would support her.

Hers and mine main priority were to contact her GP which I did there and then and booked her a medication review and to discuss her anxiety the following week. Next was the debts, which after spending a further two hours on a second 1-2-1 visit at her home address we sorted them in order of priority into piles as some were near bailiff action (in fact the bailiffs showed up the following week and clamped her car). We then discussed and searched for baby and toddler groups so she could mix more with other Mums, this was something the thought of made her feel very anxious. We sat at 1-2-1s and also discussed the tension between her and her neighbour. Discussing this openly she was able to understand that what her neighbour was complaining about was in fact justified and she was able to see how she had overreacted due to the stress.

As I know it today, she now has an amicable relationship with her neighbour, we have managed to write off 80% of her debts and the bailiffs returned their positive judgement to the council. She is now attending a mother and toddler group and her medication is stable, she’s sleeping well, eating well and she feels the best she has in a long, long time. We discussed her finances also along with budgeting and she seemed confident that this has all been extremely enlightening and will now move forward feeling happy and responsible with her finances.

2. A woman came to us in a very distressed way, lots of fear after her experience of being arrested, caught up in the chaos of an emotionally, financially and mentally abusive marriage. She was staying at her daughter’s house for safety and respite. During the initial assessment it was identified that she needed accommodation desperately, a solution to her debts and out of the abusive marriage. A referral was already in place for a specialist agency, but I quickly contacted her case worker and we discussed her options. I continued my support with weekly checking in and we made an application for the local council as she wanted to move out of area to be closer to her daughter and grandchildren. She completed several online cognitive behavioural therapy based online interventions. Emotional

support was a big deal for her as she needed that listening ear as to not bog down her daughter with her emotions and worries.

She has just recently moved into her own property and a grant for white goods is on its way to her. She is now out of her abusive marriage, has regained her confidence and we can now laugh when we have our weekly calls. The difference in her now to when I met her is huge and it is beautiful to watch someone come back to life when someone feels so low. I will miss her but keep in touch here and there after our 'all the best' phone call next week.

3. The police referred a woman from custody and they were very concerned as the woman was not allowed to return to her property and had nowhere to go. She also had difficulty as English was not her first language and there were domestic violence concerns, and she was vulnerable and very upset. I made contact that day and met her within a few hours of receiving the referral. I took a phone and sim card for her to have a means of contact and some security to know she was being supported. The situation was a complicated one, as she had been a victim of domestic violence for a long time; however, she had been arrested as a perpetrator of domestic violence (seemingly reactive violence) and was unable to return home to where her son was. She was very isolated and didn't have a support network around her, as she had been controlled for a long time throughout the relationship. She was staying in homeless accommodation which was a concern for her safety and mental health.

   We discussed her situation at length and the issues she was facing. She was really struggling to accept the end of the relationship and it was further complicated by her part ownership of the house, so the council refused to house her. I managed to secure her a grant to assist her with getting a room locally where she would be able to see her son in safety. I was able to refer her into legal support and attend these meetings with her. As she was unable to drive, she was unable to get to these important meetings alone as well as finding them incredibly stressful and emotional. We were able to attend appointments together and then talk through what all the legal jargon meant in real world terms and in a way that she started to understand. Due to her different culture the idea of divorce was

incredibly shameful, and we did a lot of work around acceptance and moving on and what her life might look like in the future. We discussed what she wanted and what she hoped her life might look like without the abusive relationship and the possibilities she could see for herself.

During the course of our support, she was able to start to move on, she arranged to see her family and take the shame of divorce away and then work with the legal support we had put in place to engage with the proceedings and make a start at living her life on her own terms. Through our support she was able to keep her job which was of paramount importance to her as it provided security and freedom, find suitable legal support to represent her, work with her GP to get mental health support in place to enable her to better engage with the process she was going through, have a safe place to live while things were getting sorted and feel like she wasn't alone while she was facing such turbulence and uncertainty in her life.

I believe having someone to talk to, seek for reassurance and provide practical elements of support such as referrals and lifts to appointments, as well as a phone with credit was very important for her to feel like she wasn't alone, and she hadn't been abandoned. She was being heard throughout what was one of the most stressful and confusing times in her life as she grappled with the end of her marriage, a stable home, the British legal system as well as the police and the arrest process itself. The added complication of a different culture, second language and a lack of local cultural support was a massive factor in the process and made it all the more important that she had someone she could talk to, ask questions without shame and feel free to disclose to without judgement this was a significant component to how effective the support was in helping her to move forward.

4. A woman came to us very distressed with lots of unmet support needs after being cautioned for shoplifting. She was very hesitant to engage and was only touching briefly on the support she would like from us. However, over the last three months, this woman's attitude has changed; she is engaging, motivated, happy and has even disclosed to her employer her borderline personality disorder (BPD) diagnosis. She hadn't been able to disclose it in the time she had been working

there. She completed several online cognitive behavioural therapies based online interventions and now she is interested in doing some face-to-face groups in the centre to understand emotionally why she feels the need to go out shoplifting.

She has a very positive attitude compared to three months ago and really wants to change her lifestyle after her caution. I have worked closely with her to recognise the emotions she feels when her BPD is not under control as this was a massive trigger for her shoplifting and she is now engaging well with her GP, something she struggled to do beforehand. She believes that she can do this independently herself moving forward.

5. A woman was referred to us as she was placed on a caution. She was very upset and frustrated about her caution which made her feel as though she didn't want to engage deeply with us. After a month of meeting with me weekly she learnt to trust that we wanted to support her with what she was struggling with. She disclosed about her domestically abusive relationship which was the reason she was living in this specific area. She previously was in a refuge and saw no way of returning to the town that she grew up in and where all her family continue to live.

   She started to attend groups within the Nelson Trust and with a little encouragement she also attended groups with the local drug and alcohol organisation. She has been sober now for a few months. We have completed and set up a housing application in her hometown and she has been awarded the second highest banding thanks to her supporting letter from us at the Nelson Trust. She is now bidding on properties so she can be closer to her children and mother. She is a completely different woman to the person I first met. She is open, engaging, confident and is positive about her life moving forward.

6. I am currently still working with a woman that was issued a caution. During the time that I have spent supporting her she has been able to access the Job Centre and been accepted for incapability payment, so she doesn't need to keep giving sick notes at work. She has attended all her child services appointments and wants to work to getting shared custody with her mum. With help and support she has left an abusive relationship and she has secured accommodation at a

supported living property. She is currently accessing the GP for her medication review and accepted a referral to a mental health support service.

7. A woman was referred but was poorly at the time of referral, so we arranged telephone appointments. We talked about her health and prioritised contacting her GP surgery as they wouldn't change her medication due to her alcohol consumption. She began to engage with online alcohol support and the GP then agreed to review her medication after three weeks. Her and her partner have accessed private relationship counselling and have been making progress to live back together. I continue to support this woman alongside her caution.

8. A woman was referred through caution after being arrested for domestic violence against her current partner. She was really engaging, open and honest from the start of our appointments and specifically talked about the trust issues she faces within her relationships. She explained how a lot of her jealousy and paranoia is heightened when she has consumed alcohol. I referred her onto an online alcohol awareness intervention and discussed signposting her to local mental health agencies. However, prior to our appointment she had already taken it upon herself to self-refer into the mental health team which was great. I was then able to link in with her current mental health assigned worker to liaise and ensure she had wrap around support and to confirm with them that she was able to access emotional skills group and therapy, so we didn't duplicate our groups alongside. She had sadly experienced trauma [from a death in the family], so I referred her over to bereavement support in the area. As we spoke throughout our appointments, she opened up about a history of being in emotionally abusive relationships in her past.

   She showed a keen interest in accessing the groups we provide at our Women's Centre, and I enrolled her onto one of our courses. She learnt from this that her behaviors stem from her childhood and alcohol is linked with her anger and impacts her behavior. She has found it useful to learn de-escalation techniques, grounding activities, calming strategies and the container exercise. She has also participated in further hobbies such as reading books. Once her emotional skills group had finished with the mental health team, we set a clear support plan for her

to access our emotional health groups. I also referred her onto our 12-week counselling sessions we can offer from an accredited therapist at the centre; she's starting this very soon.

Throughout our appointments and every time we met again you could see the transformation of her and how well she was doing and she would start the sessions by saying she was in a really positive, happy place. She would express how highly she thought of the Trust and how much it has helped and the confidence she now feels. She has been abstinent for a period and I provided her with the recovery agency contact details for further support around this. Another really positive outcome from our support is she was able to recognise triggering and reoccurring behaviors from new relationships and identify it wasn't a healthy relationship and ended this relationship. She has really grown in confidence, has maintained her non-offending status, and has attended and engaged in all appointments.

9. A woman self-referred after being street homeless and returning to live with her elderly mother, her drinking became more dependent and she would become a risk to herself and her mother. Following a further arrest, she was given a caution to engage with The Nelson Trust and part of those conditions were to engage with alcohol support. As part of her caution, we completed a referral to a specialist agency so she could access alcohol support in the community. Throughout my support we have sorted her finances and PIP (Personal Independence Payment) of which has gone to tribunal. She was actively bidding on properties through local housing, however, we completed a number of homeless referrals and due to her alcohol misuse and her not being able to engage appropriately, they would often close the case, this also happened with Adult Safeguarding. She began taking alcohol medication to stop the craving. Due to the positive steps she took to reduce her alcohol intake and working with specialist agencies she has been allocated a flat and we have received funding for furniture and she is getting ready to move. This has reduced the vulnerabilities to herself and the risk to her elderly mother.

10. I had a woman referred to the service from ASCEND as a caution with conditions to engage with The Nelson Trust. She was young, vulnerable and a little hesitant to begin with, but we kept up with regular appointments where we would go out for coffee and a chat to see what was happening in her life. Slowly we built a relationship of rapport and trust, so she felt confident to open up to me and complete her assessment and support plan alongside her caution. She had debts which were impacting her ability to get a house for herself and meant she was relying on a questionable relationship which made her unduly vulnerable to him. We worked on referring and getting her support through a mental health support organisation so she could start to have a plan to move into her own house and she got a new job that was much better for her mental health and lifestyle.

    She began to see a future and was happy at her new job and she was talking about how she wanted to start driving and things were really looking up. She then found out she was pregnant and her partner kicked her out of the house and she had nowhere to go. I advised her how to get housing and she was instantly supported by the council for housing support, we talked about her options and what she wanted to do and I found her immediate counselling for her situation so she knew she wasn't alone.

11. A woman came to us as a referral from ASCEND. She was very anxious due to having physical health issues and the referral coming through whilst she was in hospital. During our initial phone call, she expressed that her mental health was deteriorating and that she wanted to engage but was worried to meet with me due to her anxiety. We had another phone call and I managed to encourage her to meet with me in person. We had a home visit where she disclosed that her drinking and alcohol intake can be a big factor in her mental health. We were speaking about what else affects her mental health and her main worries were around accommodation and her rent arrears. We managed to complete her housing application so she can attempt a mutual exchange out of area as she would like a clean start to progress. We also worked together to set up her benefits and to contact her housing provider to set up a workable payment plan for her rent arrears. During our last home visit, she disclosed that she is feeling a lot

more positive and said that there is a weight of her shoulders knowing she will be getting her first Universal Credit payment this month and that she can pay off a small amount to her housing provider. I have noticed emotionally how much more open she is during our appointments and it is amazing how much more confident she is to engage compared to when referred.

12. A woman who was referred through to SHE on a conditional caution presented on her first appointment as very emotional and lost. She explained the extensive trauma she had experienced since moving to the country, including being coerced and manipulated into trying drugs which she soon became reliant on. She spoke about being a hardworking woman, having had jobs and motivations for the future. She spoke of wanting to stop using substances, and the positive impact she knows this will have on the rest of her life. In her temporary accommodation she had been referred to the local drug and alcohol service so I prompted her around these appointments, linking in with supporting professionals to ensure wrap-around support where we are all on the same page. I am currently supporting her to work with the police around compensation for an injury as a result of her being the victim of a brutal crime. The road to recovery will not happen overnight, but her motivation to change and access support continues to amaze me.

13. I began supporting this woman a few months ago; she was in a poor accommodation situation, living in a house of multiple occupancy with mainly males, working a stressful job, and isolated from her family (who live in a different country). Through the following months supporting her, she secured more stable accommodation with friends who she gets on with, and recently secured a job in care which she was really pleased about. She was able to disclose her caution and impress them with her passion and relevant skills for the role. Following her caution compliance, she was offered to continue support, however she felt she has good things in place now to continue on her positive path. She took our office number and is aware she can make contact in the future if she requires our support again.

Annex 2
Methodological approach

To inform the development of the data collection tools for all phases of the study, a targeted literature review was conducted of relevant academic and grey literature published after 2016. Targeted searches were conducted in Google and Google Scholar to identify relevant papers. Once screened for relevance, included papers were subsequently screened in detail to identify key concepts and gain an understanding of the current policy and practice context, as well as the planned shift towards a statutory two-tier plus framework. Furthermore, additional papers were identified by looking at potentially relevant references in previously included papers (snowballing). In total, 12 documents were deemed relevant and included for analysis.

Phase 1 data collection activities

Fieldwork interviews

Number and selection of interviewees

For the Phase 1 data collection, the study team conducted 148 interviews (each up to two hours long) between January and May 2022 with up to six interviewees from each participating force area. Interviews were conducted virtually via Microsoft Teams. With the informed consent of the interviewees, interviews were audio recorded and written notes were taken by the fieldworker. The research team sought to speak with the key stakeholders in OOCD policy and implementation from each force area, and those who were most knowledgeable about how OOCDs worked in that force area. These interviewees included police force staff and OOCD partners such as Liaison and Diversion (L&D) leads/practitioners; service providers; persons who commission or manage services that are relevant to an offender with health vulnerabilities; and local authority representatives. The research team took a flexible approach to interviewee representation and sought the guidance of each force's OOCD lead on the most appropriate stakeholders to approach for an interview.

Data collection and tool design

The data collection tool for the Phase 1 fieldwork commenced with preliminary questions establishing the OOCD process within the force and whether an OOCD policy or standard practice is in place. All interviewees were asked to describe, to the best of their knowledge, the services that were available (as of March 2022) to be attached to OOCDs for adult offenders in their force area. For each service, interviewees were asked to specify which health vulnerabilities each service aimed to address. Interviewees were also asked to shed light on four key decision points in the OOCD process in their force area: identifying and assessing the offender's vulnerability; identifying the service to be attached to the OOCD; monitoring compliance with the condition; and managing non-compliance with or withdrawal from the condition attached to the OOCD.

As shown in Table A2.1 below, the tool was structured by these four decision points in the OOCD process, starting from the point at which it has been decided to give an offender an OOCD.

The design of the data collection tool ensured that data collected across all the participating forces are structured, comparable, and include an appropriate level of detail. The tool also allowed for fieldworkers to capture complexity and context (for example, divergent practices within a police force.)

Table A2.1: Phase 1 data collection tool structure

Decision point 1: Identifying and assessing vulnerability

This section of the tool covered if, how, when, where and by whom a vulnerability assessment of the offender is undertaken, information about which tools are used, if any, and any variations within the police force in conducting the assessment.

Decision point 2: Identifying services

This section covered:

1. How decision makers identify and select conditions to be attached to an OOCD
2. The services available within each force area that could be attached as a condition to an OOCD – including:
    - **a.** Whether or not these services are attached as a condition to OOCDs
    - **b.** Why or why not
    - **c.** Information on the vulnerability that the service is seeking to address (coded by vulnerability categories drugs, alcohol, mental health, physical health, neurodiversity/ learning disabilities, services that address all vulnerabilities, others)
    - **d.** Information on the cohorts that are the target of the service (women, young adults, people with physical disabilities, neurodiverse people)
3. Variations within the police force to identifying services

Decision point 3: Monitoring compliance

This section covered mechanisms or practices that are in place to monitor an offender's compliance with the conditions attached to an OOCD.

Decision point 4: Breach

This section gathered information on the policy or practice in cases of non-compliance or withdrawal from conditions attached to OOCDs to address health vulnerabilities.

Data collection tool use

There was only one data collection tool for Phase 1 interviewees, but the questions contained within it were tailored to different stakeholders:

- Some questions, which sought to discover processes and other contextual information about the force and their OOCD system, were asked only to the force's OOCD lead and their response validated by a second police representative.
- All other questions were asked of all police interviewees.
- Non-police interviewees, such as service providers and local authorities, were typically only asked questions around Decision Point 2 (Identifying Services) and questions in the concluding section of the tool, as they were typically not familiar with other aspects of the OOCD process in their force area. However, they were asked if they could speak to the other decision points, such as monitoring compliance.

Approaches to analysis of information

At the conclusion of the fieldwork, the study team cleaned the data and analysed all interviewee responses to produce a single synthesised entry for each force into a dataset which gathered the data from all participating forces. The data was then analysed by the study team to identify themes across all the interviews. An initial listing of themes was organised manually in a codebook and the research team coded the interview data with amendments to the codebook as needed. Once all data was coded, the team reviewed the coded excerpts and used them to develop a narrative analysis.

Aggregated data request

The study team asked all forces to provide an aggregate dataset that described police disposals and who received them, the content of OOCDs and whether they were complied with between 1st January 2021 and 31st December 2021. Thirty-one forces completed an Excel template with some, or all requested data (see Table A2.2 for details on the datasets requested and the number of returns).

Table A2.2: Aggregate data returns

Dataset requested	Returns from forces
Total disposals	31
Disposals by Home Office offence groups	30
Disposals by demographics and important flags (age, ethnicity and gender and DA and hate flags)	30
Disposals by health vulnerability	12
OOCD conditions and interventions	12
OOCD conditions started and completed	11

The data returns were checked for completeness, and queries were raised and resolved with the forces. An analyst combined the data into one dataset for analysis.

Phase 2 data collection activities

Sampling of the seven Phase 2 case study forces

Sampling was undertaken in collaboration with the MoJ to try ensuring representation against the following characteristics:

1. Rural / urban Office for National Statistics (ONS) classification 2011 (Predominantly urban; Predominantly rural, Urban with significant rural)
2. OOCD rate, whether in top 25%, middle range 25%-75%, bottom 25%. Defined as proportion of positive outcomes that were OOCD in year September 2020 to August 2021, weighted for crime category.[52]
3. Number of OOCDs used between April 2011 and March 2021.[53]
4. Reasonably be drawn from different parts of England and Wales.
5. Custody case management system (i.e. NICHE, Athena, Policeworks, Connect).

Fieldwork interviews in the case study forces

Number and selection of interviewees

The research team conducted an additional 91 interviews in the eight case study forces (up to 21 in total for each force across Phases 1 and 2), again seeking the guidance of each force's OOCD lead on the most appropriate stakeholders to approach for an

[52] Police.data.uk, accessed November 17, 2021.
[53] Ibid.

interview. Interviewees included police force staff and OOCD partners such as L&D leads/practitioners; service providers; persons who commission or manage services that are relevant to an offender with health vulnerabilities; and local authority representatives. Some interviews involved more than one interviewee. In advance of each interview, interviewees were provided with materials to ensure their informed consent, including the project information brief; consent form; privacy notice; and withdrawal form.

Data collection tool and design

The data collection tools for Phase 2 build on the Phase 1 Tool. The tool captured interviewees' perspectives on the effectiveness of each decision point of the OOCD process (Decision point 1: assessing vulnerability; Decision point 2: Identifying services; Decision point 3: Monitoring compliance; and Decision point 4: Breach).

Data collection tool use

There were two data collection tools to be used for the case studies to ensure that the interview time was used efficiently.

1. All interviewees from Phase 1 were asked to participate in the Phase 2 interviews for case study forces. We developed a single tool for these interviews that combined questions from the Phase 1 and 2 data collection.
2. For the additional non-police interviewees who did not participate in Phase 1, we developed a separate tool which covered the same topics and was tailored to their areas of expertise.

For both Phase 2 tools, the data was collected by the nominated fieldworker responsible for all interviews with a particular force and entered into the data collection tool.

Fieldwork team

As with the Phase 1 interviews, the team of fieldworkers conducted interviews with OOCD stakeholders in the case study forces. Interviews were conducted virtually via Microsoft Teams. There was an additional session at the half-day training session with the fieldworkers for those who were responsible for case study data collection.

Approaches to analysis

The interview questions for the case study forces used more free text responses than the questions posed in the Phase 1 data collection, as we were particularly interested in gathering qualitative data around stakeholder perceptions of the effectiveness of OOCDs. With the informed consent of the interviewees, interviews were recorded and written notes were taken by the fieldworker. The interview data was cleaned by the responsible fieldworker and inputted into a master spreadsheet containing all Phase 2 interview data. An internal workshop was held by the research team to identify themes across all the interviews relevant to the study's research questions. An initial listing of themes was organised in a codebook and the research team coded the interview data with amendments to the codebook as needed. Once all data was coded, the team reviewed the coded excerpts and used them to develop a narrative analysis during Phase 3 of the study.

Table A2.3: Phase 1 and 2 interviewees by role

Phase 1 and 2 interviewees by role	
Police officer	142
Service provider	54
Police staff	28
L&D	10
Other	3
PCC	2
Total	**239**

Phase 3 data collection activities

The aim of Phase 3 was to ensure an in-depth understanding of OOCD processes in the case study force areas, with the intention of using this information to implement the learning from the study's first two phases and fill the data gaps that were identified in Phase 1. To this end, the research team carried out a number of tasks.

In-depth review of OOCD processes

Additional document review

For each case study force, an additional review of key documents relating to OOCDs not already reviewed in-depth as part of Phase 2 was carried out, with a particular focus on any criteria used for decision making, eligibility and consistency of OOCD application.

To undertake the additional document review, the research team:

- Met with the OOCD lead for each of the seven police force areas to go through the documentation that was discovered in the earlier phases of the evaluation.
- Confirmed whether the previously found documentation was still extant or whether it had been superseded, updated, or amended.
- Discussed with the OOCD lead of each of the forces the rationale for any changes or new developments. Additionally, these conversations were used to understand how the forces are anticipating the forthcoming legislative changes.

Case review

The purpose of the case review was to provide detailed accounts of the decision-making processes and to identify the causes of any inconsistencies in processing OOCDs within and between police forces. We know from previous research (e.g. Kane et al, 2021) that there were variabilities between forces in the processing, for example regarding:

- An offender's route into custody (e.g., via arrest or voluntary attendance).
- The type of offence for which the offender was arrested (some investigating teams will be more conducive to giving OOCDs).
- Time of day the offender was referred (can vary the options available to officers).
- Type of personnel who processed the OOCD (individual officers can have differing attitudes to the use of OOCDs).

The case review was conducted based on a purposive sample of at least eight OOCD disposals with a health vulnerability: where possible, four where the scrutiny panel deemed them to be appropriate and four where the panel deemed the OOCD to be inappropriate.

In conducting the case review, the research team undertook a review of case files contemporaneously with the forces' scrutiny committee's own reviews. This served to

avoid a “fishing exercise” for closed cases in the police forces that lack the appropriate documentation or context to make a proper review. The study team fieldworkers originally planned to undertake site visits to observe the proceedings of the scrutiny panel, record details of the cases under scrutiny in a data collection instrument and seek follow-up conversations with those involved in the scrutiny process to clarify any matters. However, this was not feasible as at the time of data collection no scrutiny panels were being held.

The fieldworkers used the data collection instrument to record the contextual factors and outcomes for the cases that are subject to the scrutiny panel’s review. The instrument required the fieldworkers to collect the following information:

- General overview of the case
- By what process did the individual come to receive an OOCD? Are the processes selected? E.g., crime, arrest / voluntary attendance, persons involved and their rank.
- Why was the individual selected for an OOCD?
- What intervention did the offender receive?
- How was the intervention monitored?
- How successful was the intervention?
- What data are collected at each stage?

The instrument recorded detailed, open text responses. This data was then subjected to analysis, where the study team coded and identified themes within the cases.

Stakeholder interviews

Final queries and clarifications arising from the document review and case review were addressed in four interviews with local stakeholders for each of the seven case study forces in order to confirm the local arrangements that were made for OOCDs.

These interviews were held with representatives from:

- Criminal Investigation Department
- Custody suites
- Police administrative support (regarding data and record keeping)
- Liaison & Diversion

Topics discussed included, among others:

- How the local policies are being implemented and executed
- How offender's health vulnerabilities are being addressed
- The appropriateness of the disposal
- Collection of appropriate data

Workshops

After the above-mentioned data was gathered, the study team organised a 'solution-focused' workshop with each of the seven case study forces. Key partners within and outside the force who had a stake in the decision making in the use of OOCD for individuals with health vulnerabilities were invited to these workshops.

The following topics formed the focus of these meetings:

- A definition of solution to identified problems
- The required systems changes
- The resources required (and if they were available)
- The strategy to implement.
- Definition of appropriate performance indicators

Furthermore, the research team also focused on identifying where better partnership working within the force and across agencies was needed and how this may be achieved effectively, as well as the guidance, training or support tools that may be needed and how these could best be delivered.

The output of the workshop was a set of solutions for any problems or issues identified. These were subsequently captured in seven frameworks that describe the problems, the solutions, actions, and provided an appropriate timetable for each of the seven case study.

Annex 3
The evidence base for OOCDs

The research team conducted a targeted literature search to identify existing evidence regarding the effectiveness of OOCDs with conditions for health vulnerabilities in adult offenders.[54] Relevant literature was identified by scanning Neyroud's (2018) NPCC literature review paper on OOCDs,[55] and conducting a search on Google Scholar limited to papers published from 2017 onwards to update this review. Relevant literature from the MoJ library was also searched using the same search parameters. Twenty-eight papers were read in full following a title and abstract screening, and from this a further nine papers were excluded. Therefore, the evidence emerged from information contained in nineteen peer-reviewed articles and evidence reviews.[56]

The evidence suggests that using OOCDs to address health vulnerabilities can reduce crime. This section describes OOCDs' impact on the following outcomes:

- **Compliance**, such as attending and completing services that are conditions within an OOCD
- **Improvements in criminogenic needs**, such as addressing a drug addiction or providing a mental health intervention
- **Victim satisfaction**, such as understanding what disposal was given to an offender and why, and the victim's satisfaction that justice was achieved; and
- **Reductions in reoffending.**

[54] The following key words were used for the search: (effectiveness OR impact OR outcomes OR evaluation) AND ("out of court disposals" OR OOCDs OR "pre court intervention" OR "diversionary intervention" OR "pretrial intervention" OR "pre charge intervention") AND (drug OR alcohol OR physical OR mental OR "mental health" OR neurological OR neurodiversity OR "learning disability" OR "intellectual disability") AND vulnerability.

[55] 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. Accessed 18 November 2022.

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

Compliance

Compliance is an essential first step as it determines whether the offender will continue with a programme's entire course, potentially enabling them to benefit from any intervention and reap further positive outcomes. Reviews by both Lange et al. (2011) and Cordis Bright (2019) found that pre-trial diversion programmes for offenders with mental illness and substance abuse effectively increased the use of appropriate services.[57,58] Lange et al. (2011), for example, point to an evaluation of the Women Specific Caution (Easton et al. (2010), a disposal method for low-risk female offenders piloted in Leeds, Bradford, and Liverpool between 2008 and 2009. Following semi-structured qualitative interviews with 21 female offenders, the researchers found that over 80% of offenders who were given a support plan following their initial assessment subsequently engaged voluntarily with the support services suggested to them.[59]

Furthermore, a literature review by Harvey et al. (2007) discovered that in the 37 reviewed papers which reported the number of participants maintaining attendance or graduating from treatment, a mean of 59% of offenders either maintained compliance or graduated.[60]

Looking into what determines high compliance rates, Weir et al. (2021) discovered that Durham's Checkpoint Programme (which deals with mental, physical, drug and alcohol vulnerabilities) had a rate of 78% of offenders completing their contracts.[61] The offender decided whether to take part in the Checkpoint programme or to be dealt with via the standard criminal justice process. Hence, it may be that providing offenders with a choice to follow through with the OOCD condition will increase compliance. In addition, the Checkpoint programme provided each offender with a comprehensive needs assessment

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[57] Lange, S., Rehm, J., & Popova, S. (2011). The effectiveness of criminal justice diversion initiatives in North America: a systematic literature review. International Journal of Forensic Mental Health, 10(3), 200-214.

[58] Cordis Bright (2019). Cordis bright evidence reviews - What works in delivering court diversion and deferred prosecution schemes? Available at: https://www.cordisbright.co.uk/admin/resources/10-evidence-reviews-diversion-and-deferred-prosecution.pdf.

[59] Ellis, H., Silvestri, M., Evans, K., Matthews, R., Walklate, S. (2010), Conditional Cautions: Evaluation of the women specific condition pilot. Ministry of Justice Research Series 14/10.

[60] 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.

[61] Weir, K., Kilili, S., Cooper, J., Crowe, A., & Routledge, G. (2021). Checkpoint: An innovative Programme to navigate people away from the cycle of reoffending – a randomised control trial evaluation. The Police Journal, 95(3), 562–589.

and a one-to-one navigator to cultivate a trusting relationship and confidence. Compliance is associated with relationships based on trust and confidence, which are likely to increase a sense of support, encouraging the offender to keep attending the intervention.

Overall, the evidence indicates that when suitable conditions are attached to OOCDs for adults with health vulnerabilities, compliance frequently emerges as an outcome, especially when the service provides a respectful and supportive environment for the offender.

Criminogenic need and well-being

If an offender complies with the order, the evidence further suggests that there will be criminogenic improvements, and also improvements in health, well-being and substance misuse (the most evaluated types of OOCD interventions in the literature). Focusing firstly on positive changes to wellbeing as a result of an OOCD-referred intervention, Cordis Bright (2019) note that several studies have found improved wellbeing to be an outcome of diversion and deferred prosecution schemes.[62] For instance, 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 involved in these programmes and found that 61% of participants reported that they had had a positive impact on their depression, while 63% reported a positive impact on their anxiety levels.[63]

Moreover, Australia's court-integrated services programme (CISP) investigated diversions targeted towards mental illness, substance abuse, and disabilities using a coordinated, team-based approach.[64] The programme linked offenders to services such as mental health, drug and alcohol treatment, and housing. A so-called 'SF-12' short-form physical and mental health survey that scores participants on a 0-100 scale was conducted on a sample of 67 CISP clients both at the beginning and at the end of their time on the

[62] Cordis Bright (2019). Op. cit.

[63] 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.

[64] Department of Justice. (2010). Court Integrated Services Program - Tackling the Causes of Crime. Available at : https://www.mcv.vic.gov.au/sites/default/files/2018-10/CISP%20tackling%20the%20causes%20of%20crime.pdf.

programme showed a statistically significant improvement in physical and mental health (an increase in the mean score from 38 to 45 and 50 to 54 respectively).[65]

Hence, providing offenders with a programme that includes support and access to various tailored services, including housing, can positively impact mental health.

Cowell, et al. (2004), on the other hand, found that the relationship between pre-trial diversion programmes for offenders with mental illness and an improvement in mental health was not statistically significant.[66] Nevertheless, there appears to be promising evidence overall that providing pre-trial diversions to tackle mental health issues may result in positive changes to mental health.

Similarly, researchers have discovered improvements in substance misuse related to diversionary strategies. In Harvey et al.'s (2007) review paper, most reviewed studies that examined the impact of diversionary strategies involving drug interventions on drug use (six out of nine) found a positive impact on drug-use outcomes, as drug-use was reduced among participants compared to control groups which went through the usual criminal justice procedures.[67] An evaluation of police drug diversion interventions in Australia (Payne, et al. (2008) also found that diversion and deferred prosecution schemes positively impacted drug and alcohol usage, and that programmes designed explicitly for offenders with substance misuse issues may effectively reduce drug use and reoffending.[68] This study found that of those who had committed at least one offence in the 18 months before diversion, between 53% (the Australian Capital Territory) and 66% (New South Wales) recorded fewer offences in the 18 months after diversion. It may be that, frequently, offenders with substance misuse issues never receive any recognition or treatment for their vulnerability. Diversions, therefore, allow the offender to recognise their actions and behaviours and change their current way of living with the support of services.

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[65] Ross, S. (2009), Evaluation of the Court Integrated Services Program: Final Report.

[66] Cowell, A.J., Broner, N. (2004). The Cost-Effectiveness of Criminal Justice Diversion Programs for People with Serious Mental Illness Co-Occurring with Substance Abuse, Four Case Studies. Journal of Contemporary Criminal Justice 20(3), 292-314.

[67] Harvey et al. (2007). Op cit.

[68] Payne, J., Kwiatkowski, M., Wundersitz, J. (2008). Police drug diversion: a study of criminal offending outcomes. Australian Institute of Criminology. Research and Public Policy Series 97. Available at: https://www.aic.gov.au/sites/default/files/2020-05/rpp097.pdf.

As Allen (2017) stated, OOCDs may provide an opportunity to give people treatment which meets their needs, addressing the issues which may trigger their offending behaviour and helping them to realize what these behaviours are.[69]

In particular, cognitive behavioural therapy (CBT) programmes are highly effective in many contexts, such as managing anger or substance misuse, by helping individuals, identify and detect their behavioural choices that drive them toward offending.[70] This is supported by the results from Lipsey's meta-analysis (Lipsey, 2009), in which CBT ranked as the intervention with the largest mean effect for any intervention type.[71] Spyt et al.'s (2019) paper concerning the development of the Drugs Diversion Pilot collected feedback from offenders attending this programme that they found highly beneficial and which apparently helped them improve communication and develop a better understanding of themselves without being made to feel like a criminal.[72] Offenders were also aware of various adverse side effects of drugs which encouraged them to reduce their usage.

Overall, there is evidence for the effectiveness of OOCDs with conditions for health vulnerabilities on criminogenic need, particularly in substance use and mental health. Currently, there is a lack of evidence regarding impacts on physical health, learning difficulties and neurodiversity. Researchers, however, point to an overall improvement in criminogenic need through the sense of recognition, support, and awareness the offender receives through attending a programme tailored to their needs. Hence, evaluating the impact of OOCD services on these health vulnerabilities can be worthwhile. Furthermore, these findings suggest that improving criminogenic need also reduces reoffending rates, which the next section explores in more depth.

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

[70] Neyroud, P. (2018). Out of court disposals managed by the police: a review of the evidence. Commissioned by the National Police Chief's Council of England and Wales. University of Cambridge.

[71] Lipsey, M.W. (2009). The Primary Factors that Characterize Effective Interventions with Juvenile Offenders: A Meta-Analytic Overview. An International Journal of Evidence-based Research, Policy, and Practice 4(2), pp. 124-147.

[72] Spyt, W., Barnham, L., Kew, J., Sergeant, D., Unit, P. S., & Inspector, D. (2019). Diversion: Going soft on drugs. Thames Valley police journal, 4(1), 44-68.

Victim satisfaction

Finally, victim satisfaction is another important outcome that may arise from using OOCDs, specifically in relation to offenders who suffer from health vulnerabilities. Previous research has demonstrated that victims tend to primarily focus on the offender's rehabilitation for lower-level offending, with a key concern being the prevention of the offender reoffending in the future.[73] It may often be the offender's health vulnerability that leads them to offend in the first place. Therefore, referring the offender to a service providing an intervention to remediate their vulnerability can be considered a form of rehabilitation to prevent future reoffending, which may increase victim satisfaction. Walsh (2018) noted that victims and offenders might often share similar attributes, such as their vulnerabilities.[74] By working on the offender's vulnerabilities and communicating this to the victim, the victim may feel justice has been served, and the offender is on the way to change. Finally, research suggests that in some instances OOCDs may be better overall for victim satisfaction than a court sentence, as victims are not always informed of court outcomes.[75] Thus, demonstrating that an offender has received rehabilitation for their health vulnerability and antisocial behaviours through an OOCD with a condition may bring greater satisfaction to victims.

Reoffending

Better compliance and improved criminogenic needs can develop into a longer-term outcome of reduced recidivism. As mentioned, motivating offenders to attend a programme that makes them feel supported and addresses their health vulnerabilities might tackle the cause of their offending behaviours. 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.[76] That paper supported the notion that providing access to appropriate services is an effective way to overcome drivers of offending, also promoting early intervention to be

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[73] Slothower, M. (2014). Victim Perceptions of Legitimacy of Diversion to a Conditional Out-of-Court Disposal: A Randomized Controlled Trial (Doctoral dissertation).

[74] Walsh, T. (2018). Keeping vulnerable offenders out of the courts: lessons from the United Kingdom. Criminal Law Journal, 42(3), 160-177.

[75] Allen (2017). Op. cit.

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

essential for 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 toward drug offenders resulted in a reduction in recidivism. Broner, et al. (2005) found, for example, that treatment for mental health and substance use issues had significant positive effects on recidivism, with fewer felony, misdemeanour and violation rearrests at both 3 and 12 months after diversion.[77]

Part of why these programmes improve criminogenic need and recidivism may be due to the design of the interventions used. The Miami-Dade Diversion Initiative in the USA was established to divert individuals with serious mental illness or co-occurring severe mental illness and substance misuse.[78] The programme offered offenders a selection of community-based treatments alongside support and housing services, assisting the offender in re-entering society and providing them with hands-on support. The offenders were monitored for up to a year following the programme's end to ensure they had access to services and support. This programme was found to be successful in reducing recidivism rates, decreasing among participants from 75% to 20% annually. It is likely that the strong support network and accessibility of services provided by this programme generate a suitable environment for the offender to work on their needs and reduce their likelihood to reoffend.

Similarly, Lange et al. (2011) found reductions in recidivism in pre-trial diversion programmes for offenders with mental health or comorbid mental health/substance abuse issues. Moreover, the court-integrated services programme in Australia, which linked offenders to appropriate services to meet their complex and diverse needs, led to a 20% reduction in reoffending rates.[79] This reduction included a notable decrease in the seriousness of any future offences compared to offenders with the same profile who did not attend the programme. The programme's clients explicitly mentioned increased

[77] 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.

[78] Mooney, S., Bunting, L., Coulter, S., & Montgomery, L. (2019). Applying the Sequential Intercept Model to the Northern Ireland Context. A selective review of practice innovations to improve the life chances of justice-involved young people and adults with complex needs.

[79] Department of Justice. (2010). Op. cit.

physical and mental health, strengthening the link between criminogenic need and recidivism.

Once again, compliance is shown to be linked strongly to future outcomes such as recidivism. In Kane County (USA), those that completed the state attorney's second chance programme (a drug programme involving drug testing for those with substance misuse issues) were less likely to offend over six months than those who failed the programme: participants who successfully completed the programme reoffended at a rate of 8%, compared to 19% for counterparts who failed to complete.[80]

Overall, the available evidence indicates that early outcomes such as compliance and criminogenic need are linked with future reductions in recidivism. Supportive interventions provided to offenders alongside good accessibility to appropriate services have been particularly connected with a reduction in reoffending.

[80] Halbesma, M. K. (2014). Diversion Programs: Are We Reaching Desired Effects? (Doctoral dissertation, Aurora University).

Annex 4
Ethics and data protection

Ethics

In advance of any data collection for the study, a full assessment of the potential risks and harms to study participants was undertaken by the study team. All organisations involved in the study were experienced in conducting research with practitioners and services users – including those who are vulnerable. We drew on these experiences to ensure our research met the highest standards of research ethics and governance. Specifically, we ensured that the study fully complied with Ethical Assurance for Social Research in Government and the MOJ shared all study materials and the GSR checklist for the project with MOJ's Ethical Advisory Group.

We applied for approval of this study via Europe's Research Ethics Advisory Group (REAG) and the RAND Corporation's Human Subjects Protection Committee (HSPC). REAG is the first port of call for all ethics queries at RAND Europe and provides researchers with tailored advice on project-specific ethical concerns. They advised us to approach the HSPC with a request for formal ethics approval. We shared all study materials and other required information with the HSPC and went through two rounds of review before receiving final approval.

Data protection

RAND Europe, GtD and SfH&J are all certified to ISO 27001:2015. RAND Europe, the lead organisation, holds a Cyber Essentials Plus certification, demonstrating our commitment to the protection of personal data. RAND Europe recently achieved an excellent rating of its data procedures in an audit by NHS Digital. The study team drafted a Data Protection Impact Assessment (DPIA) covering our intended activities and the measures that would be put into place to protect any personal data being processed. It included a description of the envisaged processing operations and their purpose, an assessment of the necessity and proportionality and of the risks to the rights and freedoms of data subjects, and our recommendations on appropriate measures to address these. This document states who the Data Controller and Data Processor(s) are for the data

being collected. The DPIA was included in the submission to the ethics review committee and once approved was signed off by the MoJ team.

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