The Journal of Forensic Psychiatry & Psychology

ISSN: 1478-9949 (Print) 1478-9957 (Online) Journal homepage: www.tandfonline.com/journals/rjfp20

Brief summary of a realist process evaluation of liaison and diversion services for children and young people

Charlotte Lennox, Lucy Smith, Rebecca Hefferman-Clarke, Jane Senior, Wendy Dyer, Prathiba Chitsabesan, Nathan Hughes & Jenny Shaw

To cite this article: Charlotte Lennox, Lucy Smith, Rebecca Hefferman-Clarke, Jane Senior, Wendy Dyer, Prathiba Chitsabesan, Nathan Hughes & Jenny Shaw (30 Jul 2025): Brief summary of a realist process evaluation of liaison and diversion services for children and young people, The Journal of Forensic Psychiatry & Psychology, DOI: 10.1080/14789949.2025.2536259

To link to this article: https://doi.org/10.1080/14789949.2025.2536259

Published online: 30 Jul 2025.

THE JOURNAL OF FORENSIC PSYCHIATRY & PSYCHOLOGY
https://doi.org/10.1080/14789949.2025.2536259

Routledge
Taylor & Francis Group

Brief summary of a realist process evaluation of liaison and diversion services for children and young people

Charlotte Lennox[a], Lucy Smith[a], Rebecca Hefferman-Clarke[a], Jane Senior[a], Wendy Dyer[b], Prathiba Chitsabesan[c], Nathan Hughes[d] and Jenny Shaw[a]

[a]Division of Psychology and Mental Health; School of Health Sciences; The University of Manchester; [b]University of Northumbria; [c]Pennine Care NHS Foundation Trust; [d]University of Sheffield

ABSTRACT

Liaison & Diversion (L&D) helps people, at the point of arrest, to access health or social care services. L&D services run across England, for anyone aged 10 and over (all-age model). Some research has shown that L&D is helpful, but the evidence is mixed and much of the research has not focused on children. Here, we present a summary of the research and the recommendations presented to NHS England. The study aimed to look at how L&D was delivered for children. Part one was a Rapid Realist Review (RRR) of the literature and undertaking realist interviews with people involved in developing and evaluating L&D. Part two consisted of mixed-methods data collection from six providers of L&D in England to see how L&D works. The RRR identified within the literature seven programme theories (procedural justice, child-centred approach, trauma informed approach, non-labelling, trained workforce, coordinated response and partnership working). The process evaluation showed that delivery was variable and limited by resources, which contributed to gaps in provision and the L&D model was not always working for children and in particular some children, e.g. those already known to services. A series of short- and long-term recommendations were highlighted.

ARTICLE HISTORY Received 6 March 2025; Accepted 14 July 2025

KEYWORDS Liaison & Diversion; arrest; police custody; youth justice; children and young people; mental health

Background

Liaison & Diversion (L&D) services provide support through the early stages of the criminal justice system (CJS), referring to appropriate health or social care services or even diverting people away from the criminal justice system. NHS England commissioned an all-age L&D service and full coverage in England

CONTACT Charlotte Lennox charlotte.lennox@manchester.ac.uk

was achieved in March 2020. Earlier research suggested that L&D services may be effective in targeting some health and criminal justice outcomes, but the evidence is mixed (Disley et al., 2016, 2021; Kane et al., 2020; Scott et al., 2013). To date, much of the L&D research has not included children (aged 10–17). Where research did include children, implementation and contextual differences between children and adult L&D pathways exist. For example, fewer referrals to L&D for children as they are less likely to come into police custody, children's needs can be missed depending on who completes the L&D assessment (Greater Manchester Collaborative Commissioning Network, 2021) and many children are already in contact with a range of services which seems to reduce the number of onward referrals following contact with L&D (Ministry of Justice 2019). As this research highlighted likely contextual differences between the adult and children's pathways and for different children, approaches that can investigate, how L&D works, for whom, and under what circumstances is important. Realist process evaluation is a way of looking at how mechanisms impact outcomes, and how context affects those mechanisms.

This study aimed to understand how L&D for children was being delivered, how it worked, for whom, and under what circumstances. The study was split into two parts. The first, a Rapid Realist Review (RRR) of the literature to describe the causal pathways of how L&D is thought to achieve its outcomes for children. The second, a mixed-method realist process evaluation to understand what components of L&D are being delivered, whether the components are working, which children they are working for and under which circumstances. This brief report provides a summary of the research, with a full list of recommendations that have been presented to NHS England. The RRR and process evaluation will be written up for separate publications.

Methods

Rapid realist review

The full details of the RRR are to be reported elsewhere. The review protocol (PROSPERO 335,317; Lennox et al., 2022) has been published. The review process was informed by the RAMESES guidelines and publication standards for a realist synthesis (Wong et al., 2016) and followed the five-stage approach.

In brief, 42 full-text articles were accessed and analysed, with the addition of eight realist interviews conducted with L&D developers, researchers involved in earlier evaluations of L&D, and clinicians working in L&D services with children.

We coded the articles and interview transcripts in NVivo using its traditional node function (one node for each theory) and supplemented this with additional nodes for Context, Mechanism, Outcomes, where likely candidates were

identified. Explanatory accounts were then developed. These were causal statements that identify an enabling or constraining factor(s) present in the data, the impact of those factors on one or more mechanisms, and the outcome(s) produced.

Process evaluation

Six providers of L&D services took part. They were based around England: London, North East and Yorkshire, North West, South East and South West, with the aim to try and ensure an L&D provider per NHS England region. The research team collected a range of data about each provider. This included:

- L&D Indicators of Performance (LDIPs) (data from NHS England Health & Justice on provider performance). The research team requested access to April 22 – March 23 data for the providers.
- Service documents were collected from each provider, e.g. service description/mode, standard operating procedures/policies, case identification tool, and screening/assessment tools. These were: (1) quantitatively coded whereby documents were checked against the national service specification; (2) qualitatively coded whereby documents were read line-by-line and coded against the programme theories developed in the RRR. Context meetings were also organised with senior staff for each provider to discuss how their service worked, any barriers and facilitators, and day-to-day activities of the site to form process maps.
- Semi-structured interviews were conducted within each provider area, including core L&D staff and stakeholders working with L&D, e.g. police, social care, justice services. Across the six providers, 29 interviews with core L&D staff and 27 interviews with stakeholders took place.
- Observations were conducted of L&D meetings. Across the six providers, 16 observations took place.

The LDIP results were imported into NVivo to be coded alongside qualitative data. All other data were coded in NVivo using its traditional node function, based on the programme theories developed in the RRR and the questions we wanted to answer (study objectives).

The evaluation was approved by (removed for anonymity) Research Ethics Committee (Proportionate; Ref: 2023–15238–27477) and Health Research Authority and Health and Social Care Wales and West Midlands – Coventry & Warwickshire Research Ethics Committee (Ref: 22/WM/0246).

Findings

Rapid realist review

We created a logic model to present explanatory causal statements of how L&D is proposed to produce its outcomes and to help us understand the evaluation data collection and analysis. These statements were grouped around seven main programme theories: four core programme theories focusing on L&D approach (procedural justice, child-centred approach, trauma informed approach and non-labelling) and three organisational programme theories (trained workforce, coordinated response and partnership working). The full details of this RRR will be reported as a separate publication.

Process evaluation

Between April 22 – March 23, there were 6,160 children referred to the six providers. Across the data set, 57% of variables were blank, missing or invalid. The level of missing data ranged between 23% and 73% across the providers. The research team had planned to undertake a detailed analysis of the data to understand and quantify which components (referral, screening, assessment of need, referral to onward services to meet need) were being delivered and to whom, but due to the level of blank, missing or invalid data, this was not possible. Therefore, only high-level descriptive data could be reported, see Table 1 for demographics and referral information, however this may not be truly representative due levels of missingness. Further details and discussion around the use of NHS performance indicators for research will be reported as a separate publication.

The full details of the process evaluation will be reported as a separate publication. Below is a summary of factors that were identified by the data as impacting the delivery and implementation of L&D for children.

Variability. Some variability to local context was to be expected. However, we found components of the L&D service specification to be vague and/or in conflict with the data requested by the LDIP, e.g. around definitions of screening/assessment and time limits. Providers' interpretation and delivery of the service specification varied. There were 'strict' and 'broad' interpretations of L&D. 'strict' models – we saw as delivery in police custody by skilled NHS mental health professionals, whilst 'broader' models focused within the community, seeing children before the point of arrest, staffed with non-health staff, e.g. youth workers. These models focused on different cohorts of children, at different points of the pathway and had different priorities, e.g. identification of health needs versus engagement. It is, therefore, likely that the outcomes of the services provided may be different.

Table 1. Demographics and referral information for children referred to each site.

	All Data (*N* = 6160)	Site 1 (*n* = 1224)	Site 2 (*n* = 1610)	Site 3 (*n* = 1112)	Site 4 (*n* = 1422)	Site 5 (*n* = 466)	Site 6 (*n* = 326)
Mean age (SD)	15.38 (1.49)	15.39 (1.47)	15.77 (1.24)	15.07 (1.56)	15.39 (1.45)	15.15 (1.71)	14.79 (1.81)
Gender N (%)							
Male	3879 (63)	1037 (84.7)	221 (13.7)	869 (78.1)	1129 (79.4)	362 (77.7)	261 (80.1)
Female	838 (13.6)	159 (13)	38 (2.4)	230 (20.7)	246 (17.3)	104 (22.3)	61 (18.7)
Non-binary	4 (.1)	-	-	1 (.1)	2 (.1)	-	-
Self-describe	4 (.1)	2 (.2)	-	12 (1)	2 (.1)	-	-
Not known/Unknown	1395 (22.6)	26 (2.2)	1351 (84)	-	43 (3)	-	4 (1.2)
Ethnicity N (%)							
White	3628 (58.9)	1033 (85)	237 (14.7)	805 (72.4)	939 (66)	356 (76.4)	250 (76.7)
Mixed/Multiple Ethnic Groups	346 (6.5)	31 (2.5)	99 (6.1)	51 (4.6)	123 (8.6)	18 (3.9)	24 (7.4)
Asian/Asian British	231 (3.8)	39 (3.2)	69 (4.3)	25 (2.2)	63 (4.4)	34 (7.3)	1 (.3)
Black/Black British/ Caribbean/African	206 (3.3)	15 (1.3)	-	42 (3.8)	100 (7)	21 (4.5)	25 (7.7)
Other Ethnic Group	93 (1.5)	5 (.4)	38 (2.4)	23 (2.1)	20 (1.4)	1 (.2)	6 (1.8)
Other/Not known/ Unknown	425 (6.9)	93 (7.6)	119 (7.4	166 (15)	1 (.1)	36 (7.7)	10 (3)
Missing	1234 (20)	-	1048 (72.1)	-	176 (12.4)	-	10 (3)
Referral Setting N (%)							
Police Custody	4750 (77.1)	1181 (96.5)	1187 (73.7)	1000 (89.9)	1194 (84)	-	188 (57.7)
Court	373 (6.1)	31 (2.5)	315 (19.6)	8 (.7)	19 (1.3)	-	-
Other	254 (4.1)	12 (1)	-	104 (9.4)	-	-	138 (42.3)
Not known/Unknown	466 (7.6)	-	-	-	-	466 (100)	-
Invalid	317 (5.1)	-	108 (6.7)	-	209 (14.7)	-	-
Previous L&D Contact N (%)							
Yes	1899 (30.8)	529 (43.2)	302 (18.8)	419 (37.7)	516 (36.3)	63 (13.5)	70 (21.5)
No	3790 (61.5)	695 (56.8)	1049 (65.2)	693 (62.3)	901 (63.4)	196 (42.1)	256 (78.5)
Not known/Unknown	424 (6.9)	-	212 (13.2)	-	5 (.4)	207 (44.4)	-
Invalid	47 (.8)	-	47 (2.9)	-	-	-	-
Voluntary Attender N (%)							
Yes	802 (13)	94 (7.7)	81 (5.0)	10 (.9)	97 (6.8)	432 (92.7)	88 (27)
No	4308 (69.9)	1129 (92.2)	502 (31.2)	1102 (99.1)	1316 (92.5)	22 (4.7)	237 (72.7)
Not known/Unknown	1049 (17)	1 (.1)	1027 (63.8)	-	9 (.6)	12 (2.6)	1 (.3)

Resources. Availability of funding and staffing issues dictated delivery models. In all-age services, adults were prioritised over children and some children prioritised over others, e.g. a focus on children who were first time entrants. Additionally, some services reported a pressure to discharge children quickly due to resource limitations, with children being assessed and discharged on the same day.

Gaps in provision. There were gaps in provision against the service specification, mainly voluntary attendance coverage and operating hours. Sites acknowledged that they needed to develop a voluntary attendance pathway but did not currently have sufficient resources to do so. Services were mostly provided 8am-8pm, 7 days a week, but in some sites, cover was weekdays only and only during 'office hours' (9am-5pm). Another limitation identified was a lack of dedicated children's practitioners during all operational hours, therefore children did not always see a child specialist worker.

LDIP data quality. The evaluation highlighted significant data quality issues, both missing and erroneous. Some evaluation sites had no administrative support, with frontline workers responsible for all aspects of data management. Missingness increased as the dataset progressed, L&D teams were more able to record what they did verses more distal outcomes, such as engagement of the child with onward referral services and impact of L&D on those services. There were also inconsistencies between expectations set in the L&D service specification and what was captured by the LDIPs, and inconsistencies in the numerator and denominator for the LDIPs, which all produced differences in how services were interpreting what the LDIPs were asking for.

L&Ds unique selling point and service fragmentation. The evaluation highlighted, in line with other research, that children were often already in contact with a range of other services prior to L&D contact. While a key role of L&D is coordinating and navigating a response, adding in L&D potentially risked further fragmentation in the system. In addition to this, the diversification of the L&D workforce, identifying a broad range of needs, and, in some cases, L&D teams operating in the 'early intervention' space risked duplicating the role of other services.

Limited work involving parents and carers. The L&D teams often had limited contact with children following assessment, which meant there were little opportunities to involve parents and carers. This reflects the current all-age service model of L&D, in which the primary agent is the person arrested.

Model not sufficient to influence outcomes. It is written into the service specification that children do not respond well to 'signposting' approaches, and that outcomes of L&D include integration with other community-based services. The evaluation highlighted that signposting was often what was provided by teams to children, frequently due to resources. In addition, measuring and/or having any impact on integration with onward referral services was challenging as the L&D teams had little influence on the service to accept the child or the child to engage. Therefore, it is likely that the current delivery of L&D for children is not sufficient to influence outcomes or that the outcomes being set for L&D are unachievable. The limited outcome metrics and data quality issues also contribute to limited evidence of effectiveness of the L&D model for children.

12-week model. The evaluation highlighted inconstancies around a 12-week model. The service specification for L&D makes no mention of this, however, it is captured as a metric within the LDIP.

Access to courts. Provision at court was another example where the all-age model service specification does not always fit the children's pathway. All child cases going to court start at the youth court, but it is only the justice services who can input at this stage as the court is 'closed' to all others, including L&D, yet this is included in the LDIP as a reporting metric.

Discussion and conclusion

This research aimed to understand how L&D for children was being delivered, how it worked, for whom, and under what circumstances. Here we provide a commentary on the findings, and the full research papers will be published separately. The research identified that improving the experience and outcomes for children who have contact with L&D services requires both short- and long-term strategic change that focus on implementation issues but also core changes to the L&D model. The recommendations that are set out below have been shared with NHS England to inform further commissioning decisions.

Several key adjustments can be made to enhance the effectiveness and clarity of L&D services for children. A primary recommendation is the integration of the four core approaches – procedural justice, child-centred care, trauma-informed practice, and non-labelling – alongside the three organisational strategies – a well-trained workforce, a coordinated response, and strong partnership working – identified by the RRR. These approaches are fundamental in achieving positive outcomes for children in contact with L&D services. By embedding these principles more explicitly into L&D guidance, providers can better understand how L&D services facilitate change, allowing

them to make informed implementation decisions tailored to local contexts. This aligns with research highlighting the importance of evidence-based, context-sensitive approaches to implementation (e.g. Dryden Palmer et al., 2020). Currently, variability in interpretation leads to inconsistent service delivery and this would promote uniformity in practice while allowing flexibility for local adaptations, thus maintaining fidelity to the model's core principles.

Furthermore, revising the service specification and LDIP is essential to eliminate ambiguities, particularly regarding definitions of case identification, screening, assessment, and the engagement period of 12 weeks. This may encourage sites to move away from using a 'signposting' model, although this may have resource implications. Currently, missing and erroneous data severely limit the ability to monitor provider performance and understand levels of need. Accurate data collection is crucial for informed commissioning decisions and continuous service improvement. Clarifying these aspects can reduce confusion among practitioners and improve consistency in service delivery. Support and encouragement from commissioners, alongside accountability measures, such as regular contracting meetings, would further reinforce this improvement.

A particularly transformative recommendation is to reconsider L&D's current all-age model. Developing a child and young person-specific service would enable commissioners to design interventions and allocate resources specifically for this group. This approach recognises the unique developmental needs of children and the importance of early, targeted interventions to prevent escalation. A comprehensive review of how L&D services operate within existing children's services is needed to avoid duplication of effort. A national evaluation could help identify overlaps and gaps, leading to a more integrated and streamlined service delivery model.

Strengths and limitations of the evaluation

The strengths of this evaluation include the variety of data collection methods, conducted across a range of evaluation sites. This meant that the data covered a multitude of delivery and implementation variations. As the research took a realist approach, it can account and help understand these contextual complexities. However, this must also be balanced with the limitations. It was not possible to include the voices of children and their families. Our plan had been to utilise their relationships with the L&D teams, however over the course of the study it became clear that the L&D teams did not have an ongoing relationship, often only having face-to-face contact at the point of assessment. This is a major shortcoming, and we suggest that any recommendations be viewed considering this and that any changes to L&D involve consultation with children and families. While the data collection methods

were varied, providing breadth, for the small number of evaluation sites, providing depth, the complexities and nuances of L&D implementation cannot be underestimated, and therefore it is likely that this evaluation will have missed or not captured some important ways of working.

This research suggests the need for a comprehensive approach to reform L&D services for children. In the short term, clarifying guidance, enhancing accountability, and improving data quality can create a more effective and transparent service landscape. Long-term strategies, including potentially moving away from an all-age model, indicate a forward-thinking approach to children's justice and health support.

However, implementing these recommendations requires careful consideration of resource implications, workforce training, and inter-agency collaboration. Policymakers must ensure that changes are supported by sufficient funding and that all stakeholders, including children and their families, commissioners, service providers, and community partners, are engaged in the transformation process. Additionally, ongoing evaluation and research are necessary to measure the impact of these changes and inform future policy adjustments.

Disclosure statement

Author Prathiba Chitsabesan is National Clinical Director for Children and Young People's Mental Health (NHS England).

Funding

This research is funded by the National Institute for Health and Care Research (NIHR) Policy Research Programme (project reference NIHR 203821). The views expressed are those of the author(s) and not necessarily those of the NIHR or the Department of Health and Social Care; National Institute for Health and Care Research [NIHR 203821].

References

Disley, E., Gkousis, E., Hulme, S., Morley, K. I., Pollard, J., Saunders, C., & Sutherland, A. (2021). *Outcome evaluation of the national model for liaison and diversion*. RAND. https://www.rand.org/pubs/research_briefs/RBA1271-1.html

Disley, E., Taylor, C., Kruithof, K., Winpenny E., Liddle, M., Sutherland, A., Lilford, R., Wright, S., McAteer, L., & Francis, V. (2016). Evaluation of offender liaison and diversion trial schemes. *RAND*. https://www.rand.org/content/dam/rand/pubs/research_reports/RR1200/RR1283/RAND_RR1283.pdf

Dryden Palmer, K. D., Parshuram, C. S., & Berta, W. B. (2020). Context, complexity and process in the implementation of evidence-based innovation: A realist informed review. *BMC Health Services Research*, *20*(1), 81. https://doi.org/10.1186/s12913-020-4935-y

Greater Manchester Collaborative Commissioning Network. (2021). *Greater Manchester children and young people youth justice emotional wellbeing mental Health pathway project*.

Kane, E., Evans, E., Mitsch, J., & Jilani, T. (2020). Are liaison and diversion interventions in policing delivering the planned impact: A longitudinal evaluation in two constabularies? *Criminal Behaviour and Mental Health*, *30*(5), 256–267. https://doi.org/10.1002/cbm.2166

Lennox, C., Shaw, J., Senior, J., Chitsabesan, P., Hughes, N., & Barrett, K. (2022). *A rapid realist review of how liaison and diversion schemes produce health and justice outcomes for children and young people, in what circumstances and why?*. International Prospective Register of Systemic Reviews. https://www.crd.york.ac.uk/prospero/display_record.php?RecordID=335317

Ministry of Justice. (2019). Youth custody service, Department for Education, Department of Health and Social Care, and NHS England and NHS improvement. *The Youth Justice Population and Entering the System*. http://data.parliament.uk/writtenevidence/committeeevidence.svc/evidencedocument/justice-committee/children-and-youngpeople-in-custody/written/106180.html

Scott, D. A., McGilloway, S., Dempster, M., Browne, F., & Donnelly, M. (2013). Effectiveness of criminal justice liaison and diversion services for offenders with mental disorders: A review. *Psychiatric Services*, *64*(9), 843–849. https://doi.org/10.1176/appi.ps.201200144

Wong, G., Westhorp, G., Manzano, A., Greenhalgh, J., Jagosh, J., & Greenhalgh, T. (2016). RAMESES II reporting standards for realist evaluations. *BMC Medicine*, *14* (1), 96. https://doi.org/10.1186/s12916-016-0643-1