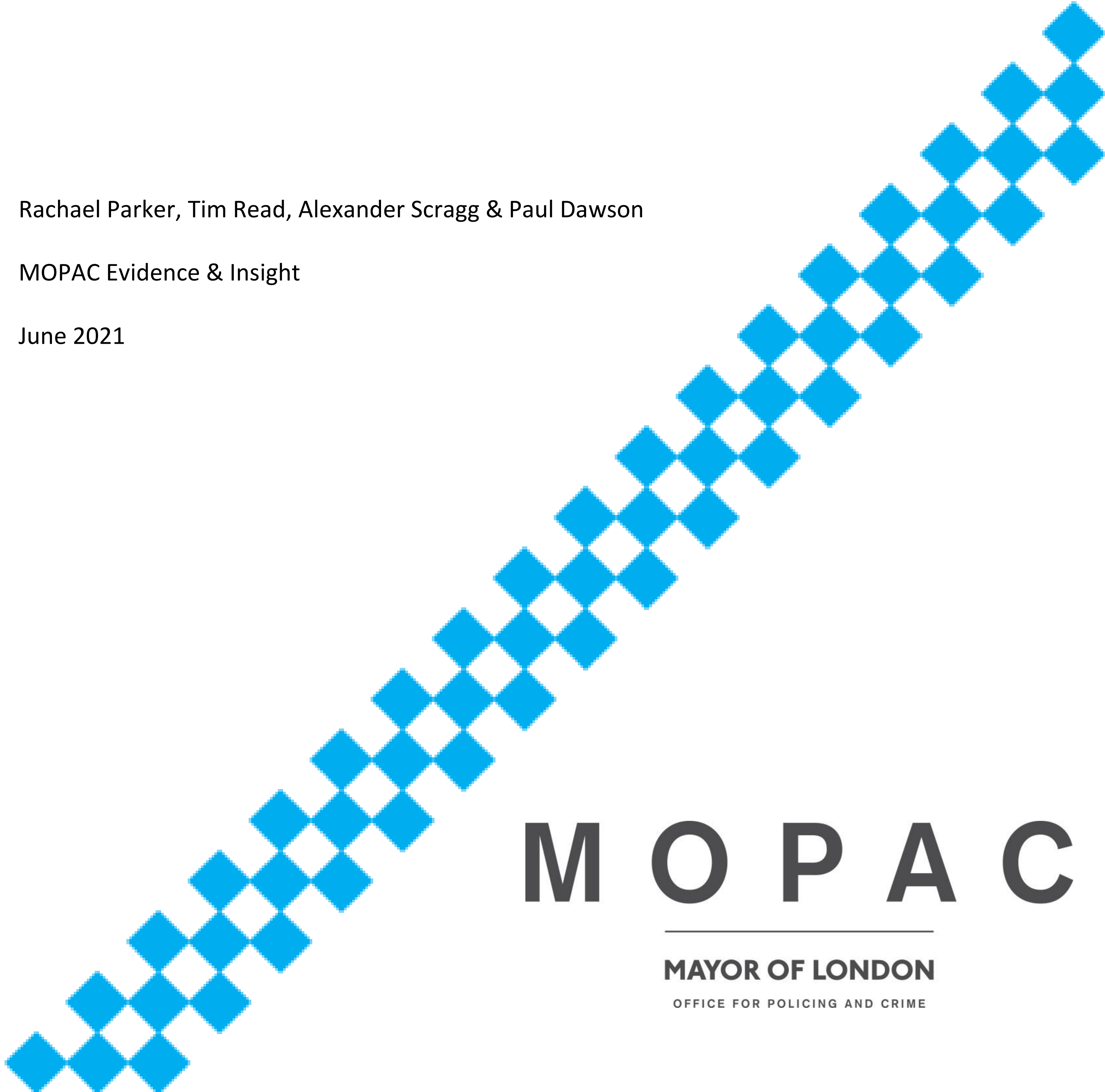
The Lighthouse: Final evaluation report

Rachael Parker, Tim Read, Alexander Scragg & Paul Dawson

MOPAC Evidence & Insight

June 2021



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Executive Summary

The Lighthouse, London's Child House, opened at the end of October 2018 initially as part of a two-year pilot, although now funded until March 2022. Bringing together a range of organisations under one roof, the Lighthouse is a child friendly, multidisciplinary service for victims[1] of Child Sexual Abuse and Exploitation (CSA/E). Based in Camden, it serves the five surrounding North Central London boroughs of Barnet, Camden, Enfield, Haringey and Islington.

The Evidence and Insight (E&I) Unit are the Mayor's Office for Policing and Crime's (MOPAC) in-house social research and analytical team and were commissioned to evaluate the Lighthouse. The E&I evaluation focuses on four distinct areas for analysis; a performance review; a process evaluation; impact evaluation and an economic evaluation. This report brings the evaluation to a close.

Results

Summary of performance insights

- Between the end of October 2018, when the Lighthouse launched, and the end of March 2021 there were a total of **889 referrals to the service**, which works out as an average of around 30 referrals per month, slightly lower than anticipated. Out of the total referrals – the majority were female (82%, n=730), with over half in the older age group between 13-17 years (57%, n=505).

- Between the end of October 2018 and the end of March 2021 the service carried out **510 Initial Assessment (IA).** This calculates at an overall conversion rate of referral to IA at 57%.

- Of these cases receiving an IA (and whom consented, n=360) the demographics were similar to the overall cohort of referrals. The majority were female (85%, n=306); an average age of 13; nearly half were between 13-17 (n=171, 48%). Of these, ethnicity data was recorded for 301 service users and there was a fairly even split between BAME and non-BAME clients (n=161, 53% and n=140, 47% respectively).

- In terms of vulnerabilities – **84%** (297/354) of those receiving an IA were reported to present at least one type of vulnerability (at a total of 793 vulnerabilities with an average of 2.7 each). 201 (68%) of these service users have at least 2 types of vulnerability. Among the most frequent categories of vulnerability were anxiety and/or depression (60%, n=121), followed by history of domestic violence (55% DV, n=110) and education problems (41%, n=82).

- Across the Lighthouse lifespan there was a considerable amount of delivery – at a glance the data indicates:

  - A total of **4780** telephone, video or face to face sessions.
  - **936** professional meetings (excluding strategy and consultation meetings).

[1] Referred to as victims throughout the remainder of the report.

- There were **29** psychologist-led ABE (Achieving Best Evidence) interviews that took place at the Lighthouse (averaging at 1.6 per month).[2] Over the same period there were 43 police led ABE interviews at the Lighthouse.[3]
- The Lighthouse made **91** onward referrals to local services, most commonly within the voluntary sector (34%, n=31), followed by Social services (26%, n=24).
- Between April 20 and March 21, **137** strategy discussions that took place and **118** consultations delivered by the Social Care Liaison Officers (SCLOs).

Summary of learning from implementation

- Overall, the pilot was well implemented. Staff, partners, children & young people (CYP) and parents were positive about the general service. As expected, given the size and scale of the Lighthouse, the pilot experienced several implementation and maturation challenges – some of these were required and indeed instigated by staff, others were due to wider factors that staff had to work around, and these resulted in changes to the model and often staff not working in a way initially envisioned. However, staff responded well, and although some aspects were not totally addressed, many were resolved over the duration of the pilot.

- Implementation of the Lighthouse was heavily disrupted by the CV-19 pandemic. In response, considerable changes were made in order to deliver the pilot – and to the credit of staff the service continued. Indeed, many of these virtual changes became embedded into the routine way of working, but overall staff felt that virtual working whilst necessary, was lacking therapeutically compared to face to face.

- Overall, partnership working was a resounding positive to emerge from the evaluation, appearing to bring a wide range of benefits to the service as well as the clients – something supported by specific roles (Police Liaison Officer [PLO], Social Care Liaison Officer [SCLO]) that enabled such a way of working. However, it is clear some tensions as a result of different organisational cultures and working practices were evident which were not able to be fully reconciled over the pilot duration. This serves to illustrate how such working cultures are very difficult to avoid and should be borne in mind when devising and running any similar programme.

Exploring impact of the service

- In order to explore the question of *'impact'* the evaluation seeks to triangulate across a range of data sets. This is the most suitable approach given the limitations across timeframes, sample sizes and methodology. The analysis sees the Lighthouse compared to a Business as Usual (BAU) service from a nearby geographic area – North East London (NEL) – across issues such as performance, referrals and Criminal Justice Outcomes. Key results indicate:

  - As expected, Lighthouse reached a far larger number of clients and delivered far more outputs compared to the BAU site.

  - Emotional Wellbeing outcome data is variable across sites, however comparing available data between Lighthouse and NEL indicates 89% of Lighthouse goals were achieved or partially achieved – whereas for NEL there were improvements in 47% of

[2]There were more psychology led ABEs planned between April and June 2020, but a number were cancelled due to family anxiety about travelling in for an interview during COVID lockdown.

[3] The Lighthouse is contracted to offer 3 psychologist-led ABEs a month.

outcomes (see Appendix for full breakdown of outcome results). This is a significant difference although caveats should be borne in mind.

- Upon comparing two key outcomes of cases progressing through the Criminal Justice System (charge and conviction) there was almost no difference between Lighthouse and NEL two groups. The Lighthouse cases had **7%** (n=6) cases charged by the Crown Prosecution Service (CPS) and a **5%** (n=4)[4] conviction rate; compared to NEL who had **6%** (n=4) charged by the CPS and **a 4%** (n=3) conviction rate. The analysis was limited by the proportion of cases progressing through the CJS and the sample sizes.

- Comparing across a range of investigative actions between the two groups, there were some positive and encouraging findings. For example, the Lighthouse had significantly higher instances of positive investigative actions such as increased suspect arrests (44% vs 27%, $p<0.05$), and proportion of cases submitted to the CPS (24% vs 10%, $p<0.05$). Additionally, more early investigative advice was sought from CPS as compared to NEL; something that was actively worked on between Lighthouse and CPS during the pilot through case progression meetings.

- The qualitative data obtained indicated that staff, parents and clients themselves all spoke very positively about the impact of the service.

Exploring the economics

- Economic analysis was commissioned out and completed by RQ. They provided an indicative cost-benefit analysis (CBA) which involved exploring the benefits of the Lighthouse against the costs associated with setting up and delivering the Lighthouse. This was then compared against a comparison group and a difference-in-difference analytical approach which estimates the differential effect of the Lighthouse on its service users.

- The overall costs of the Lighthouse pilot comprise the annual operating costs of **£2.387m** per year[5] plus the one-off capital costs of refurbishment, installation of IT and infrastructure (**£3.9m** allocated to cover a period of eight years at **£0.49m** per year). This equates to **£2.88m** per year in total.

- With this overall cost, and 420 clients per year, the unit costs for the Lighthouse are of the order of **£6,860**. Costs of a Havens service were estimated at **£4,925 per case**.

- Unfortunately, despite development of a comprehensive dataset for monitoring performance and utilisation rate, accurate data on many outcomes is not available.

- Outcome measurement is particularly challenging for CSA services due to the complexity of the recovery with every child's journey likely to be different.

- This total cost can then be set against the wider social value identified across three broad areas: wellbeing to the client, useful savings from public sector spend and additional public sector spend on essential activity.

- These results show that there is a financial return to the public sector from the operation of the Lighthouse, with a net gain in public expenditure per client of £14,570. The ratio

4 One of the guilty outcomes includes two suspects within the same case (both convicted).
5 Comprising the costs of directly employed staff, diagnostic equipment, drug costs, clinical supplies and IT, and overheads together with rent, service charge and rates (£0.38m per year), and police and social care costs (£0.28m per year).

between future savings and cost of the intervention is 3.12 : 1.0 (calculated as £21,430 ÷ £6,860). However, the comparator scheme also shows a good financial return, with a net gain in public expenditure per client of £9,460. The ratio between future savings and cost of the intervention is 2.92 : 1.0 (calculated as £14,385 ÷ £4,925). These were calculated over a period of 30 years.

- The calculations suggest that the use of the Lighthouse compared to the Haven costs perhaps £1,935 per case more, but saves an additional £7,000 on future public expenditure, and improves wellbeing by an additional £10,300[6].

Conclusion

This report brings the 3-year evaluation of the Lighthouse service to a conclusion. This was a substantial project, spanning 4 reports, and comprised of a multi-method action research approach incorporating the views of over 200 individuals (staff, clients etc…), performance analysis, wider analysis on outcomes as well as economic methods.

Lighthouse received 889 referrals and completed 510 IAs over the evaluation. Clients were highly vulnerable. There was considerable delivery of services. Overall, perceptions towards the Lighthouse were positive across all groups. Implementation was good, and whilst not entirely as expected this was often due to staff agency in reacting to unexpected challenges as well as wider issues out of their control. There was a huge effort in response to CV-19 to continue the service and many aspects of virtual working became embedded into routine practice. Partnership working emerging as a critical benefit, although some organisational tensions remained throughout. Exploring impact triangulated across a range of data – compared to a BAU; Lighthouse delivered more, had more positive wellbeing outcomes, had more positive investigative actions but no difference in terms of charges or convictions. Cost data indicated that Lighthouse was more expensive than the BAU but may be able to generate a more positive financial return over a long time period.

The evaluation is the largest of its type in the country and has generated a wealth of useful information for practitioners, staff and wider academics within the CSA/E field. There is a need for continuing research into the impact of the Lighthouse, particularly around criminal justice outcomes because of the small number of cases available. Safeguarding will remain a key issue for London and beyond and it is hoped the findings herein can contribute to keeping young Londoners safe and protected.

[6] Details of the calculations that underpin these figures are provided in Appendix F of this report

Glossary of Acronyms

ABE	Achieving Best Evidence
ACE	Adverse Childhood Experience
BAU	Business As Usual
CAMHS	Child and Adolescent Mental Health Services
CBA	Cost-Benefit Analysis
CMS	Case Management System
CPS	Crown Prosecution Service
CRIS	Crime Record Information System
CSA	Child Sexual Abuse
CSE	Child Sexual Exploitation
CYP	Children & Young People
DfE	Department for Education
DWP	Department for Work and Pensions
E&I	Evidence & Insight
HMCTS	Her Majesty's Courts and Tribunals Service
IA	Initial Assessment
LTFI	Letting the Future In
MASH	Multi-Agency Safeguarding Hub
MOPAC	Mayor's Office for Policing and Crime
MPS	Metropolitan Police Service
NEL	North East London
NFA	No Further Action
NHSE	National Health Service England
NSPCC	National Society for the Prevention of Cruelty to Children
P&R	Protect & Respect
PLI	Psychologist-Led Interview
PLO	Police Liaison Officer
RCADS	Revised Children's Anxiety and Depression Scale
SCLO	Social Care Liaison Officer
TSCC	Trauma Symptom Checklist for Children
UoB	University of Bedfordshire
VRI	Video Recorded Interview

Acknowledgements

MOPAC E&I would like to thank all the practitioners, stakeholders and service users who gave up their time to share their views and perspectives with the evaluation team. In particular we would like to thank;

Staff at the Lighthouse, particularly Emma Harewood, Georgia Johnson, Meta Madden, Vicky Mattison, Prince Nwanguma, Martin Slack and Eimear Timmons.

Chloe Collins at NHS London, Dr Anna Riddell at the Royal London Hospital and Justine Wilson-Darke at Barnardos.

Claire Bethel and Neil Reeder at RedQuadrant for their work on the cost benefit analysis.
Dr Helen Beckett, Claire Soares and Dr Camille Warrington at the University of Bedfordshire for undertaking the service user evaluation.

Our policy colleagues in MOPAC (particularly) Gareth Linington and Dean Nevill.

The following colleagues at Evidence and Insight for their assistance with the research;
Lynne Conroy and Dr Zoe Hobson for their earlier work on the evaluation,
Barry Charleton and Emanus Prospere for their assistance coding CJS cases,
Laura Duckworth for help with transcription and analysis,
Valerie Forrester for providing CSA data.

The members of the Lighthouse Academic Advisory Board for their advice and guidance;
Professor Simon Hackett,
Dr Julie Harris,
Dr Katrin Hohl,
Professor Liz Kelly,
Professor Michael Lamb,
Lisa McCrindle.

1. The Lighthouse evaluation

Background

This report presents the findings of a three-and-a-half-year evaluation of the Lighthouse, London's Child House – an innovative service to support victims of Child Sexual Abuse and Child Sexual Exploitation (CSA/E). This first section provides an overview of the rationale of the model and the previous evidence relating to it.

The Lighthouse, London's Child House, opened in October 2018 initially as part of a two-year pilot, although funding was subsequently extended until March 2022. Bringing together a range of services (medical, social care, police, advocacy and therapeutic support) under one roof, the Lighthouse is a child friendly, multidisciplinary service for victims and survivors of CSA/E. Based in Camden it replaces the existing services[7] and serves the five surrounding North Central London boroughs of Barnet; Camden; Enfield; Haringey; and Islington.

The Lighthouse builds on the CSA Hubs but offers enhanced support to children and young people (CYP) aged between 0 – 18 years old (or those aged over 18 to 25 years of age with learning delay or disability for whom a child or young person-oriented service appears more suitable), as well as non-offending parents/carers/family for up to two years. The service is provided by University College London Hospitals National Health Service Foundations Trust (UCLH) in partnership with the Tavistock and Portman National Health Service (NHS) Foundation Trust and the National Society for the Prevention of Cruelty to Children (NSPCC). It offers a joined-up approach where, if required, service users can get access to medical, social care, police, advocacy and therapeutic support 'under one roof' (for example, the service has two dedicated Metropolitan Police Service (MPS) liaison officers (PLOs) and two Social Care Liaison officers (SCLOs) working from the building).

Levels of CSA and CSE in England and Wales

Measuring the scale and nature of child sexual abuse is challenging. While administrative data sources do not represent the full scale of the issue, these sources of information can provide some indication of the resources needed to support the child protection system.

In 2018/19, there were 73,260 sexual offences against children recorded by the police in England and Wales, a 3% increase compared to the previous year (70,869 sexual offences recorded in 2017/18). In 2018/19, there were 30,720 assessments following a referral to local authority children's services in England where sexual abuse was identified as a factor and 18,720 assessments where sexual exploitation was identified as a factor. At the end of March 2019, 2,230 children (2 per 10,000) in England were subsequently the subject to a child protection plan with a primary concern of sexual abuse, a 2% increase from the previous year.[8]

Turning to London, in 2020/21 the MPS recorded 1,891 offences flagged as child sexual abuse, an increase of 20% compared to the previous year, and 4,357 sexual offences involving a victim aged under 16, a decrease of 18% compared to the previous year. The same year the MPS recorded 1,004 CSE offences, an increase of 55% compared to the previous year.

It is unknown how much of these increases are due to an escalation in prevalence; improved police recording; or a reflection of an increased willingness to report abuse following high profile

[7] NB CYP Havens continue to provide the acute/Forensic Medical Exam (FME) service.

[8] Source: Child sexual abuse in England and Wales - Office for National Statistics (ons.gov.uk)

cases in the media. Regardless, the critical aspect is the substantial increase in demand. Given the prevalence of CSA/E, it is increasingly being recognised as a public health problem (Brown *et al*, 2011), impacting substantially on long-term outcomes including physical health (Bellis *et al*, 2014). The road to recovery following CSA/E is complex and requires specialist care and tailor-made support. However, this is not the routine provision - services are often delivered from a variety of agencies including, but not limited to: the NHS; police; and other criminal justice agencies; children's social care; and agencies from the voluntary and community sector; making care disjointed. Concerns were raised in 2015 by the Office of the Children's Commissioner, as only around one in eight victims of sexual abuse come to the notice of statutory authorities (Children's Commissioner for England, 2015).

In response, NHS England (London region) commissioned the *"Review of Child Sexual Assault Pathway for London"*, to map the various pathways for CYP following CSA. Findings from the London CSA Review highlighted variation in the available services across all London boroughs and gaps in medical provision, emotional support and the prosecution process. The report made recommendations advocating the need to establish better overall services for CYP who have experienced CSA/E (Goddard *et al.* 2015). A direct result of the review was the introduction of Child Sexual Abuse Hubs (CSA Hubs) across London. Designed and built on good practice, they created virtual teams of CSA/E experts in local areas. In 2016, two NHS sector Hubs were established, the first located in the North Central NHS sector and a second established in Southwest London. These provided medical and short-term emotional support for victims of CSA/E and an integrated response for the families, but the police and social care were not directly involved. However, the London CSA Review identified a better approach would be to introduce 'Child Houses' to London (Goddard *et al*. 2015).

Child House

Child House is the term that refers to the British model for survivors of CSA based on international best-practice. Initially developed in the US in the 1980s, the Child Advocacy Centre (CAC) model was proposed as a solution to many problems associated with standard responses to CSA, including: lack of therapeutic services; low conviction rates; traumatic investigation processes; and inter-agency conflicts (Herbert and Bromfield, 2016). Research into CACs in the US found positive results, particularly around reducing the trauma experienced by victims of CSA and improving levels of satisfaction with the overall service for both children and parents (Elmquist *et al*, 2015).

Barnahus (Children's House), a model used in Iceland since 1998, was inspired by the CACs (although there are some differences in service delivery between CACs and a 'Child House' model). Barnahus is a child-friendly, interdisciplinary and multi-agency centre where different professionals work under one roof in investigating suspected CSA cases and providing appropriate support for victims (Children's Commissioner for England, 2016).

The main components of the Barnahus model are:

- A home-like setting with all services delivered under one roof;
- Helping victims disclose abuse through exploratory interviewing, conducted by child psychologists;
- Use the least possible number of interviews conducted by child-expert staff;
- Improved evidence through the reduced need for children to testify in court; and
- Guaranteed and rapid access to therapy for abused children.

Compared to before and after its inception, the initial Icelandic Barnahus model was considered to yield positive results across many outcomes, such as: improved partnership working between

police and social services; improved therapeutic outcomes for children and their families; improvements in children's and families' experiences of the criminal justice process; and improvements in the quality of investigations; trebling the number of perpetrators charged; and doubled the number of convictions (Children's Commissioner for England, 2016). As a result, the Barnahus model has since been adopted in several other countries such as Sweden, Norway and Denmark. The EU Promise project brings together research across European pilot countries and provides standards, learning and best practice.[9] However, although findings across these later adaptions appear to be relatively positive, most evaluations are based in the US and the CAC model, rather than on Barnahus. In addition, previous evaluations primarily concentrate on the underlying processes, with fewer robustly assessing impact or economics. This is a considerable gap in research learning and one that the current evaluation has sought to address.

The Lighthouse - a Child House for London

Following the London CSA Review, NHS England (London region) approached MOPAC for support with a bid to the Home Office Police Innovation Fund, initially to pilot two Child Houses in London. The joint bid was successful, and funding was awarded in April 2016. The Child Houses subsequently formed a commitment within the new Mayor's Police and Crime Plan (2017 – 2021), as part of keeping London safe for CYP. The Mayor and Home Secretary announced the plans for two Child Houses in September 2016, originally anticipated to open in April 2017. When deciding on service location there were several criteria used, one of the key aspects being a suitable property to house multi-agency services. Other considerations were the state of readiness of the NHS Sector with regards to seeing Child Abuse as a high priority, and a wider prevalence of CSA in those areas.

Based upon these, a decision was made to develop services in the North Central London NHS Sector and the Southwest. However, it became apparent there was insufficient funding to run across both sites. A decision was made to proceed with one location, making it possible to include the enhanced staffing levels; an extension of the service to 18-25-year-olds with additional needs; extended opening hours; and consideration of accepting neighbouring sector/out of sector referrals. In deciding the one location - again, criteria were employed (i.e., need; strategic alignment of the wider health community; existing clinical leadership; demand projections; premises availability) and it was decided that North Central London was best place to proceed with the pilot. Although based in a Camden property, the service would take referrals from Barnet; Camden; Enfield; Haringey; and Islington. This geography would form a coherent area and the boroughs presented a substantial demand – with 2016/17 MPS data indicating a total of 683 victims of sexual offences aged 17 or under. Borough level data showed each area had seen a steady increase in MPS CSA/E figures, with Barnet the largest increase of 61% in yearly totals. Enfield the highest levels overall and Islington and Camden had consistently the lowest levels of CSA among the North Central boroughs.

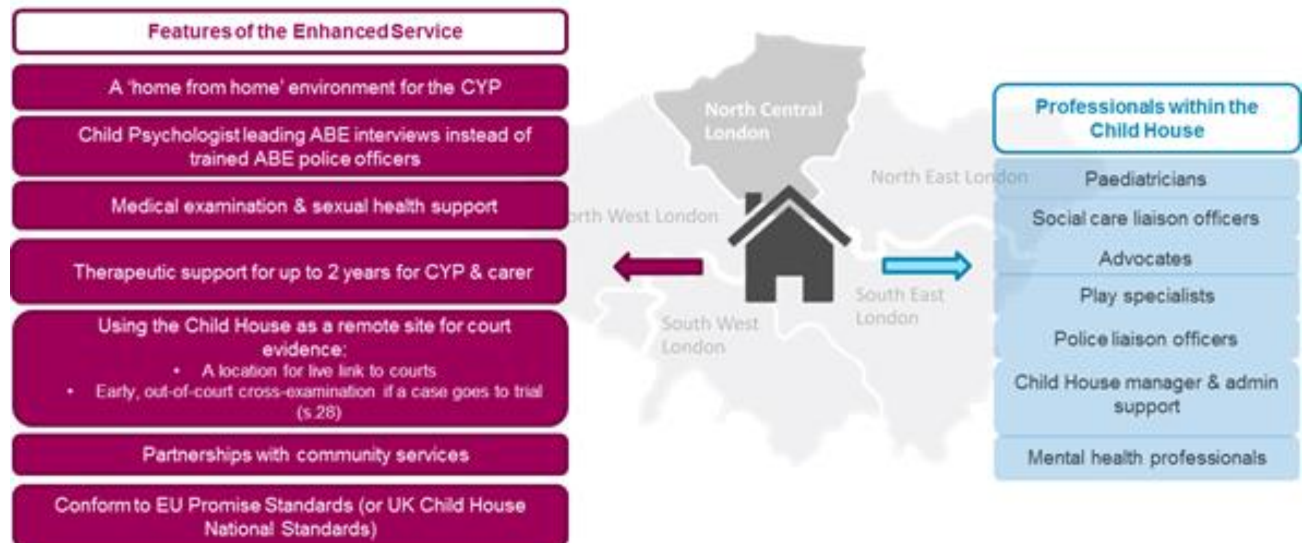
In February 2018, the commissioned contract was awarded to the University College London Hospitals NHS Foundations Trust (UCLH) and their sub-providers, brought in to deliver specialist elements of the service, namely - the Tavistock and Portman NHS Foundation Trust; the NSPCC. Delivery of what was initially to be a two-year pilot (subsequently extended by 18 months) was to follow a six-month mobilisation period.

The Lighthouse provides enhanced support to CYP aged between 0 – 17 years old (or those between 18-25 years of age with learning delay or disability for whom a child or young person-oriented service appears more suitable), as well as non-offending parents/carers/family for up

[9] https://www.promise-project.eu/

to two years. It offers a joined-up approach where, if required, the CYP can get access to all medical; practical; social care; police; and therapeutic support 'under one roof', although the CYP Havens continue to provide the acute/Forensic Medical Exam (FME) service. Figure 1 below provides a summary of the service provided by the Lighthouse.

Figure 1: the Lighthouse model



Included within the Lighthouse model above are a number of roles which are self-explanatory (such as Paediatricians, Play Specialists and Mental health professionals), however there are other unique roles at the Lighthouse:

- The CYP's **Advocates** support the service users throughout their time with The Lighthouse, ensuring that the voice of the child is heard by professionals within and outside of the Lighthouse. They can be involved at any stage of the pathway including: a show around prior to first appointment, work with the young person outside of the Lighthouse before attending, support on the day of their evidential interview following Achieving Best Evidence (ABE) guidance, at the initial assessment (IA), advocating with school, social care and the police; and finally, a key role in support throughout the police investigation, court preparation and support during the trial. The advocates are trained Independent Sexual Violence Advisors (ISVAs).
- **Police Liaison Officers (PLOs)** bring criminal justice expertise in child abuse investigations to the Lighthouse and assist with the flow of information between organisations at policy and individual case level. They also manage the Psychologist-led (PLI) interview process and provide safeguarding advice to outside agencies.
- **Social Care Liaison Officers (SCLOs)** triage the referrals that come into the Lighthouse, ensuring all appropriate information has been received from the referrer. They also act as a go-between for Lighthouse and borough social care teams and provide expert advice and support in safeguarding to the local teams.

The Lighthouse pilot set out to meet the following outcomes:

- Enhanced referral pathways into and out of the Lighthouse,
- Enhanced CYP, family and carer experience of support received post disclosure, Enhanced CYP experience of the criminal justice process post disclosure,
- Enhanced mental health and well-being outcomes for CYP,

- Enhanced professional awareness, competence and confidence,
- Increased likelihood of charge or conviction for those cases within the Lighthouse,
- Enhanced partnership working, and
- To provide CSA victims with care and support to reduce the long-term impact of victimisation.

The Evidence and Insight (E&I) Unit is MOPAC's in-house social research and analytical team which has been commissioned to undertake a multi-year mixed methods evaluation of the Lighthouse. This is the fourth and final E&I evaluation report [10] and in presenting closing results seeks to provide valuable learning for many interested parties, related to not only the Lighthouse, commissioners, but wider areas such as CSE, as well as playing a significant contributor to the national and international evidence base.

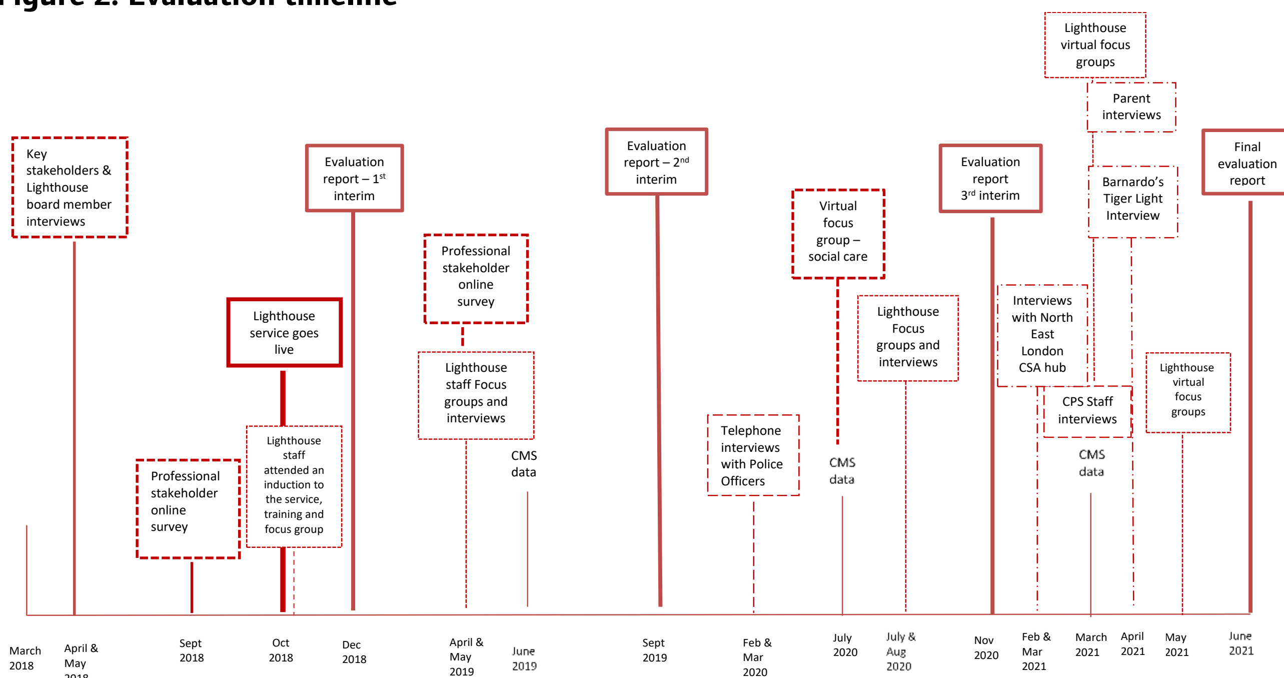
Methodology

This section sets out the methodology used within the evaluation. Overall, a broad *action research* perspective was utilised (Avison *et al*. 1999). That is, findings are continuously fed back to the programme teams, the academic advisory group, to the official Partnership Oversight Board and other relevant meetings to ensure learning is continually shared as part of an active feedback loop. To note, this has led to many practical improvements being made to the service during the evaluation timeframe and could well be seen as best practice in how an evaluation can actively support a programme over the duration.

The evaluation used a mixed methodology approach – balancing qualitative context from staff, stakeholder or service user feedback, with 'harder' performance figures indicating how the service is running on a day-today basis. It focuses on four distinct areas; **performance insights; process; impact and economic analysis.** See Figure 2 below for the overall timeline for the evaluation.

[10] The previous evaluation reports can be found on MOPAC's website at:
https://www.london.gov.uk/sites/default/files/childhouse_jan19_report.pdf
https://www.london.gov.uk/sites/default/files/2019_117_childhouse_2nd_evaluation_report_for_publication.pdf
https://www.london.gov.uk/sites/default/files/childhouse_nov_2020_interim_evaluation_report_for_publication.pdf

Figure 2: Evaluation timeline



The methodology behind each of these will now be expanded upon.

Performance management data

Performance data is a key ingredient in understanding the basic delivery of the Lighthouse – that is - what has been delivered, when, and to whom. The evaluation team had several data sources to contribute to the performance insights covering the entire length of the evaluation (end of October 2018 to March 2021). Firstly, aggregate data was provided by the Lighthouse Data Officer which included total referrals by month, referring borough and referral source, as well as the age categories and gender of the CYP. The second, and more comprehensive, data source was individual-level data produced from Excelicare (Lighthouse's case management system [CMS] devised specifically for the service). This data was for **all clients who consented to** have their data used in the MOPAC evaluation and included detailed information on their demographics, vulnerabilities and risk. Additional data on service activities (such as open cases to services, onward referrals, numbers of consultations and meetings with professionals and service users) was also provided by the Lighthouse through their quarterly monitoring returns which date back to October 2019. Overall, this data was able to provide the evaluation with an excellent description of the core programme details and cohort over time.

Qualitative fieldwork undertaken during the evaluation

Over the duration of the evaluation - a key aspect has been the capture of the voices of those individuals that can provide insights into the implementation and working of the Lighthouse. This has ranged from practitioners, key stakeholders, to family members and the young people themselves. As the evaluation timeline above presents, this has spanned multiple years so to explore not just the general perceptions, but whether these perceptions have changed during the life of the programme. This capture over time was especially valuable in understanding the entire life of the programme – such as the initial set up, delivery, the impact of COVID-19, as well as exploring views towards sustainability and future working.

In total, the evaluation over the 3-year period has captured the views of **over 200 individuals** through a variety of methods. This has consisted of:

Staff focus groups and interviews

The details of the staff focus groups and interviews are as follows:

- In October 2018, all Lighthouse staff attended an induction to the service and training. Afterwards, staff were asked to participate in a focus group to explore their views of the Lighthouse; how ready they felt to open the doors to the public; training needs; and potential challenges going forward. In total, **13 staff members** attended from a potential 27 practitioners.

- Focus groups and interviews were held in April and May 2019 with Lighthouse staff to explore their perceptions of the early implementation of the Lighthouse. Data were collected from **23 individuals** (all but one staff members); **15 people** attended one of two focus groups, and in-depth face to face interviews were undertaken with **7 practitioners**, and written feedback to the interview questions was obtained from a practitioner with whom it proved impossible to arrange an interview. The staff who participated were from a range of occupations and included paediatricians, advocates, psychologists, admin staff, SCLOs and PLOs.

- Focus groups and interviews were held between July and August 2020 to explore perceptions of the implementation of the Lighthouse: undertaken face to face and virtual interviews and focus groups with **14 members** of Lighthouse staff from several teams including senior management, Letting the Future In (LTFI), PLOs, SCLOs and health staff.

- **Seven virtual focus groups** were undertaken between March and May 2021 with approximately 25 staff, including the following: the medical team, LTFI, Children and Adolescent Mental Health Services (CAMHS), a combination of SCLOs, PLOs and administrative staff, and advocates. Two further focus groups were conducted with CAMHS staff, one to specifically discuss the work that had been undertaken in the development of the parents' group, and another with the CAMHS staff who had developed their model of working.

Stakeholders and external agencies

- In April and May 2018, during the design phase of the pilot **18 face-to-face interviews** were undertaken by E&I and RedQuadrant with key stakeholders and Lighthouse board members. These interviews focused on the history of the project; procurement; commissioning; design specification; and initial implementation. To supplement the interviews, all programme board members received a short online survey to capture opinions around the design and initial implementation of the Lighthouse. In total, **13 people** responded.

- In September 2018, immediately prior to go-live, an online survey was distributed to professional stakeholders (police, charity workers, mental health practitioners, etc) who worked in the five Lighthouse boroughs with CYP who might have experienced CSA/E. The survey covered themes such as the respondent's confidence in identifying and addressing CSA and CSE, and knowledge and awareness of the Lighthouse service. A total of **54 people** responded from a range of occupations (Police Officers (39%, n=21),

Nurses (15%, n=8), Victim Charity workers (15%, n=8), Mental Health practitioner (11%, n=6) and Other (20%, n=11)). The survey was repeated in April and May 2019 asking similar questions about CSA/E, awareness of the Lighthouse, and experience of the service provided by the Lighthouse if applicable. This time there were **75 respondents**, predominantly from schools and the police but also some medical professionals.

- In July 2020 a virtual focus group was undertaken with representatives from social care from 4 of the boroughs covered by the Lighthouse and in February and March 2020 telephone interviews were undertaken with **13 police officers** and written email feedback obtained from a further **2 officers.** The focus of this work was to specifically explore perceptions of the SCLO and PLOs.

- Between February and March 2021 Crown Prosecution Service (CPS) staff working with the Lighthouse or on Lighthouse cases were interviewed to ascertain their views on the service, gauge the level of CPS-Lighthouse interaction and reveal any concerns about the service when it comes to its dealings with the CPS. Overall, **6 interviews** were conducted; two with CPS staff from the Strategy and Policy Directorate, 2 with CPS lawyers who managed colleagues working on Lighthouse cases, and 2 with CPS lawyers that had worked on Lighthouse cases. Interviews were conducted using Microsoft Teams because of COVID-19 restrictions.

- Two semi-structured interviews were conducted with staff from the North East London (NEL) CSA hub in February 2021 and the Barnardo's Tiger Light programme between April and June 2021. These enable the evaluation to offer qualitative reflections from a Business As Usual (BAU) CSA service.

Service users and parents

- A vital aspect of the evaluation was the capture of the voices of the young people themselves that experienced the Lighthouse service first-hand. This work was undertaken on E&I's behalf by staff from the Safer Young Lives Research Centre at the University of Bedfordshire[11]. In total, 11 young people were interviewed about topics such as their general perceptions of the Lighthouse (aspects of service delivery and physical space), the benefits of the model and its impact, and suggested areas for improvement. The interviews took part between May and July 2021. 28 children and young people were put forward by Lighthouse staff as potential participants. Risk and needs assessments were carried out for all. 17 of the 28 young people risk and needs assessed were not subsequently interviewed, for various reasons. All the young people who have taken part in the interviews are females aged 15+.

- Virtual semi-structured interviews were undertaken in April 2021 using Microsoft Teams with **4 parents** of children who had attended the Lighthouse, three of whom had been engaged with the Lighthouse's Parents' Group. The parents were asked for their perceptions of the service they and their child/children had received, what they thought had worked well, and areas for improvement.

[11] The University of Bedfordshire have produced a separate report which provides further detail about the methodology they developed for the service user interviews, and the findings from the young people themselves. The report ("There's something there for everyone'- Learning about the Lighthouse: Young people's perspectives on London's Child House', Beckett *et al* 2022) is available on the university's website.

Attempting to understand impact of the Lighthouse

A unique aspect of the current evaluation - when compared with comparable evaluations of such programmes - is the examination of a range of outcome measures that seek to explore the *impact* of the Lighthouse across a variety of different measures (i.e., criminal justice, health and well-being) comparing these to a BAU service provided to victims of CSA in another area of London (the CSA hub in NEL). This section outlines the broad approach to exploring impact.

It should be stated up front that exploring 'impact' herein seeks to triangulate across data sets - both in terms of the service delivery, as well as some core relevant outcomes. This was necessary because many of the traditional means of developing a counterfactual were not feasible (i.e., Randomisation was not ethical or an option). Evaluating such a locally enhanced service offer also presents challenges – as no other service is directly comparable to the same degree. To counter this, efforts were made to select the most appropriate BAU service for CSE as a broad counterfactual.[12]

As will be outlined, whilst a unique feature, exploring impact herein was not without limitations and these are acknowledged (i.e., sample sizes, timescales, particularly in relation to the criminal justice outcomes, impact of the COVID 19 pandemic) – and these should be borne in mind - but never-the-less - the results can be seen as *indicative* of what the Lighthouse was able to deliver, at what cost and how this compares to a BAU service and is able to provide valuable insights that could be built upon in future research.

The comparison group selected was NEL and the evaluation team engaged with NEL Clinical Commissioning Group (CCG) to gain an understanding of the provision there for victims of CSA/E. The services engaged with included Barnardo's Tiger Light,[13] and a service provided by a Paediatrician. NEL was selected as a comparison area for the Lighthouse due to its geographical proximity, and that the CSA Hub in that area was more established in comparison to other areas of London.

The Lighthouse and NEL are compared across performance and outcome data. These cover:

- Throughput, number of referrals, referral sources – all drawn from performance data;
- Service provision and staffing details drawn from qualitative interviews with managers;
- Service user information: age, gender, ethnicity, disability – all drawn from performance data;
- Mental health and well-being measures; and
- Criminal Justice Outcomes (i.e., charge, conviction, wider attrition through the system).

Most of the above measures are relatively straightforward, taken from routine performance data. However, it is worth outlining more detail on the Criminal Justice Outcomes. As outlined by previous E&I evaluation reports,[14] one of the methods of impact was to undertake in-depth and resource intensive case study coding on these core elements related to Lighthouse service. Given the resources required to conduct the coding, sample sizes are modest. However, this ought to be adequate for the development of insights that when paired with wider performance and outcome data can be triangulated to generate insights.

[12] C&YP who experience an acute sexual assault in London generally attend the Havens for immediate treatment and support, including a forensic examination. The Lighthouse is being set up to improve the services delivered to C&YP who are victims or survivors of non-recent CSA/E. The aim is to bring together a range of services delivered by a specialised multi-disciplinary team with outreach to a wide range of services.
[13] https://www.Barnardo's.org.uk/what-we-do/services/tiger-light-nel
[14] Conroy *et al.* (2018)

For Criminal Justice outcomes - Lighthouse cases were selected during 2019 – the rationale being that this time period enabled the programme to have had a bedding in period whilst also allowing time for cases to progress. All Lighthouse cases in 2019 were eligible if consent was given. This resulted in a total of **139** cases identified. From these 53 were deemed inappropriate for a variety of reasons,[15] leaving a final cohort of 86 cases to track relating to CJ outcomes.

The evaluation sought to identify equivalent CSA/E within NEL boroughs at a similar timeframe (i.e., cases reported to police in 2018 and 2019). To generate a comparison group, three separate queries were run on MPS systems (the Crime Record Information System – CRIS). The first was to search for victims aged under 18 and where the classification was one of rape, sexual assault, penetration female, penetration male, and CSE. The second search was to repeat the search with the same classification types, but with the victim aged 18-25 and with a recorded learning disability. The third search was to search again for victims aged 17 and under, using CSA/E to search instead of classification types (and then any duplicates from the first search were removed). These three separate searches were conducted to capture as wide a sample as possible to draw a representative sample of the referral criteria of the Lighthouse (i.e., a victim of CSA/E aged up to age 17, or aged 18-25 with a learning difficulty). Together, these searches generated a total sample of **2,955** cases.

As per the Lighthouse sample, those inappropriate were removed resulting a sample of **1,869**. Given the in-depth nature of the coding, a modest sample of 80 were randomly selected for the final coding. Comparisons were made between the sample of 80 and the wider sample. The evaluation team were satisfied with the similarities between them in terms of demographic and case type (see Appendix A for breakdown). Of these, a further 13 were excluded as there was no criminal investigation. Therefore, the final comparison sample for the analysis is **67 cases**.

In terms of these two groups, the Lighthouse and counterfactual were broadly comparable across a number of demographic and offence criteria. Overall, the Lighthouse group were slightly younger (a mean of 11 vs 14 at time of reporting); gender proportions were similar (Lighthouse 80% female vs NEL 88% female); no significant differences across ethnicity (the Lighthouse split of White and BAME victims was equal at 50% each, and for NEL there was a split of 56% white and 44% BAME). In terms of the case characteristics, there were some differences such as Lighthouse cases being more familial abuse (41% of cases compared to 19% for NEL) and NEL had a higher instance of peer on peer and stranger abuse. Full details can be found in Appendix B.

However, the evaluation was not looking for an exact statistical match, rather, the aim was to identify who would have been likely to be eligible for a Lighthouse service within the new area. This is a subtle but important difference given how local demographics and offending profiles can vary.

The coding itself involved in depth reading of the police cases (both Lighthouse and comparison) across 70 variables covering: victim characteristics; suspect characteristics; offence characteristics (the circumstances of what happened); procedural characteristics (the police response and investigation); and outcomes.[16] A coding frame was devised, piloted and four coders completed

[15] 37 were deemed inappropriate due to the type of classification where there was no investigation (e.g., Crime Related Incident, Child Care Issue, No Crime, Non-Crime CSE, Rape not Confirmed, or Rape Transferred). A further 16 cases were excluded because the dates of the criminal justice investigation did not overlap with referral and support from the Lighthouse, therefore there was no opportunity for the Lighthouse to have an impact on the outcomes.

[16] Appendix A presents the variables coded and the descriptive characteristics for the full samples.

the in-depth work, with supporting quality and reliability checks overseen by regular meetings. Analysis focused upon comparing group differences on the key outcomes of interest.

Economic analysis

Economic analysis was commissioned out and completed by RedQuadrant. They provided an indicative cost-benefit analysis (CBA) which involved exploring the benefits of the Lighthouse against the costs associated with setting up and delivering the Lighthouse. This was then compared within a difference-in-difference analytical approach estimating the differential effect of the Lighthouse on its service users.

The focus of the economic analysis is on the comparison of Lighthouse against standard forms of provision in London, in particular those considered in Harewood and Baine (editors) (2018) "*London Child Sexual Abuse Learning Report*".[17] This report examined three models funded by the London CSA Transformation Programme, all aiming to support CYP after experiencing CSA. These models were (1) the Children and Young People's Haven Service (CYP Havens) based within London's Sexual Assault Referral Centre, (2) the Child House and (3) CSA hubs.[18]

The economic analysis involved RedQuadrant:

- Collating evaluation data on key outcomes at baseline and after treatment from the Lighthouse;
- Collating data on expected levels of improvements for these outcomes from the existing literature on the after-effects of CSA/E for victim-survivors; and
- Reviewing the improvement for Lighthouse versus that identified by the literature.

The intended benefits are wide-ranging and can be categorised in a number of different ways. Some of the expected benefits are likely to be evident in the short term, others will not manifest themselves for many years – until the victim or survivor has reached adulthood, in some instances. There were three broad areas of social value set out: *wellbeing to the client*, *useful savings from public sector spend* and *additional public sector spend on essential activity*. The model sought to identify the benefits that accrue. The following domains of social value were considered:

- **Health**: This comprises sexual health, physical health and substance misuse.
- **Wellbeing**: This looks at wellbeing from the perspective of the NHS and Local Authority, the individual child or young person, and the family.
- **Children's services**: The report looks at both the possible impact on child protection action and on the need for any additional school support.
- **Employment**: CSA/E often has significant impact during adult life; the report considers the possible impact of the Lighthouse on loss of earnings and take-up of benefits.
- **Criminal justice**: The benefits examined are the costs of enforcement action against alleged perpetrators, and the impact on possible criminal activity committed by victims of CSA/E during adulthood as a result of their abuse.
- **System effects**: Better co-ordination of multi-agency services at the Lighthouse has a tendency to lead to improved productivity.

The focus of the analysis is on those categories of benefits whose effects are identifiable, measurable, both in the short term as well as long term and these have been used in turn to

[17] https://www.england.nhs.uk/london/wp-content/uploads/sites/8/2019/05/London-CSA-Services-Learning-Report-2018-v1.2-002.pdf

[18] The analysis undertaken uses data taken from both the Havens and a CSA hub (North East London). This was dictated by the quality of the cost data available.

provide an extrapolation to those benefits. The CBA model identifies the benefits that accrue compared against two hypotheses: (a) treatment under non-specialist services; and (b) under a partly integrated approach.

2. Performance insights

A core aspect of the evaluation was to monitor the performance data underpinning the Lighthouse. Performance insights have been generated at frequent intervals throughout the pilot and have enabled the evaluation to monitor overall throughput to the service, the internal workings and processes, activities, client demographics and a closer look at clients' vulnerabilities. This section will present the findings of this analysis over the lifetime of the pilot – from October 2018 to the end of March 2021 - with insight into how these aspects may have changed or developed over time. Such data is crucial in understanding what was *actually delivered*, whilst also laying the key foundations that will enable considerations around impact later in the report. The data in this section will cover the following aspects:

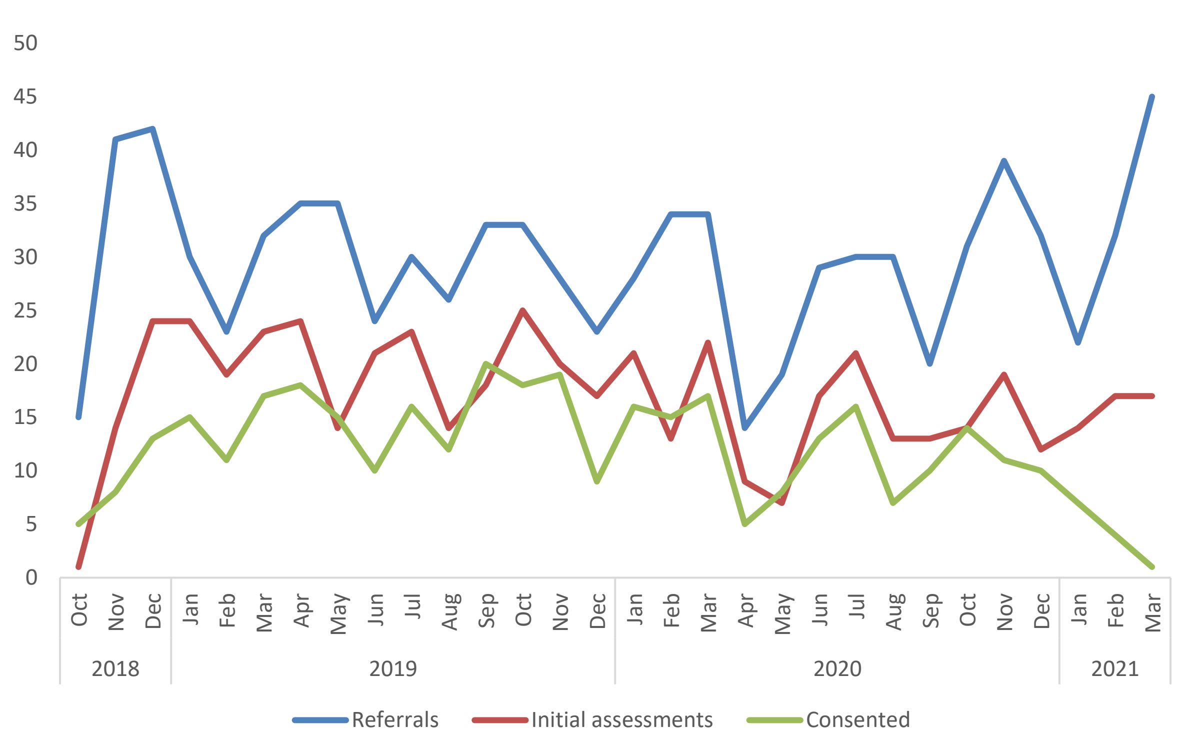
- Numbers of referrals
- Referrals by month
- Referring borough
- Referral source
- IAs at the Lighthouse
- Client demographics – for those consented
- Client vulnerabilities and disabilities – for those consented
- Offence and criminal justice overview – for those consented
- Service delivery and activities – for all clients

Referrals to the Lighthouse

Between the end of October 2018, when the Lighthouse launched, and the end of March 2021 there were a total of **889 referrals to the service**, which works out as an average of around 30 referrals per month, slightly lower than originally predicted. Out of the total referrals – the majority were female (82%, n=730), with over half in the older age group between 13-17 years (57%, n=505) – something that was a consistent finding throughout the evaluation. Further detail on demographics of the cohort is found later when exploring those who consented to the evaluation.

Between Year 1 (end of Oct 2018 and Oct 2019) and Year 2 (Nov 2019 – Oct 2020) there was a 20% decrease in total referrals from 399 to 320, however 31 of the first year referrals had originally been made to the CSA Hub, and which were subsequently transferred to the Lighthouse. The remaining decrease in referrals in Year 2 could be attributed to the Covid-19 pandemic where there was a notable decrease in referrals in April and May 2020, to 14 and 19 respectively, where up until that point the service had seen an average of 31 referrals per month. Since the end of Year 2 (November 2020) the average number of referrals has increased to 34, and March 2021 saw the highest number of referrals ever seen at the Lighthouse in one month (n=45; see Figure 3 below).

Figure 3. Total number of referrals, IAs, number of services users who consented to the evaluation.



Looking at the entire 29-month period of the Lighthouse, all 5 boroughs referred a similar proportion of CYP to the service, with only 3 percentage points between Haringey who referred the most (21%, n=184), and Camden who referred the fewest (18%, n=158) CYP. There were very few referrals outside of the core 5 boroughs or from outside of London. Looking at the pattern of referrals over time, with the exception of Barnet, all other borough referrals reduced from Year one to Year two. This was likely influenced by CV-19. See Table 1 below.

Table 1. *Referrals to the Lighthouse by borough, by year (Note - Year 3 is year to date)*

Borough	**Year 1 (end of Oct 2018 - Oct 2019)**	**Year 2 (Nov 2019 - Oct 2020)**	**Year 3 (Nov 2020 - March 2021)**	**Total**	**Percentage**
Haringey	82	67	35	**184**	21%
Barnet	76	78	25	**179**	20%
Enfield	71	65	40	**176**	20%
Islington	73	60	33	**166**	19%
Camden	84	42	32	**158**	18%
Other London Borough	13	3	4	**20**	2%
Outside of London	0	5	1	**6**	1%
Total	**399**	**320**	**170**	**889**	

Children's Social Care has consistently been the largest referral source over the length of the pilot, referring over half of all CYP to the service (52%, n=460), whereas medical sources (GPs, hospitals and sexual health clinics) made up only 6% (n=59). These patterns have remained consistent over the entire duration of the Lighthouse (see Table 2).

Table 2. *Referral's source to the Lighthouse*

Referral source	Referrals	Percentage
Children's Social Care	460	52%
Police	107	12%
Other	72	8%
Self-Referral	57	6%
CAMHS	37	4%
CYP Havens	33	4%
CSA Hub	31	3%
GP	29	3%
Hospital	26	3%
School	18	2%
Third Sector Provider	15	2%
Sexual Health Clinic	4	0.4%

One of the aims of the Lighthouse was also to provide timely support to CYP, and the Lighthouse collected information on time taken from referral to support being provided or allocated. Overall there was an average of 2 days between referral to the Lighthouse and an intake meeting[19] (as expected, due to the latter being twice-weekly), and an average of 30 days from intake meeting to an IA.

Initial assessments at the Lighthouse

Lighthouse referrals are discussed at twice-weekly intake meetings – with the SCLOs playing a key role within this process. For those referrals accepted, an action plan will be made which includes assigning the case to the primary case holder or lead practitioner and the CYP are then invited in for their IA at the Lighthouse (either face to face or virtually) where they meet with a number of Lighthouse practitioners to assess needs and decide on care plans.[20] There are many reasons why a referral did not reach an IA – for example, lacking information or CYP/parent not wanting the service or not feeling ready.

Between the end of October 2018 and the end of March 2021 the service carried out **510 IAs.** Therefore, the overall conversion rate of referral to IA overall for the evaluation period was 57%.[21]

After October 2018 (where 1 IA was conducted)[22], the level of IAs remained at an average of 18 per month and varied between 7 and 25 a month. There was a large drop in IAs in April and May 2020 (9 and 7 IAs respectively) due to the building being temporarily closed following the Covid-19 lockdown. During this time, practitioners at the Lighthouse conducted IAs virtually using an NHS system called *Attend Anywhere*. After those two months, the number of IAs recovered well, although between Year 1 and Year 2 there was still a 23% decrease (n=57). See figure 1 above.

[19] Previously called allocation meetings

[20] On average there are three professionals present at each IA (this data relates only to those service users who consented to providing their data for the evaluation), most frequently a Paediatrician (for 91%, n=327) for a medical assessment, followed by a CAMHS worker (present at 48%, n=172 of IAs), and an Advocate (47%, n=170).

[21] It is difficult to interpret whether this referral rate is appropriate or not. For the 379 referrals that did not reach an IA (yet), this could be for many valid reasons - pending further information; the CYP and/or parents/carers did not want the service; they did not meet the criteria; they received a consultation to the professional network; they attended for a VRI; they may be pending CYP availability, or the CYP are not feeling ready yet. There is somewhat of a delay between referrals and IAs and the conversion to IA may occur in subsequent months.

[22] The service opened to referrals on 23rd October, therefore it was unlikely to start seeing children until after at least a week in order to give them enough notice to attend.

A deeper look - background of clients who consented to evaluation

So far, the report has presented wholesale numbers on total throughput, but additional detail was available for those individuals whom consented for the evaluation. The performance analysis will now turn to this group. Over the entire timescale of the evaluation, there was a consent rate of 71%[23], which equates to 360 clients out of the 510 clients who reached IA. This consent rate for the Lighthouse is good in comparison to a systematic literature review which found an average 65% consent rate across 43 studies involving schoolchildren[24]. This section will provide a summary of the demographics and vulnerability for the service users who consented for their data to be used in the evaluation.

Consented cohort demographics

The demographics for the 360 service users who consented were very similar to the overall cohort of the Lighthouse, something that has remained consistent over time: the majority were female (85%, n=306); an average age of 13; nearly half were between 13-17 (n=171, 48%).

Ethnicity data was recorded for 301 service users and there was a fairly even split between BAME and non-BAME clients (n=161, 53% and n=140, 47% respectively; see table 3 below); and broadly mirrors the same splits seen across the same age groups in wider London[25] (48% White and 52% BAME). Most service users are in full-time education (81%, n=285/354), half of which are in secondary school (n=139). There are 76 CYP recorded as having issues with non-attendance (63 of which are aged 14 and over).

Table 3. Ethnic breakdown of service users

Ethnic groups	Service users	Percentage
White	140	47%
Black	70	23%
Mixed White and Black	31	10%
Asian	23	8%
Other Mixed	20	7%
Other Ethnic group	10	3%
Mixed White and Asian	7	2%

Client vulnerabilities

A variety of assessments are completed by Lighthouse staff, often at the IA stage – for example, the Adverse Childhood Experiences Questionnaire (ACE-Q). Staff will also assess and record **current** vulnerabilities of the children (such as depression, anxiety, eating disorders, drugs and alcohol) whilst also taking into account any **history** of self-harm or previous attempted suicide. Practitioners will also assess any **future risk** such as risk of suicide, self-harm, or risk to others. These are not all asked of every client and are recorded across different areas of Excelicare - so sample numbers on vulnerability data varies. However, one aspect is clear - looking across these datasets in summation the evaluation sees, as expected - a highly vulnerable client group.

[23] The consent rate improved considerably since the start of the project, where the consent rate was just 24% for the first four months. The evaluation team worked closely with the Lighthouse staff on this issue (i.e. conducted a training session around consent and the evaluation and provided visual aids for staff to use with clients to explain consent).
[24] Blom-Hoffman *et. al* (2009).
[25] Wider population data derived from "2016-based Round of Demographic Projections Local authority population projections - Housing-led ethnic group projections November 2017". © GLA 2016-based Demographic Projections, 2017.

The Adverse Childhood Experience Questionnaire (ACE-Q)[26] was completed for 222 clients[27] whose ages ranged from 1 to 25. For these service users, the ACE – with scores ranges from 0-9 – had an average of 3. The majority (n=193, 87%) of service users had a score of *at least* 1, and two in five (n=88, 40%) had a score of 4 or more. The most common ACE for the Lighthouse service users was sexual abuse (n=83, 82%),[28]followed by parents divorced/separated (n=102, 46%; see Appendix C for the prevalence of all ACEs). Putting these figures into context: Lighthouse ACE scores are above non-clinical national populations[29], but lower than other at-risk youth populations.[30]

Moving into the wider data collected at the IA stage – again, to note this data is not routinely captured on all clients. In terms of vulnerabilities – **84%** (297/354) were reported to present at least one type of vulnerability (between these 297 cases they presented a total of 793 vulnerabilities with an average of 2.7 each). 201 (68%) of these service users have at least 2 types of vulnerability. Among the most frequent categories of vulnerability were anxiety and/or depression (60%, n=121), followed by history of domestic violence (55% DV, n=110) and education problems (41%, n=82). A fifth of service users (39%, n=78) had a history of self-harm. Additionally, 22% of clients were recorded as having a disability (n=78/354)[31], with 23 (6%) having more than one. Mild (n=20, 26%) or moderate (n=19, 24%) learning difficulties were the most common forms of disability. A full breakdown of service user vulnerabilities and disabilities is presented in Appendix C.

Moving to a different dataset - risk assessments conducted by staff – again, there is a variety of valuable information captured to further the knowledge on vulnerabilities (again, the sample size varies as it is based on confirmed responses to each aspect). Risk assessment data illustrates information such as whether a service user is *currently* known to children's social services (n=65% 219/337), or whether they have *previously* been known to children's social care or early intervention support services (n=61%, 192/314).[32] The assessments also show that 39 of 322 service users are subject to care order or child arrangement orders.

Finally, there is data calculating *future risk* which further highlights client vulnerability, whereby the Lighthouse worker assessed if there is further risk to the CYP or others (see table 4 below). This was captured for 239 of those service users that consented. It is apparent that many of the service users were assessed as presenting a risk; 33% (n=82) of suicide, 46% (n= 110) self-harm, 60% (n=144) of further abuse and 10% (n=23) a risk to others.

[26] The ACE-Q is an internationally validated self-report tool encompassing 10-items across 10 areas which cover household dysfunction (parental separation/divorce, parental domestic violence, parental substance misuse and mental illness, and parent incarceration), child abuse (sexual and physical), and child neglect (emotional and physical). The ACE questionnaire has been used internationally and the original ACE study used a 10-question tool (Felitti *et al.* 1998), however the ACE-Q has sometimes been adapted by other organisations or researchers and has either been shortened or lengthened in terms of the number of items (Bethell et al. 2017)The more events that a person experienced before the age of 18, the higher their ACE 'score' will be, and literature demonstrates that the higher the score (a maximum of 10) the greater the risk of health issues (i.e., mental or physical), substance misuse, victimisation and offending in adulthood. This emphasises the importance of providing holistic, integrated support to these young people to mitigate the risk of health and lifestyle problems in adulthood.

[27] ACE-Qs were not completed for all clients due to an issue at the start of the pilot where there were issues as the service adjusted to using a new patient record system and ways of working.

[28] NB previous caveat refers.

[29] As a baseline, a nationally representative survey of adults in the UK found that 46% of respondents reported at least 1 ACE, and 8% reported at least 4. This was undertaken by Bellis *et al.* (2014) with 3885 18-69-year olds in the UK. There have also been many other studies, in various populations and nationalities, which have also shown that most adults (between 52%-75%) have experienced at least one ACE (Zarse *et al*, 2019).

[30] In a study that looked at vulnerable young people with mental health problems in Scotland (who present serious harm to others), there was a much higher prevalence of ACEs; 93% (out of 130) had experienced at least 1 ACE, and 59% had experienced at least 4 (Vaswani, 2018). In another study which looked at a sample of 64,329 juvenile offenders in Florida: 87% reported at least two, 71% reported at least three, 51% reported at least four, and 31% reported five or more (Baglivio *et. al*, 2014).

[31] Disability information was not recorded for the whole sample.

[32] Please note that the base size differs due to gaps in data collection.

Table 4. Risk assessment details

Risk	Ongoing and potential immediate risk	Some risks/concerns	None	Total
Further Abuse	19 (8%)	125 (52%)	95 (40%)	239
Self-harm	20 (8%)	90 (38%)	128 (54%)	238
Suicide	8 (3%)	74 (31%)	156 (66%)	238
Risk to others	2 (1%)	21 (9%)	208 (90%)	231

Offence details

Looking at the Excelicare data for the **346** clients who consented to the evaluation, the majority (n=317, 92%) made a disclosure of the offence, most commonly to someone in their family (n=169). Other individuals disclosed to were someone in their school (n=33), a health service (n=21), Police (n=18), social services (n=18). For 29 out of the 346 clients, a suspicion of CSA was reported. The most frequent offence was intra-familial sexual abuse (n=166), followed by peer-on-peer sexual abuse (n=90).[33] 112 CYP were recorded as being repeat victims.

Delivering the Lighthouse service

This section of performance insights now turns to the total activities and services delivered in aggregate (i.e., not just those that consented) at the Lighthouse. It should be noted that much of this data (provided by the Lighthouse's quarterly monitoring returns) only became available from October 2019 (not Oct 2018 when the Lighthouse went live). Over the period examined, data indicates a considerable amount of service delivery (see Appendix C for a quarterly breakdown of the data) – to illustrate:

- Between Oct 2019 and March 2021[34] there were **4780 telephone, video or face to face sessions.** This breaks down as 3442 telephone sessions Following CV-19 (i.e., April 2020 to March 2021) there were **829 sessions** delivered via video call, compared to 509 face to face sessions within the same timeframe (and only 15 face to face appointments between April and June 2020).
- **936 professional meetings** (excluding strategy and consultation meetings).
- There were **29 psychologist-led ABE interviews** that took place at the Lighthouse (averaging at 1.6 per month).[35] Over the same period there were 43 police led ABE interviews at the Lighthouse.[36]
- The Lighthouse made **91 onward referrals** to local services, most commonly within the voluntary sector (34%, n=31), followed by Social services (26%, n=24).
- Between April 20 and March 21, **137 strategy discussions** that took place and **118 consultations delivered** by the SCLOs.[37]

[33] No distinction was made between rape cases or other child sexual abuse cases.
[34] This data comes from the Lighthouse's quarterly monitoring returns which only dates back to Oct 2019, not Oct 2018 when the Lighthouse went live.
[35] There were more psychology led ABEs planned between April and June 2020, but a number were cancelled due to family anxiety about travelling in for an interview during COVID lockdown.
[36] The Lighthouse is contracted to offer 3 psychologist-led ABEs a month.
[37] A key part of the SCLO's role is also to provide consultations, attend strategy meetings and offer signposting. The SCLOs conduct many consultations for several reasons and mainly with local Social Care teams, but other organisations in the community as well (such as healthcare and police). Amongst the specific reasons given were: advice to CAMHS (around referral to local authority, need for an immediate Multi-Agency Safeguarding Hub referral); consultation with Lighthouse staff about liaison with social worker around the young person's entitlements; consultation and written support in drafting a letter to the local authority

Between April 2020 and March 2021, within any given quarter there were between 489 and 695 open cases to Lighthouse workers (note that there will be duplicates of CYP open to multiple practitioners at once). The Paediatrician and the CAMHS team had the largest proportion of overall cases (each 26%, n=608 and 604 respectively).

Table 5. Breakdown of cases open to Lighthouse services, quarterly from April 2020 to March 2021

Lighthouse service	Apr-Jun '20	Jul-Sep '20	Oct - Dec '20	Jan - Mar '21	Total	Overall Percentage
Paediatrician	134	114	162	198	608	26%
CAMHS	146	126	163	169	604	26%
Sexual Health Nurse	65	99	148	119	431	18%
Advocacy	95	104	104	125	428	18%
LTFI & P&R	34	40	51	46	171	7%
Play Specialist	14	20	29	37	100	4%
Dietitian	1	1	1	1	4	0.2%
Total	**489**	**504**	**658**	**695**	**2346**	

One of the key outcomes for the Lighthouse was to improve the CYP experience of the criminal justice system post disclosure, through having support from an Advocate. Data indicates the advocates recorded **258 different goals** for a total of **98 clients**, with an average of 2.6 goals each and a range of 1-10[38]. Against these goals, the Lighthouse staff recorded an outcome against 195 of them: indicated 63% (n=122) goals were achieved; 27% (n=53) were partially achieved and 10% (n=20) were not achieved (it is not recorded why the goal was not achieved).[39]

setting out safe-guarding concerns around insufficient safety for therapeutic work; advice to Lighthouse staff around local authorities' duties around accommodation and support for a child under the Children's Act 1989 (due to concern about the closure of police investigation, and the suspect being at home with the victim); advice to Lighthouse staff and written support in drafting a letter to mother concerning limits of advocacy, and signposting in relation to complex housing situation.

[38] The most common type of goal was relating to criminal justice support (n=65) which could mean that the service user wanted to be kept updated on the proceedings or wanted to be supported by the Lighthouse throughout the investigation, which may include help in understanding their options or to demystify the criminal justice processes. The second most common type of goal was around education and support in school (n=38), which may include getting help getting back into school, or for the Lighthouse to liaise with the school around a support plan, or help communicating the service users' needs to the school.

[39] For the remainder there was no indication of the progression of the goal although it may be because they are still in progress or data error.

3. Implementing the Lighthouse

This section seeks to present the challenges and learning relating to the design, delivery and implementation of the Lighthouse across the entire evaluation timescale reflecting upon key learning. Key issues focussed upon are *the initial set up of the Lighthouse and the maturation of the model*; *A focus upon the impact of Covid-19*; and *the value and challenges of partnership working*. Overall, these themes have remained consistent across the entire evaluation having emerged across our previous reports.

Initial set up and maturation of the Lighthouse

A key aspect within the delivery of *any* programme is initial design and subsequent implementation. There is a strong evidence base upon relating to the importance of programme integrity and resultant benefits (see, for example Duwe and Clark, 2015). Whilst this is the case for all programmes, it could be viewed as especially important for large scale, expensive and innovative pilot programmes – such as the Lighthouse.

Overall, implementation of the Lighthouse can be seen as a huge achievement for all partners and stakeholders involved. The set up was massively complicated across procurement, commissioning, estates, IT and mobilisation and to the credit of staff only incurred minimal delays. Given the level of underlying complexity and size of the model this is something to be celebrated.

On a wider note - all staff, partners, stakeholders, service users, parents and external agencies have been very positive in terms of the vision, design, governance, set-up and partnership approach of the Lighthouse across the entire evaluation period.

'Service itself is excellent, and the concept is brilliant, the way it was explained to us, all of the different specialists under one roof, and the close work and interaction with the police, it works very well, conceptually it's great'
(Parent 2021)

'The response of the Lighthouse is tailormade to what is presented and requires sorting'
(Medical team member 2021)

'[We] have time in IA to really try to understand the family and come together to come up with a bespoke support plan which is child focused but takes the whole family into consideration as well; the first time you do it, it feels quite amazing'
(Advocate 2021)

One of key elements of the Lighthouse - critical from the very beginning of set up was the need for the 'child-friendly' nature of the premises, and positively, CYP had been involved in early discussions about the design of the facilities and continue to be involved via a number of consultative groups established by the Lighthouse in discussions about the design of the premises and aspects of service delivery. From the outset and throughout the evaluation, feedback about the service and facilities (i.e., the appearance of the building, the quality and nature of its decoration, its atmosphere) provided by the Lighthouse has been positive from service users, staff and external agencies alike. The young people interviewed were all very complimentary about the Lighthouse, describing it as welcoming, homely, safe, less clinical and more 'youth-led'

than other services they had been to before.[40] Parents described their children's keenness to attend the premises; police officers favourably contrasting the 'child oriented' video recorded interview (VRI) facilities available at the Lighthouse with those available in police stations, and CPS staff commented upon how welcoming the facilities were. Again, this was a consistent positive throughout the evaluation.

'The building was very nice. It was all new. There was a hammock in the reception, and books. It was colourful and relaxing. Like you think 'wow, this place is really nice'. It was very calm. There is a little kitchen with a snack cupboard. And toys for young people, and books, things for people from primary age up to my age. It was warm and welcoming and made you think you'd want to go there again'
(Young person 2021)

'I've been to the Lighthouse. It's a lovely space. I physically went into the room where she would be interviewed. I know what an interview suite looks like in police stations, and the physical environment was infinitely superior to the environment in police stations'.
(Parent 2021)

There were a number of aspects of the original Lighthouse model that were *amended or evolved* in the light of operational experience and feedback from service users. Within such a large and complex initiative, this is not unexpected and exploring these facets in more detail can provide valuable insights into implementation.

A number of these changes seemed to arise out of **staff agency and responsiveness** – that is, seeking to respond to unforeseen or necessary circumstances. For example, in April 2019 the decision was taken not to open the Lighthouse on Saturdays because of low levels of usage and feedback received from service users (as opposed to the original planned extended hours and weekend operation).[41] Changes were made to the IA in response to feedback from children and parents feeling 'overwhelmed' that one of each team at the Lighthouse was present at the IA. Subsequently the IA met the child and family initially and then split up into separate rooms so that the child was able to meet them individually and focus on the area that mattered to them. This resulted in a more focussed – timelier – IA to which staff were far more positive about. There were many other examples where the initial model was *refined* – whether this was changing the frequency of intake meetings (daily to twice weekly), and retaining a consistent chair function (Consultant Psychiatrist) at these meetings to provide more time to collect the information required, ensure greater continuity overall, and to lessen the time/resource implications of the meeting, or the work conducted in Summer 2019 to develop vision and values for the Lighthouse resulting in a change to the management structure. In addition, in mid-2020 the senior leadership team was expanded to include Heads of Service: office manager, an SCLO, PLO, health team, CAMHS, LTFI/Protect and Respect (P&R) and an advocacy lead. All such changes can be seen as a highly responsive action throughout delivery of the Lighthouse.

Perhaps the best illustration of the responsive nature of service development at the Lighthouse is to be found in the **groupwork developed with parents and CYPs**. The Parents' Psychoeducation Course was developed 6 months into the Lighthouse's implementation partly due to the amount of sexual abuse disclosed by parents and lack of wider support for them.

[40] The CYP interviewed expressed mixed feelings about the location of the building – they liked the fact that it is relatively private and tucked away but also made it feel inaccessible/unsafe for some.

[41] It was not possible to open the Lighthouse on Saturdays for the first 3 months of operation because security staff were not available at weekends. After the reduced hours the weekends were still used for activities such as groupwork, if requested by parents, and members of staff continued to attend case conferences off-site at the weekend.

'Over half of families that we see, the parent themselves has also been exposed to sexual violence, victim of sexual violence or abusive relationship, often have two clients in the room'
(CAMHS member of staff 2021)

'There's no spaces for parents, just a huge amount of shame and stigma. Our hope that if there was a criminal justice process going on that it wouldn't prevent or preclude people from accessing the opportunity to meet with other people, [the] key thing that people draw out is the opportunity of meeting other people who understand and how it reduces shame'
(**CAMHS member of staff 2021**).

As there was no appropriate model in the UK, members of the CAMHS team looked at the international literature and built a course around the work that had previously been undertaken by the Washington Coalition of sexual assault in their Circle of Hope programme.[42] It was stressed that this was not a therapeutic model, but focused on the impact of disclosure, and moving from disclosure to healthy relationships.[43] Much of the work in the parents' group was about trauma caused to family/impact on family arising from the child's disclosure, and the destructive impact of that, often inter-generational, trauma. While it was not the intention of the group to provide a space for parents for their own therapeutic recovery, one of the consequences of having the group was that it had led parents to seek support for themselves, which in turn had led to the formation of the **Parents' Discussion Group**. Parents stressed the benefits of being able to talk to individuals who had been through the same experience as they had (the importance of the role played by the external consultant who had lived experience, and who had been brought in to assist with the running of the Parents Group and had subsequently joined the Lighthouse staff was specifically mentioned in this respect).

In terms of the developed group work with CYP, in 2020 the Lighthouse implemented the **Young Persons Feedback Group** to provide CYPs with an opportunity to provide insight, guidance and suggestions related to service development. This group in turn had led to the creation of the **Youth Forum and the Lantern Project**. The latter, still ongoing (as of May 2021) provided an opportunity for young people to work alongside an artist to create a new lantern/lamp to be installed on the street outside the Lighthouse. The Youth Forum (also ongoing) was launched in early 2021 providing a service user participation opportunity for 14–18-year-olds who meet with Lighthouse facilitators every 6 weeks to discuss issues related to service development. The young people are paid for their time and are consulted as experts (a recent session had involved consultation with the group about the language being used on forms being developed by the Lighthouse). Finally, a **Young Women's Wellbeing Group** had also been launched on-line in April 2021 for young women (15-18) accessing the Lighthouse to come together and support one another. Two additional service user consultation groups (one for younger children, and one for children with disabilities) and a repeat of the art project were also in development. Feedback from the CYP interviewed indicated that those who had participated in the Youth Forum welcomed the opportunity to influence developments at the Lighthouse, and the opportunity to meet others in a similar situation to themselves.

Outside of these responsive changes to the model, there were many changes that were **brought about by wider issues** – such as IT-related, external factors beyond the Lighthouse's control,

[42] Details of the Circle of Hope course can be found at https://www.wcsap.org/resources/publications/tips-guides/support-group-guides/parent-support-group-guide. As well as this material staff also drew on 'a mixture of Webster Stratton, [the] Cygnet parenting course and 2 other [courses] for parents of children with disabilities that were added because there wasn't a fit for purpose model'.

[43] Parents attending the group consented to not share any details of their child's case with each other, so as to protect any criminal justice processes underway.

or a combination of both. These presented staff a different type of challenge to overcome. The best example of this type of implementation hurdle can be seen within topics such as S*ection 28 and Live link*. One of the aims for the Lighthouse was that its facilities would be used for both s.28 and Live link.[44] Interviews with CPS staff indicated that they felt the Lighthouse *"was so well placed for [trialling Section 28]. It fully understood the purpose of how it would fit in the process and the pathway."* While this remains the long-term ambition, and permission has been obtained from the judiciary in principle for both to take place, in practice neither has yet occurred. The national implementation of s.28 was delayed, and the technology to allow s28 was not installed at the Lighthouse until October 2020. At present the Local Implementation Team (LIT) is developing local procedures for the use of s.28 and it is unlikely that the Lighthouse suite will be used for a s.28 hearing before September 2021.

Similarly, although permission from the senior presiding judge for the use of the Lighthouse as a Live-link site was received in the summer of 2020, and the technology was installed by October 2020, no applications to use the Lighthouse's facilities for a case have yet taken place. The use of psychologist-led rather than police-led interviews could be seen as another delay out of the control of staff – and staff interviewed suggested that this process had been more difficult and taken longer, than anticipated, as in practice it wasn't a simple transfer of skills. In the early months of the Lighthouse service, one of the PLOs had spent much of their time training the psychologists. A contributory factor to the delay was the psychologists' clinical work and "full caseloads" reducing their availability to conduct or practice VRIs.[45]

What the above serves to illustrate are the challenges in implementing such a complex and innovative programme, and the extent to which practice at the Lighthouse has evolved over the two-and a half year since its inception. To an extent this is unsurprising, bearing in mind the complexity of the model. Indeed, staff commented that the Lighthouse's pilot status meant that it, and they, had the latitude to work in different ways, and to develop practice in the light of what they observed, or in the light of feedback provided by service users.

Notwithstanding the above where there were changes to the proposed implementation, there were other challenges during maturation. Throughout the evaluation staff spoke frankly across a range of issues related to building design or IT, such as **soundproofing**, **poor wi-fi connectivity**, **layout of medical rooms**, and the **limitations of CMS; Excelicare** (i.e., the absence of an appointment system from the latter has been particularly criticised). These issues caused staff some frustration – but it should be noted – they sought out many proactive solutions around many of these issues (i.e., walking without shoes on, or not booking two adjacent therapeutic rooms at the same time).

[44] The Youth Justice and Criminal Evidence Act 1999 (YJCEA) introduced 'special measures' which aim to help vulnerable and intimidated witnesses give their best evidence in court and relieve some of the stress associated with giving evidence. Special measures apply to prosecution and defence witnesses, but not to the defendant and are subject to the discretion of the court. Amongst the special measures Section 28 enables the recording of evidence and cross-examination prior to trial away from the court room and includes all child witnesses. This evidence is then played during the live trial, which, in most cases, means the vulnerable person does not need to attend in person. Another special measure is Live link (again, available for vulnerable and intimidated witnesses) which enables the witness to give evidence during the trial from outside the court through a visual link to the courtroom. The witness may be accommodated either within the court building or in a suitable location outside the court https://www.gov.uk/government/news/section-28-for-vulnerable-victims-and-witnesses-in-crown-courts https://www.cps.gov.uk/legal-guidance/special-measures.

[45] Feedback obtained from the CPS suggested that their views on PLIs were positive, with respondents suggesting they were of higher quality. However, it was also suggested that they were longer compared to police-led equivalents, leading to longer charging decisions. The increased length was attributed to the work being in its early stages, and the fact that techniques by the psychologists to build rapport with the CYP were recorded in the VRI, but not in the police equivalent. It was also suggested that the fact that psychologist-led VRIs at the Lighthouse were undertaken with police present might also contribute to their length. Feedback from police officers about PLIs, where expressed, was also generally positive.

Over the duration of the pilot, remedial work to try and address many of these concerns was undertaken (something highlighted in previous evaluation reports). Improved soundproofing in the form of carpeting, and better doors and grills to minimise sound carrying between rooms/floors were installed. In addition, the decision to add more desks to the mezzanine level at the Lighthouse, sacrificing the 1st floor staff rest-area meant noise carrying from the staff kitchen down to the Lighthouse's reception on the ground floor ceased to be a problem, and increased desk capacity at the same time. The recruitment of a dedicated data officer to assist with the operation of the CMS and provide training for staff was also highly beneficial, and there were changes to the functionality of the CMS during the pilot's lifetime, and more are about to take place, but even with these efforts, concerns about soundproofing, telephony (poor wi-fi reception) and the CMS remained to a degree.

Overall, the pilot was well implemented. Staff, partners, children & young people (CYP) and parents were positive about the general service. As expected, given the size and scale of the Lighthouse, the pilot experienced several implementation and maturation challenges – some of these were required and indeed instigated by staff, others were due to wider factors that staff had to work around, and these resulted in changes to the model and often staff not working in a way initially envisioned. However, staff responded well, and although some aspects were not totally addressed, many were resolved over the duration of the pilot.

Implementing during Covid-19

It is not possible to consider issues around implementation and maturation without discussing the impact of the CV-19 pandemic and wider societal response on delivery of the Lighthouse. Following lockdown in March 2020, the Lighthouse closed, apart from allowing occasional urgent ABE interviews and medicals (which were also available at UCLH), although staff stressed that '*most people chose to wait'* for a session or support. The Lighthouse would not reopen until June 8th 2020.

However, before this reopening a host of work was undertaken by staff to enable and embrace virtual working. Understandably, the focus at the beginning of lockdown was upon *staying connected* with the child or young person rather than delivering therapeutic work (i.e., at this time is was not possible to offer medical examination inspections). For example, intake meetings continued but moved to video conference with triage and consultation for new referrals. IAs were offered as 'Virtual IAs' with the CYP and family meeting the full Lighthouse IA team on an NHS video consultation facility called 'Attend Anywhere'[46]. Medical history details were taken but examinations were delayed until reopening. Unsurprisingly, as shown in the performance analysis, the number of referrals to the Lighthouse and IAs declined in the months following Lockdown but recovered relatively quickly. During this time there was an increase in telephone contact and ad hoc virtual appointments to keep in contact with families and staff were positive around the attendance at such virtual appointments.

Meetings between professionals took place on Microsoft Teams – and attendance was felt to be good, with GPs and CAMHS attending. Generally, under lockdown there was an increased frequency in the number of virtual team meetings. CAMHS set up a daily meeting with the SCLOs to provide safe-guarding advice because of concerns about the impact of Covid-19 restrictions on the CYP they were managing in terms of the mental health, isolation and increased anxiety. Heads of service met initially 3 times a week, although the frequency of the meetings subsequently decreased to twice a week and then once a week.

[46] Although concerns were expressed by staff that the quality of the virtual IA was poorer than that offered in person.

The Lighthouse reopened for face-to-face IAs from 8th June 2020 onwards and VRIs and IAs took place at the Lighthouse regularly, together with limited therapeutic sessions (the latter tends to be a mix of virtual and face to face work). The introduction of social distancing at the Lighthouse here also meant that working practice had to change (consultations with masks on, restricting the number of people in rooms). Some CYP remain on remote appointments only. In addition, the parent group course that began in July 2020 was undertaken virtually.

At the time of writing, May 2021, the Lighthouse operates a 'hybrid' model with some activities being undertaken at the Lighthouse as before, and others being offered virtually – such as Teams online meetings, or in combination. Similarly, while some members of staff are back working at the Lighthouse, others remain working at home, working alternates between weeks at home and in the Lighthouse, providing services face to face and virtually as circumstances demand.

When considering these changes brought upon as a response to CV-19, this was a mixed picture. There were many benefits identified to the virtual methods – less time was taken up with travel, especially with external agencies (for example, the SCLOs mentioned they were attending more consultations and strategy meetings when working virtually), staff were able to attend more meetings. Staff also mentioned that attendance by professionals at virtual meetings had improved.

In addition, the introduction of virtual consultations meant youths who lived further away or were not able to travel to the Lighthouse, could receive a service. The virtual consultation also allowed the CYP to *'test the water'* in terms of what the Lighthouse offered, prior to attending in person. It was also suggested that virtual work suited some children, particularly teenagers, and one parent suggested that the advent of the virtual parent group meeting allowed people to *'open-up'* in a way that had not been the case for face-to-face meetings.

However, *on balance,* the positives provided by virtual working appeared to be outweighed by a range of negatives. These covered both therapeutic challenges and some wider reflection on impact upon the youths or themselves. In terms of therapeutic challenges, feedback from across those interviewed indicated that some CYP did not want to engage virtually or were uncomfortable accessing services by video call or phone. In addition, staff reflected that working virtually made it more difficult therapeutically to gauge how the young person was reacting versus working face to face.

The virtual working resulted in the reduction in the use of measures of stress and anxiety (for example the Trauma Symptom Checklist for Children and the Revised Children's Anxiety and Depression Scale) due to difficulties completing detailed evaluation questions over video link due to reduced ability to engage with the child, issues around confidentiality in their own home for CYP when answering, and shorter appointments generally. Staff had tried to arrange more frequent but shorter contacts with CYP. This had also had an impact on waiting lists and waiting times for services as staff had not been able to close cases, and pick-up new ones, as previously.

'I haven't been able to do all the work I could have done as it hasn't felt safe to do virtually and go into the depth required. In order to contain and appropriately assess how children are doing and their mental health and emotional need it needs to be face-to-face, also working from home has been really challenging for lots of reasons which impacts your capacity to work with young people virtually'.

(LTFI worker 2021)

'If I'm assessing risk of harm and disclosures it's hard when I won't visibly see that young person. I felt like I was retraining myself to do this work virtually'
(LTFI worker 2021)

Staff also reflected upon the wider impact of CV-19 on CYP's mental health, for example; outlining that young people may not being able to access alternative support (youth clubs, for example), or that youths were more isolated, and more reliant on Lighthouse support subsequent to CV-19. Furthermore, the impact that remote working had on their own morale and mental health was also raised by staff, especially dealing with traumatic and difficult subjects (often) within their own homes, especially where there was *'no commute to distance yourself from work'*. For other members of staff (i.e., the administrative team) the ability to work from home had not been an option as they were expected to maintain a presence at the Lighthouse, and this had been a source of frustration.

Implementation of the Lighthouse was heavily disrupted by the CV-19 pandemic. In response, considerable changes were made in order to deliver the pilot – and to the credit of staff the service continued. Indeed, many of these virtual changes became embedded into the routine way of working, but overall staff felt that virtual working whilst necessary, was lacking therapeutically compared to face to face.

The value and challenges of partnership working

A common theme across many largescale programmes, indeed incorporating child advocacy centres and Barnahus are the manifest benefits of partnership working (Herbert & Bromfield, 2016, 2017; Landberg & Svedin, 2013). Throughout the evaluation - results were very clear – feedback was highly positive around the many benefits of the partnership model employed at the Lighthouse. One of the advocates said that she had been drawn to the Lighthouse from her old job because of its multi-agency approach. As she remarked *'I see what I thought would happen actually does happen in practice'*. Specific aspects focussed upon were the benefits of co-location, joint working (within the Lighthouse and across external agencies, for example the establishment of case-progression meetings with the CPS) and information sharing, with benefits for both the service itself (i.e., speedier conversations, access to varied agencies, wider skills and disciplines) and the service user (i.e., quicker access, joined up support). Feedback from the service users at the Lighthouse reflected on the benefits of having access to different professionals in the one place – the sense of a 'wrap around' service and a team of people helping them.

'I was told there was a nurse there. And therapy was always there. It was a safe space. [Was that good to have things like a nurse there?] I think it's great. If I had any problems – there would be a solution for most things. Like if you'd headaches, the nurse could help. Everything being under one roof is very reassuring, which you need when you are anxious'
(Young person 2021)

The benefit of not having to repeat themselves was consistently raised by service users, as was being able to get all the help they needed in one place. Service users made specific reference to getting support with criminal justice processes (including doing the VRI at the Lighthouse) and the benefits of advocates being able to liaise with others as needed; and being able to get (specialist) health support rather than having to go to a community GP.

'Just yesterday I was doing an appointment with a young person and could link in with the health team……not being in the same building I don't think I would have been able to get her to

a health team, that's enough effort on her part to go to the health team, and where is there a set up where they can access consultant paediatricians? And being able to build up that relationship with doctors, especially in Protect and Respect where prior to the Lighthouse I would spend so much of my time sitting in sexual health clinics with them, going to meet social work and police with them travelling around it's amazing they can have that all under one roof'
(LTFI worker 2021)

Similarly, this was also acknowledged by parents in terms of the partnership benefits.

"through my discussions with (the advocate) because at times she hasn't known how, how to help. There's a sort of in-house consultant, child and adolescent psychiatrist too, so you know, sometimes when (the advocate) was like, 'Oh my goodness, I don't quite know what to do and I don't know how to help, and I'm not a mental health professional', she has liaised with those services and even though they don't know my child, they come back with far more helpful responses than the services who do know my child."
(**Parent 2021)**

This was often conceptualised as a 'Lighthouse Way' and covered both practical staff but also Lighthouse Senior Management, which itself was expanded in 2020 across many varied Heads of Service – another positive example of partnership working.

However, there are specific aspects of good practice around partnerships – and a good example can be seen within the PLO and SCLO roles. These were new, innovative, roles established within the Lighthouse and a considerable amount of work was undertaken to communicate and embed these roles within the service and wider partners. To illustrate, staff commented on how the PLO performed an important liaison role with police officers outside the Lighthouse, who commented very positively upon the position in arranging VRIs at the Lighthouse and for 'chasing up' and facilitating the CSA cases with which the officers were involved.

'I have no words, they are fantastic. They are just an absolutely fantastic resource to have'
(Police officer 2020).

Likewise, SCLOs were described as *'the glue between social care and other professionals, paediatricians, psychologists within the Lighthouse'*. Respondents also stressed the SCLOs' usefulness in offering suggestions and guidance about how to navigate referral pathways, and their role in terms of quality assurance. Both of these roles offer insights and demonstrate the inherent value in such roles that specifically set out to work across partners and to a degree acted as a wider enabler of positive partnership working.

When the referral comes in the fact it's screened and triaged by police and social care so any safeguarding issues can be addressed straight away. That intake process and making decisions as a group, there's already been a layer of additional safeguarding which wouldn't have occurred if the Lighthouse wasn't available. Traditionally, the police etc would have put safeguarding in, but here we can address as a group and get additional safeguarding issues addressed. In the intake process there is critical analysis of that family.
(LTFI worker 2021)

Whilst the benefits of partnership working were clear to all staff; as outlined in multiple previous interim evaluation reports (and wider literature) the issue of partnerships can also bring frustrations. Tensions as a result of different organisational cultures and working practices were apparent during the pilot. To illustrate, staff highlighted differences across terminology, pay, annual leave, training (determined by the individual's employing organisation rather than being

standard across the Lighthouse); disagreements on relative contribution of certain aspects (i.e., was it too medically orientated), and can be illustrated by differences across many staff as to whether they saw themselves as employees of the Lighthouse or of their parent organisation.

Overall, partnership working was a resounding positive to emerge from the evaluation, appearing to bring a wide range of benefits to the *service* as well as the *clients* – something supported by specific roles (PLO, SCLO) that enabled such a way of working. However, it is clear some cultural tensions were evident which were not able to be fully reconciled over the pilot duration. This serves to illustrate how such working cultures are very difficult to avoid and should be borne in mind when devising and running any similar programme.

4. Impact of the Lighthouse

One of the most important questions behind any programme is the question of 'impact'. That is, did the programme achieve what it intended do – and can we compare such outcomes to other groups that did not receive the service. This section seeks to explore the impact of the Lighthouse – by drawing upon a variety of data (referrals and throughput, health and wellbeing outcomes, criminal justice outcomes, and views from participants such as practitioners, and service users) that when triangulated can generate insights.

The methodology section outlined the rationale behind the selection of the Northeast London CSA Hub as the comparison group for the Lighthouse. Table 6 below provides a high-level overview comparison of both services – the Lighthouse and NEL CSA Hub. For more detail on service provision in NEL please see Appendix D. As can be seen from this table, the Lighthouse covers fewer boroughs but provides a larger number of services and as such – a larger number of staff members – compared to NEL. The Lighthouse is also eleven times more expensive than NEL CSA Hub.

Table 6. Comparison of Lighthouse with NEL service provision

Service	Lighthouse	NEL CSA hub
Boroughs covered	Barnet, Camden, Enfield, Haringey and Islington	Barking and Dagenham, Hackney, Havering, Newham, Redbridge, Tower Hamlets and Waltham Forest
Services provided	CSA clinic, play therapy, sexual health, Advocacy, LTFI/P&R, VRI, CAMHS, PLO, SCLO, groupwork (parents/CYP), dietician.	CSA clinic (Paediatrician) at Royal London Hospital – 1 day a week (with occasional support from hospital play therapist) Barnardo's Tiger Light EES (8 – 11 weeks of support)
Number of referrals	889	CSA clinic - 90 Tiger Light programme - 141
Throughput	510 IAs	Tiger Light – 120 CYP PA
Staffing details	Approx. 30 staff overall Delivery manager, strategic lead; clinical lead, consultant psychiatrist; paediatricians, clinical nurse specialist, play specialist, advocates, CAMHS, PLOs, SCLO, office manager, admin support, data officer.	RLH Paediatrician x .25 WTE Barnardo's 2.6 WTE
Cost of service (£ PA)	£2.3 million See Economic Evaluation section for further detail.	CSA clinic £60,390 (staffing costs of £59,640 plus £750 annually for maintenance of colposcope) Barnardo's Tiger Light costs £148,000 (staffing costs of £131,590 and other expenditure of £16,410) Total = £200,390.

Comparison of Performance data: Lighthouse and NEL CSA hub

This first section exploring seeks to compare referrals data between the Lighthouse and NEL (both Barnardo's Tiger Light and the Paediatric services), and a comparison of service user demographics (largely as contextual setting).

Referrals and throughput

As outlined, Lighthouse overall received 889 referrals and conducted 510 IAs. Over a comparable period, Barnardo's Tiger Light in NEL had a total of 141 referrals to the service, most of which were accepted, working out at an average of 5 referrals per month.[47] In the same time period, the Paediatrician within NEL CSA Hub received 90 referrals relating to CSA (although did receive a total of 131 to their service in that time),[48] which works out at an average of 3 referrals per month (see Appendix E for breakdown of referrals by borough in NEL). In this case, the Lighthouse saw on average 22 additional CYP per month.

In terms of referral sources, the Lighthouse had a much wider spread of sources (Social care, police, Self-referral, CYP Havens) whereas NEL predominant source was from Social Care (87%, n=116). See table 7 below for full breakdown.

Table 7. Comparison of Lighthouse and Barnardo's Tiger Light referral sources

	Lighthouse		NEL Tiger Light	
Referral source	**CYP**	**Percentage**	**CYP**	**Percentage**
Children's Social Care	196	54%	116	87%
NHS	24	7%	10	7%
Early Help Services	0	0%	3	2%
Education	7	2%	2	1%
MASH	0	0%	1	1%
Police	34	9%	1	1%
Youth Offending	0	0%	1	1%
CYP Havens	16	4%	0	0%
Other	32	9%	0	0%
CSA Hub	3	1%	0	0%
Self-referral	29	8%	0	0%
Third sector provider	7	2%	0	0%
CAMHS	12	3%	0	0%
Total	**360**		**134**	

Comparing the Lighthouse and NEL (Barnardo's Tiger Light and Paediatrician) clients on demographics there are some differences. Overall NEL referrals were younger (the average age for CYP being referred to NEL services is 12 years for Tiger Light, and 8 for the Paediatrician) compared to the Lighthouse (average age of 14). NEL (combined Tiger Light and Paediatrician) had significantly more referrals in the younger age group of 12 years and under (n=159, 60%) compared to the Lighthouse (n=367, 41%). Gender proportions were comparable between the two areas, and ethnicity was overall comparable with the exception of NEL which had a significantly higher proportion of Asian CYP (20% compared to Lighthouse's 8%; $p<0.05$). It is not possible to fully compare the vulnerability of the clients given data limitations in NEL – however, this is possible in one area. A total of 22% of Lighthouse clients were recorded as having a disability (n=78/354), whereas 7% (n=13/177) of Tiger Light CYP had a disability (most commonly a learning disability, n=6); this is a significant difference ($p<0.05$).

[47] There were likely just over 200 total referrals to NEL within that time (provided anecdotally) although due to Barnardo's reporting system it is not possible to accurately calculate those which were 'rejected' referrals. In January 2020 NEL switched to a new referral system where only 'accepted' referrals were added to the system (prior to this, all referrals included those rejected were added to the system). Reasons for referrals being 'rejected' were due to them not being suitable; referral declined by the CYP/family; referred elsewhere; or withdrawn by the Social Worker.

[48] Other reasons for referrals to the Paediatrician were relating to abnormal genital anatomy and unrelated to CSA.

Service users' perceptions

A critical aspect of the evaluation was the voice of the clients themselves – and the final evaluation sought to present their views. Overall, a total of 11 CYP were interviewed to obtain their perceptions of the service they had received at the Lighthouse.

While there were some areas young people felt could be improved – explanations re the Lighthouse offer; consistency of communication and clarity re information sharing, overall the young people were very positive about the Lighthouse, commenting that it had exceeded their expectations, which were typically informed by experiences of other services.. When asked to score the service out of 10, scores were all 8 plus (3 gave it 10 out of 10); there were references to 'family'/'homeliness'; and a general feeling that it was different to other services they had been to before.

They spoke positively about their engagement with different workers, including comments on how everyone (from reception on) treated them well and with respect. They described staff as genuinely caring and invested.

'Looking back on the Lighthouse, even though obviously I wish I hadn't had to go there, but I think they just made the experience of having to go there a lot less harder than it had to be. And yeah, I did feel like almost loved there, yeah. I guess that's my, looking back I don't realise, I didn't realise at the time how easier things were made for me with the Lighthouse being there. So, yeah, and it's just helped, you know, like yeah, no, they were able to just give me things that I've been able to still carry on, even though I might not need to apply them for like, just I don't know, yeah'.

(Young person 2021)

Many talked about having choice and control, being able to go at their own pace.

'Firstly, you have more control over your experience. As I have anxiety, being in control makes me relaxed. Control over your experiences, and they respect your choices. CAMHS had a very long wait list – I've personally experienced it – and when you finish they give your place to someone else. In the Lighthouse, its my choice. And they are very respectful of your choices. They are extremely kind. Anything they can do, they are there to help – even the very smallest things – like being stressed about your exams'

(Young person 2021)

Some small details stood out for them – such as recalling being asked for their opinions about which artwork should go on the walls – making them feel they were part of the service. The importance of practicalities was also mentioned – the availability of the kitchen area and snacks, clean toilets and nice rooms. 'Little things' like being made a cup of tea/coffee helped to make them feel cared for.

The flexibility of provision was consistently described by young people – feeling it was ok to cancel an appointment if they wanted to; not always needing an appointment to see the health team, for example, and experiencing staff as always willing to try and see them when needed. They compared this to negative experiences of missing appointments elsewhere and losing access to services. They also described the Lighthouse as being able to offer them help to 'do life' - with sleeping, exam stress, substance misuse etc., things that were not all directly about the abuse; *'you get to do other stuff'*.

In terms of specific aspects of the service at the Lighthouse, the young people were generally very positive about the counselling/therapeutic work they had received. Several reflected that it can take time to 'open up' and felt they were given the time and space to do this and build relationships and ways of working at their own pace.

They described therapists as being *'like a formal friend'*; and having helped them in developing coping strategies; helping them make sense of their feelings; and supporting them to grow and develop as a person. Two also specifically mentioned valuing the therapy offered to their family, which helped relationships at home.

[Young person was asked to select an image that described their Lighthouse experience, picked an image of seeds] 'Because for me it represents growth, and for me like through growth in the Lighthouse I grew into a different person, like for example, and my confidence as well. And I picked this [image of sunshine] because at first you might feel like upset and down, and you might feel, oh it's not helpful, then over time it became very helpful, and for me like going there first it was just like oh, I can't be bothered, and then after a while I actually like was kind of excited to go there'

(Young person 2021)

The advocates played a really important role for young people, sometimes in relation to support with the criminal justice process and sometimes a wider role. Advocates were described as helpful/valuable for explaining things throughout the investigation; checking in on them throughout; answering any questions they had; liaising and following up with police and others on their behalf and updating the CYP on the status of things – *'That extra little support makes you feel very reassured'*. While not all young people knew/used the term 'advocate' there was a sense of them as 'their person' and they were positive about having a single point of contact.

'So, she was kind of like a bridge between you and the police or you and the court. And there were times where I would go and, before the trial started I went to the courthouse and I would see the rooms and stuff and she would come with me, just so it wasn't as scary... So, it was just nice having someone, I didn't feel like I was in the dark…You don't really know what can happen with the court and stuff, and obviously she knew the most so she would be like, and she'd be realistic and say like, 'The outcomes could be this, the outcomes could be like that', and for me I found that reassuring, knowing the way the outcomes that could happen, but also still being reassured'.

(Young person 2021)

Longer term engagement with, and support from, the advocate when things had ended with the service was also described as important, as was the option to get back in touch with the service should circumstances change. One young person reflected positively on doing a VRI at the Lighthouse compared to doing it in a police station. The key things she noted were – the waiting space for family, the set-up of the interview space itself, the fact that the police came to you in plain clothes; her mum was in waiting room, the therapist and paediatrician were also about; and nice refreshments. Asked if she would recommend it, having done both LH and police, her response was – *"yeah, yeah, 100%. It just works"*

Young people were also very positive about the health team, describing staff as very flexible and approachable; they emphasised how good it was to be able to have all aspects of their health addressed through them (because they understood their circumstances) rather than having to go to a GP separately – *'Everything being under one roof is very reassuring, which you need when you are anxious.'* An example was given of ending up in hospital (outside of Lighthouse engagement) and the paediatrician and advocate coming to make sure the CYP was treated well.

Overall, the young people were very positive about the impact the Lighthouse service had had on their lives. A number of specific impacts were described such as increased confidence, feeling back to their normal self. When asked how she'd describe the lighthouse to an alien who had no idea what it was one service user said she would describe it as *'somewhere that helps young people become a better version of themselves really'.* Some also commented that the Lighthouse had helped them to develop short-term coping mechanisms, but also longer-term ones they could use in the future.

Parents' perceptions of the Lighthouse

The evaluation sought the views of the parents who had individuals experiencing the Lighthouse. Whilst not robust 'impact' it is essential their voices, as well as staff and youths – are included when exploring impact. Overall parents were highly complementary about the service provided by the Lighthouse, about the information provided, and about the high levels of training of Lighthouse staff.

'I've only got good things to say about it. If we didn't have that I've no idea what we would have done, because there doesn't seem to be anything similar to it, or not readily known or available even from the internet'
(Parent 2021)

In terms of impact, parents stressed the benefit of the long-term holistic support provided to the child by the Lighthouse, support that they felt was not available elsewhere. One parent described what her family had received as *'holistic family support'.* Not only had the victim received support, but the Lighthouse had also provided support to a sibling, and to the parent, provided communication with the school, and had provided onward referrals for both the mother and the sibling. The parent, describing the advocate remarked they were;

'so proactive, so when we liaise with the school, the school are actually quite good, but (the advocate) provides information, teaching information, trauma based teaching, information to the school. I'm lucky in that school, you know, picked it up and sent it to every single member of teaching staff'.
(Parent 2021)

Another parent said his young children;

'[they] looked forward to it, they liked the person they were working with, you could see noticeable improvements month by month, and a lot of it was as a result of the work being done with them. They definitely benefitted. They liked the environment itself as well. They enjoyed going to that actual place'.
(Parent 2021)

Parents mentioned the fact that there was very little information available for parents/guardians of victims of CSA aside from that provided by the Lighthouse; *'the education, the emotional and direct context education is amazing because you don't know where to start'* (**Parent 2021**). They were reluctant to seek guidance from the internet because of concerns about what they might find, where their search might lead, and about the quality of the information they found; *'I don't want to get directed by algorithms to something I really don't want to get directed towards'*. Their engagement with the Lighthouse had provided them with 'r*eally good tools and things to use in certain situations*' in relation to their child's behaviour and how to interpret and respond to it.

Parents particularly stressed the benefit of being able to talk with other people who had been through similar experiences to their own at the Lighthouse, and who could provide them with information about what to expect. As one remarked *'maybe [the] initial understanding of Lighthouse's purview wasn't so focused on the parents, and that's proved to be intensely valuable to the parents'*, illustrated personally in his ability to talk to his daughter about what had happened to her; *'Educating us to help ourselves and to help our children is incredibly valuable'*.

Emotional wellbeing outcomes

Both Lighthouse and the comparison site capture data on emotional wellbeing (albeit somewhat differently). The Lighthouse staff used several means to measure changes in emotional wellbeing in the CYP. The CAMHS and LTFI teams at the Lighthouse set individual goals which were agreed with each service user and/or their parent or caregiver.[49] The progress against each goal is then tracked. Between Oct 2018 and March 2021 there **were 204 emotional wellbeing goals** set for **88 service users** (only for those who consented), with an average of 2.3 goals each.[50] These goals were recorded as free text on Excelicare and the evaluation team coded each one on overall themes.[51] Out of the 204 goals, **117 had an outcome recorded against them**: 69 (59%) goals were achieved, 35 (30%) were partially achieved, and 13 (11%) were not achieved. For the remaining 87 there was no record of progression of the goal, which may be due to them being in progress or due to data error.

Barnardo's Tiger Light practitioners used set categories to measure CYP outcomes on (see Appendix E for list of the 18 measures and results). The CYP are marked on a score of 1 – 5 (where 1 = low risk and 5 = high risk), and there were 25 CYP who had at least two assessments completed to show progress against these. This dataset from Barnardo's compares the difference between the first and final assessment.

Comparing the proportions of **positive outcomes** between Lighthouse and NEL is problematic due to small samples as well as a lack of standardisation in data capture, in addition to the subjective nature of success. However, upon inspection, there is a significant difference ($p<0.05$) between the two groups – with **89% Lighthouse goals achieved or partially achieved** – and for NEL there were **improvements in 47%** of outcomes (see Appendix for full breakdown of outcome results).

Comparison of criminal justice outcomes and attrition

This section now moves to the findings from the criminal justice analysis that was undertaken - a comparison of key outcomes through the CJ process. This analysis – and the examination into criminal justice outcomes - was viewed as one of the core metrics in terms of exploring *impact*. This relates to **charges, convictions**, and overall **attrition** through the system (e.g., victim withdrawal, police no further action [NFA]), in addition to some contextual factors within the investigation (such as numbers of ABE interviews completed and requests for third party material).

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[49] The Lighthouse also use measures such as the Trauma Symptom Checklist Children (TSCC) and Revised Child Anxiety and Depression Scale (RCADS), however the numbers of children with measured outcomes was too low (for those who consented; 8 children with two TSCC assessments, and 4 with RCADS outcomes).

50 This group was aged between 1 and 21 years old. The majority are female (n=72, 82%), and the majority (60%, n=105) are BAME.

51 To note, some goals were very specific and detailed. Where possible the evaluation aimed to categorise and simply the overall theme of the goal.

Examining the two key outcomes (i.e., charge and conviction) there was almost no difference between the two groups. The Lighthouse cases had **7%** (n=6) cases charged by the CPS and a **5%** (n=4)[52] conviction rate; compared to NEL who had **6%** (n=4) charged by the CPS and **a 4%** (n=3) conviction rate. These results were not significantly different and further illustrate the very low levels of charge and conviction in such cases potentially pointing to a wider criminal justice issue. Given the timeframes of the evaluation, there were a relatively small number of cases from both groups that were still 'open' in some manner (i.e., 14 Lighthouse and 7 for NEL)[53] – and a longer timeframe would be beneficial to allow cases to progress.

Table 8. Key stages of criminal justice attrition

Criminal Justice Stage	Lighthouse	NEL
Total cases	86	67
Police NFA	33 (38%)	25 (37%)
Victim withdrawal	27 (31%)	30 (45%)
Suspects identified	68 (79%)	49 (73%)
Suspects arrested*	38 (44%)	18 (27%)
Submitted to CPS*	21 (24%)	7 (10%)
Charged by CPS	6 (7%)	4 (6%)
Guilty pleas	2	2
Proceed to trial	3	1
Guilty at trial	2	1
Not guilty at trial	1	N/A

**Significant difference between the two groups at 95% confidence level*

Looking at the wider Criminal Justice metrics, again *generally*, there were no significant differences between Lighthouse and NEL cases (i.e., police NFA, suspect identified, and guilty pleas were all comparable between the two groups). The Lighthouse cases had a lower proportion of victim withdrawal compared to the NEL cases (31% compared to 45%), although this was not a significant difference.[54] However, the Lighthouse did have **significantly higher instances of positive actions** within the investigation, such as increased suspect arrests (44% vs 27%, $p<0.05$), and proportion of cases submitted to the CPS (24% vs 10%, $p<0.05$) compared to NEL (see table 8).

Wider aspects of the investigation were also examined, and results indicate a significant increase in Lighthouse conducting **VRIs** (71%, n=61 Vs 33%, n=22, $p<0.05$).[55] The Lighthouse cases were also **significantly more likely to request early investigative advice (EIA)** from the CPS (21% n=18, vs 6%, n=4, ($p<.005$); and significantly more likely to request **third party material** (most commonly social services, medical records and school records) (50%, n=43 Vs 24%, n=16, $P<0.05$).

[52] One of the guilty outcomes includes two suspects within the same case (both convicted).

[53] As of the end of May 2021, 11 cases are still being investigated by police (7 of which are working on CPS actions); 2 cases are with the CPS awaiting a charging decision and; 1 case has been charged and is awaiting a trial date. NEL on the other hand had five open cases at the end of May all of which the police were still investigating and of which two the police were working on CPS actions.

[54] The reasons for victims withdrawing were broadly similar between the two groups. For 10 cases in the comparison group, the victim withdrew due to not supporting the allegation and not wanting to prosecute the suspect. In both groups, one of the most common reasons for withdrawing was due to the victim not wanting to go through the investigation or have police involvement (n=10 for the Lighthouse and n=9 for NEL). The remaining reasons for victim withdrawal for Lighthouse and NEL respectively were: Stress of exams (n=6 and n=2); general health reasons (n=2 and n=4); they had moved on and wanted to put the incident behind them (n=4 and n=2); victim became disengaged and reason was not clear (n=4 and n=2). Finally, for two of the Lighthouse cases the victims had a fear of repercussions of the allegation.

[55] The main reasons for NEL not having a VRI completed was because the victim refused (n=15) or the police did not arrange (n=13). An MG11 may have completed instead, however this was difficult to accurately capture.

In summary, exploring impact involved triangulating across a range of data and compared to a BAU example; Lighthouse overall delivered more, had more positive emotional wellbeing outcomes, and although there is no difference so far in terms of charges or convictions, the Lighthouse had more positive investigative actions such as reaching the CPS for a charging decision. Both parents and CYP were highly positive regarding the service and spoke of a range of benefits. Table 9 below outlines the outcomes identified for the Lighthouse at the outset of this report and reflects on the extent to which these outcomes have been achieved at the time of writing.

Table 9: Lighthouse outcomes and evidence of achievement

Outcome measure	***Evidence of Achievement***
Enhanced referral pathways into and out of the Lighthouse.	- The Lighthouse had a wider spread of referral sources in comparison to NEL. - Positive feedback from local borough Social Care Liaison Officers. - Evidence of onward referrals made by Lighthouse.
Enhanced CYP, family and carer experience of support received post disclosure.	- Positive feedback from interviews with CYP and parents on the support they received.
Enhanced CYP experience of the criminal justice process post disclosure.	- Positive feedback from interviews with CYP and parents on the support received from Advocates in navigating the criminal justice process.
Enhanced mental health and well-being outcomes for CYP.	- Indication of improved wellbeing through the proportions of goals achieved through the emotional wellbeing teams.
Enhanced professional awareness, competence and confidence.	- Findings from qualitative interviews with staff and external practitioners indicate excellent overall professional awareness and competence.
Increased likelihood of charge or conviction for those cases within the Lighthouse.	- Indicative impact showed there was no difference between the Lighthouse and a comparison group in terms of charges and convictions. However, further work is recommended in the future to enable a more robust analysis.
Enhanced partnership working.	- Findings from qualitative interviews with staff indicate partnership working within the Lighthouse is perceived as a large benefit; both to staff and the CYP. - Evidence of work carried out by the senior leadership team to improve partnership working. - Some challenges and tensions still remain regarding differences in organisational cultures and ways of working.
To provide CSA victims with care and support to reduce the long-term impact of victimisation.	- Positive findings from the goal-based outcomes of the emotional wellbeing teams. - Evidence from interviews with service users that the Lighthouse have supported them with many aspects of their lives including health and wellbeing, school, relationships, and self-confidence. - NB these are short term benefits and it's not possible to assess the long-term impact at this point.

5. Economic analysis and the future

The final aspect of the evaluation focusses upon economic evaluation of the Lighthouse Service, and also issues around sustainability (staff views) and future models. For the economic evaluation, MOPAC commissioned RedQuadrant to undertake this work.[56] They produced a CBA which involved adding up the benefits of the Lighthouse and comparing them against the costs associated with setting up and delivering the Lighthouse. This was then compared against a comparison group and a **difference-in-difference** analytical approach was used, which studies the differential effect of the Lighthouse on its service users, versus a comparison group forecasted over a long-term period (30 years). An overview of the approach taken was outlined in the Methodology and in Appendix F.

The overall costs of the Lighthouse pilot comprise the annual operating costs of **£2.387m** per year plus the one-off capital costs of refurbishment, installation of IT and infrastructure (**£3.9m** allocated to cover a period of eight years at **£0.49m** per year). This equates to **£2.88m** per year in total. Details are provided in table 10.

Table 10. Elements of costs for the Lighthouse

	Cost/year (£000s)
Operational staff (direct)	1,134
Operational staff (indirect)	277
Estates (ongoing costs)	380
Diagnostic Equipment, Drug costs, Clinical supplies, IT	154
Overheads (including management) and other	442
Total operating costs	2,387
Capital costs (refurbishment, one-off expenditure on IT and infrastructure spend – one-off expense of £3.95m amortized over 8 years)	495
Overall costs per year	2,881

With this overall cost, and 420 clients per year, the unit costs for the Lighthouse are of the order of **£6,860**. Costs of a Havens service were estimated at **£4,925 per case** (details of costs for the Haven are shown in Appendix F).

Unfortunately, despite development of a comprehensive dataset for monitoring performance and utilisation rate, accurate data on many outcomes is not available across the sites used for this analysis. Outcome measurement is particularly challenging for CSA services due to the complexity of the recovery with every child's journey likely to be different.

This total cost can then be set against the wider social value identified across three broad areas: wellbeing to the client, useful savings from public sector spend and additional public sector spend on essential activity. Table 11 below shows the social costs for Lighthouse, plus social costs for a comparator based on the Havens, whose proportional impact was estimated to be 67%[57] of that

56 A fuller explanation of the cost-benefit model RedQuadrant developed for the Lighthouse, and the research that underpins it, is contained in appendix F.

57 Based on a calculation that used 'referral on' rates taken from Harewood and Baine (2018) (assuming 18% for the Lighthouse and 40% for the Havens), together with an assumption of short-term support needs for the CYP cohort of 85%. This produced a figure of improving mental health of 67% for Lighthouse (85% baseline rate of referrals minus 18% referral on rate after Lighthouse intervention) compared to 45% for the Haven (85% baseline rate minus 40% referral on rate after Havens intervention); 67% of the Lighthouse figure.

of the Lighthouse over a 30-year period. Table 12 compares the costs and benefits for the Lighthouse against the Havens.

These results show that there is a financial return to the public sector from the operation of the Lighthouse, with a net gain in public expenditure per client of £14,570. The ratio between future savings and cost of the intervention is 3.12 : 1.0 (calculated as £21,430 ÷ £6,860). However, the comparator scheme also shows a good financial return, with a net gain in public expenditure per client of £9,460. The ratio between future savings and cost of the intervention is 2.92 : 1.0 (calculated as £14,385 ÷ £4,925).

The results suggest very substantial harm occurs for the victim and very substantial costs accrue to public services as a consequence of CSA/E. Per child or young person, public sector costs are estimated at some £122,000 (with the prosecution of crimes accounting for around £32,000), while the loss of wellbeing to them and their family, and the loss of earnings, is of the order of £98,000.

Calculations suggest that the use of Lighthouse compared to the Haven costs perhaps £1,935 per case more (£6,860 - £4,925) but saves an additional £7,000 on future public expenditure (£21,430 - £14,385) (excluding costs on convictions) and improves wellbeing by additional £10,300 (£31,420 - £21,100).

There are some limitations to the analytical approach – including data quality issues, as well as a lack of firm impact and attribution that precludes firm findings upon impact. None-the-less, the analysis explores the costs and potential benefits of the Lighthouse as well as comparison service.

Table 11. Social costs (£ per client) for the Lighthouse versus Havens comparator

	Social cost without Lighthouse	Social cost with Lighthouse	Social cost with comparator
Health & wellbeing			
Mental health	17,545	9,590	12,205
Sexual health, Physical health and Substance abuse	1,075	880	945
Client and family wellbeing	46,900	15,480	25,800
Children's services			
Child protection	17,585	17,585	17,585
School support	8,190	2,705	4,505
Criminal justice system			
Criminal behaviour by victim	7,100	2,340	3,905
Crimes prosecuted & convicted	32,110	33,720	33,190
Employment			
Employment losses individual)	50,875	44,270	46,440
Employment losses (HMRC)	10,170	8,850	9,285
System effects			
Closer co-ordination	28,625	26,910	27,475

Table 12. Overview of costs and benefits for Lighthouse versus comparator (£ per client)

	Difference between Lighthouse and Base case	Difference between Comparator and Base case
Reduction in public sector costs due to improved outcomes (1)	£21,430	£14,385
Cost of operating intervention (2)	£6,860	£4,925
Net gain to public sector expenditure (3) = row 1 less row 2	£14,570	£9,460
Reduction in loss of client and family wellbeing	£31,420	£21,100
Reduction in loss of earnings	£6,605	£4,435

The future

As outlined in the previous section, both Lighthouse and the comparison yielded a positive financial return over the long term. Lighthouse was funded from October 2018, and funding has been extended until March 2022 – with a question mark over what happens when this initial pilot reaches a conclusion. Provision of support services for victims of CSA differs widely across London, as is shown by the material in Appendix G which summarises the early emotional support (EES) available to victims of CSA at the point the report was written. Clearly that available at the Lighthouse is far more comprehensive than anywhere else in London, which has raised issues about the equity of the service provision. There are discussions on-going between the various stakeholders (MOPAC, NHS England, the Home Office, HMCTS, NSPCC etc) to determine what future models of CSA support might comprise, and the level of support provided to victims.

Perceptions of the future

As is the case for time limited programmes, the potential 'end point' of the Lighthouse and sustainability were regularly on the minds of staff over the course of the evaluation and was a source of concern. Indeed, pilot schemes will often suffer from such uncertainty (Dawson, Stanko, 2011) and this was no different across the Lighthouse and is something that grows as the end point comes closer.

'Many of the professionals who work in the Lighthouse are highly skilled, they will get job offers with other organisations rather than stay at the Lighthouse for the remainder of the pilot, without job security. Concerns about the loss of staff numbers if the pilot funding isn't continued'.

(Member of medical team, 2021)

Staff, partners and parents were well aware of the cost and overall innovative behind the Lighthouse, but many tended to feel that this is the service that CYP need, and others spoke about the likely benefit of a wider rollout of the service and the possibility of financial savings this could bring if any rollout was budgeted and managed at a local level. Similarly, the young people interviewed felt there should be more Lighthouse services to make them more accessible and enable a greater number of young people to benefit from them. Many had already praised and recommended the Lighthouse to their friends.

'We wouldn't take anything away. Do you want a Rolls Royce, or do you want a Skoda of a service? This service is what the children need, …'
(Member of medical team 2021)

Whereas some staff considered a future without the Lighthouse and reflected on the wider needs any future services may need to accommodate, such as the integrated service, managing risks, and the balance of attempting to do all of this in house, or as a commissioning agency.

'If thinking about the future you need an integrated service – either need a service that can do all of that and can think about the risk and the challenges (managing self-harm or suicidality) OR you have a service that provides consultation and support to the services out there which have more confidence and capacity to do that. Lighthouse is about integration and bringing people together'
(CAMHS staff member 2021)

6. Discussion

The Lighthouse represents the most comprehensive attempt to implement a Barnahus in the United Kingdom to date.[58] Its combination of dedicated child-friendly premises, the co-location of a range of specialist services, specific posts to encourage partnership working, and the provision of long-term support to CYP and family members surpasses anything that is available to victims of CSA elsewhere in the UK. Comparison of the Lighthouse to 'business as usual' elsewhere in London unsurprisingly showed that the Lighthouse reached a far larger number of clients and delivered far more outputs than practice elsewhere. As a result, there has been a great deal of interest in the emerging findings from the evaluation.

For the latter, researchers from MOPAC's Evidence and Insight unit have worked alongside those responsible for the design, implementation and delivery of services at the Lighthouse for the past three-and -a half years. The pilot used an action research rather than a summative approach for the evaluation and emerging findings have been fed back to staff at the Lighthouse, and to commissioners and stakeholders, throughout the pilot's lifetime. In terms of the duration of the research, the number of interviews and focus groups undertaken with staff, external agencies, service users and parents, and attempts to compare the Lighthouse with practice elsewhere, this has been the most comprehensive evaluation of the implementation of a Child House in the UK to date.

Findings from the performance data depict the volume of work that the Lighthouse achieved over the pilot, with 889 referrals being received between the end of October 2018 and the end of March 2021. Of those referrals, the Lighthouse saw 510 CYP for initial assessments either at the Lighthouse building in person or – since the CV-19 pandemic – virtually. For these 510 clients there was a considerable amount of work that was put in by staff, illustrated by: 4780 telephone, video or face to face sessions; 936 professional meetings; 29 psychologist-led interviews (not including the 43 police led interviews that took place at the building); 91 onward referrals into local services; 137 strategy discussions and; 118 consultations from the SCLOs. Within any given quarter there were between 489 and 695 open cases to Lighthouse worker.

The evaluators were also in receipt of individual level data from the Lighthouse's bespoke case management system (only for CYP who consented to provide their data, which was 71% out of the 510) which provided detailed insight into the backgrounds and needs of the service users. This data showed that the majority of clients were female, with over half in the age bracket of 13-17 years, and a fairly even split between BAME and non-BAME clients. It was clear from the data collected around the clients' needs and risk assessments that this is an incredibly vulnerable group of CYP with the majority 84% reported at least one type of vulnerability, most commonly depression and/or anxiety, a history of domestic violence, and education problems.

Overall, the evaluation found that the pilot was well implemented. Staff, partners, CYP and parents were positive about the general service. As expected, given the size and scale of the Lighthouse, the pilot experienced several implementation and maturation challenges – some of these were required and indeed instigated by staff, others were due to wider factors that staff had to work around, and these resulted in changes to the model and often staff not working in a way initially envisioned. However, staff responded well, and although some aspects were not totally addressed, many were resolved over the duration of the pilot.

[58] Durham Constabulary's piloting of a Child Advocacy Centre project in Durham and Darlington between June 2016 and April 2018, evaluated by the University of Durham, was much smaller in scale in terms of the services delivered, and was hampered by the failure to find suitable premises for the pilot (Hackett and Butterby, 2018).

Implementation of the Lighthouse was heavily disrupted by the CV-19 pandemic. In response, considerable changes were made in order to deliver the pilot – and to the credit of staff the service continued. Indeed, many of these virtual changes became embedded into the routine way of working, but overall staff felt that virtual working whilst necessary, was lacking therapeutically compared to face to face.

Overall, partnership working was a resounding positive to emerge from the evaluation, appearing to bring a wide range of benefits to the service as well as the clients – something supported by specific roles (Police Liaison Officer [PLO], Social Care Liaison Officer [SCLO]) that enabled such a way of working. However, it is clear some tensions as a result of different organisational cultures and working practices were evident which were not able to be fully reconciled over the pilot duration. This serves to illustrate how such working cultures are very difficult to avoid and should be borne in mind when devising and running any similar programme.

In terms of the impact of the Lighthouse, when measured against the objectives identified at its inception[59] evidence of their achievement was found for most but was largely reliant on qualitative data. Feedback from staff, from external agencies, from service users and from parents was excellent with regard to improved referral pathways, better support received post-disclosure, enhanced professional awareness, competence and confidence and enhanced partnership working. Longer term objectives (enhanced mental health and well-being outcomes for CYP for example, and the provision of care and support to CSA victims to reduce the long-term impact of victimisation) clearly could not be answered from these qualitative sources.[60] However, overall it is clear that for those who took part in the interviews, focus groups and surveys undertaken by E&I throughout the duration of the evaluation, whether they be professionals, staff, parents or service users, they all spoke very positively about the impact of the service.

Comparing two key outcomes of cases progressing through the Criminal Justice System (charge and conviction) there was almost no difference between cases from Lighthouse and the NEL cohort. The Lighthouse cases had **7%** (n=6) cases charged by the Crown Prosecution Service (CPS) and a **5%** (n=4) conviction rate; compared to NEL who had **6%** (n=4) charged by the CPS and **a 4%** (n=3) conviction rate, although clearly the analysis is limited by the small sample sizes. However, when comparing investigative actions across the two groups, there were some positive and encouraging findings. The Lighthouse had significantly higher instances of positive investigative actions such as increased suspect arrests, and a significantly higher proportion of cases submitted to the CPS. Additionally, more early investigative advice was sought from the CPS for the Lighthouse cases compared to NEL; something that had been actively worked on between the Lighthouse and CPS during the pilot.

RedQuadrant provided an indicative cost-benefit analysis (CBA) which involved exploring the benefits of the Lighthouse against the costs associated with setting up and delivering the pilot. It is clear that the Lighthouse is an expensive service. RedQuadrant calculated the annual operating costs to be £2.387m per year plus one-off capital costs of £3.9 million (covering refurbishment, installation of IT and infrastructure) which allocated over an 8-year period was £0.49m per year), equating to £2.88m per year in total. With this overall cost, and 420 clients per year, the unit costs for the Lighthouse were of the order of £6,860. Costs of the Havens service were estimated at £4,925 per case.

[59] The objectives were: enhanced referral pathways into and out of the Lighthouse, enhanced CYP, family and carer experience of support received post disclosure, enhanced CYP experience of the criminal justice process post disclosure, enhanced mental health and well-being outcomes for CYP, enhanced professional awareness, competence and confidence, increased likelihood of charge or conviction for those cases within the Lighthouse, enhanced partnership working, provide CSA victims with care and support to reduce the long-term impact of victimisation.

[60] A comparison of emotional wellbeing outcome data for the Lighthouse and NEL suggested that a significantly higher proportion of goals (89% to 47%) were achieved at the former, although there were differences between the two cohorts.

However, when these costs were set against the 3 broad areas of social value identified by RedQuadrant (wellbeing to the client, useful savings from public sector spend and additional public sector spend on essential activity) in the long term (30 years), the results suggested that there was a financial return to the public sector from the operation of the Lighthouse, with a net gain in public expenditure per client of £14,570. In comparison with the Havens the Lighthouse cost around £1,935 more per case, but saved an additional £7,000 on future public expenditure, and improves wellbeing by an additional £10,300.

The future of Lighthouse and CSA/E

CSA has been identified as a key priority by the government, MOPAC and other agencies. The Home Office's CSA strategy was published in January 2021 and stated that the government would '*help victims and survivors of recent and non-recent child sexual abuse to rebuild their lives by improving the support available and developing and embedding best practice*….. *w*e will raise awareness of support for victims and survivors and provide local commissioners with the resources to meet their needs wherever they live in the country' (Home Office, 2021, para 20). The Lighthouse is specifically mentioned in the strategy document which states that the Home Office will build on the learning from the Lighthouse pilot phase, to publish *'guidance for local commissioners and service providers seeking to introduce 'Child House' models of support to victims and survivors of child sexual abuse, and will consider how national and local funding can support the development of similar local initiatives'* (para 265, Home Office 2021). The anticipated publication of the Home Office's 'Child House; Local partnerships guidance', and MOPAC's 'Child House in a box' toolkit later in the summer of 2021 indicates the level of political support.

In addition, MOPAC's Victims Strategic Needs Assessment Summary Report (undated) has identified the 'requirement for further assessment work on the levels of needs regarding CSA, alongside a review of the Lighthouse model of provision to develop a scalable operating model that can provide a consistent quality intervention across [London]' and that MOPAC should consequently 'prioritise the funding, commissioning and resourcing of services where violence is present (inclusive of; CSA, Sexual Violence, Criminal Exploitation, Serious Violence and Domestic Abuse)'[61]. Clearly the findings from this evaluation, will play a crucial role in future discussions about the delivery of CSA.

Limitations / caveats

Notwithstanding the above, it is important to identify the limitations of the current evaluation, and the factors that have had an impact on it. In terms of the evaluation methodology it has proved difficult to establish a satisfactory comparison site in London for the Lighthouse. The service provided at the Lighthouse for victims of CSA is different from that available anywhere else in terms of facilities, extent and duration. Attempts to compare the Lighthouse against 'business as usual' is problematic when the latter varies markedly across London. In terms of the performance analysis the NEL CSA hub has been used as a comparison, although clearly the two are very different in nature (partly the justification for the comparison), and in the economic analysis, a combination of data from NEL and the Havens has had to be used – something which is obviously less than ideal, but which reflects the situation on the ground, and the availability of data.

[61] MOPAC Victims Strategic Needs Assessment Summary Report. Finding 1: Managing Demand - Expenditure is not aligned to victim need, and Finding 2: Violence is expected to increase and with it the profile of most vulnerable and affected victims is likely to change.

The case management system, whilst useful in many regards, was still unable to provide an accurate understanding of the individual Lighthouse services that were received and accessed by each client, and the duration of these services. Additionally, although the consent rate for evaluation was fairly good (71%), it should be borne in mind that this does not represent the full cohort of service users.

Similarly, with regard to the analysis of criminal justice outcomes, the current delays that are affecting the progression of cases through the courts has obviously had an impact on the number of cases from the Lighthouse available for analysis, and the sample size that has had to be used (n<100) is not ideal. Consequently, the results contained in this report should be viewed as indicative rather than definitive, and there will be the need to undertake follow-up research around criminal justice outcomes once more time has elapsed, and more data becomes available (see below). With regard to the economic analysis, the timescale available for the evaluation precludes the ability to look at the actual impact of the Lighthouse on the welfare and health of service users and family members in the longer term. Hence the alternative – the use of findings from what were felt to be relevant research, and the attribution of these benefits to the Lighthouse. Clearly the findings arising from this analysis are open to critique, but this report has tried to be transparent in terms of the assumptions made.

In terms of the findings around the implementation of the Lighthouse the situation has been complicated by the outbreak of the Covid-19 pandemic in Spring 2020 and the impact this had and continues to have on service delivery at the Lighthouse. In certain respects (the introduction of virtual working initially, and the development of a hybrid model consequently) Covid has led to the development of a model which was never anticipated, and elements of which are likely to be retained in the future. However, from an evaluation perspective the situation has been extremely problematic as there has been little continuity in terms of service delivery pre and post Covid. In addition, the impact of the changes on service users and on staff at the Lighthouse should not be underestimated.

Final thoughts

The Lighthouse evaluation has spanned three-and a half years and 3 interim products – and the current report brings the evaluation to a close. One of the aims was to deliver the largest evaluation of its type in the country covering aspects of process, performance, impact and economic value. Overall, this has been achieved and a substantial body of learning has been generated. Indeed, this manner of evidence-based working – supporting a major programme with long term and in-depth evaluation throughout its lifespan, enabling ongoing decisions to be evidence based is a positive approach to both evaluation as well as programme delivery and one that should be more frequent across criminal justice. The Lighthouse will continue to be funded in its present form until the end of March 2022, and there are specific aspects of its work which have yet to come to fruition, and with which there is likely to be continued interest. Indeed, as outlined within the report, the analysis on impact in particular would benefit from a longer analytic time period – and this is something that will be explored in terms of understanding the issue of impact more robustly.

References

Avison, D. E., Lau, F., Myers, M., D and Nielsen, P. A. (1999) 'Action Research'. Communications of the ACM, January 1999, Vol. 42 No. 1, Pages 94-97.

Baglivio, M. T., Epps, N., Swartz, K., Huq, M. S., Sheer, A., and Hardt, N. S. (2014) 'The prevalence of adverse childhood experiences (ACE) in the lives of juvenile offenders'. Journal of juvenile justice, 3(2), 1.

Barrett, A. and Kamiya, Y. (2012) 'Childhood Sexual Abuse and Later-Life Economic Consequences'. IZA Discussion Paper No. 6332.

Beckett, H., Soares, C. and Warrington, C. (2022) ''There's something there for everyone'- Learning about the Lighthouse: Young people's perspectives on London's Child House'. University of Bedfordshire, ISBN: 978-1-911168-15-7

Bellis, M., Lowey, H., Leckenby, N., Hughes, K. and Harrison, D. (2014) 'Adverse childhood experiences: Retrospective study to determine their impact on adult health behaviours and health outcomes in a UK population'. Journal of Public Health, 36, 1, 88 – 91.

Bethell, C.D., Carle, A., Hudziak, J., Gombojav, N., Powers, K., Wade, R., Braveman, P. (2017) 'Methods to assess adverse childhood experiences of children and families: toward approaches to promote child well-being in policy and practice'.

Blom-Hoffman, J., Leff, S. S., Franko, D.L., Weinstein, E., Beakley, K. and Power, T.J. (2009) 'Consent Procedures and Participation Rates in School-Based Intervention and Prevention Research: Using a Multi-Component, Partnership-Based Approach to Recruit Participants'. School Mental Health, 1(1) 3-15.

Brown, J. O'Donnell, T. and Erooga, M. (2011) 'Sexual Abuse: A Public Health Challenge'. NSPCC.

Children's Commissioner for England, (2015) 'Protecting children from harm: A critical assessment of child sexual abuse in the family network in England and priorities for action'. London.
https://www.childrenscommissioner.gov.uk/wp-content/uploads/2017/06/Protectingchildren-from-harm-executive-summary_0.pdf.

Children's Commissioner for England (2016) 'Barnahus: Improving the response to child sexual abuse in England'. London.

Conti, G., Morris, S., Melnychuk, M., and Pizzo, E. (2017) 'The Economic Costs of Child Maltreatment in the UK, a preliminary study'. NSPCC.

Conroy, L., Hobson, Z., Parker, R. and Read, T. (2018) 'The Lighthouse: London's Child House. Initial Evaluation Report'. MOPAC Evidence & Insight.

Crown Prosecution Service. Therapy: 'Provision of Therapy for Vulnerable or Intimidated Adult Witnesses'. Available at: https://www.cps.gov.uk/legal-guidance/therapy-provision-therapy-vulnerable-or-intimidated-adult-witnesses.

Daro, D. (1988) 'Confronting child abuse: research for effective programme design'. New York: Free Press.

Duwe, G., and Clark, V., A. (2015) 'Importance of Program Integrity'. Criminology & Public Policy, Vol 14 (2).

Elmquist, J., Shorey, R.C., Febres, J., Zapor, H., Klostermann, K., Schratter, A., and Stuart, G.L. (2015) 'A review of Children's Advocacy Centers' (CACs) response to cases of child maltreatment in the United States'. Aggression and Violent Behavior, 25, 26-34.

Felitti, V. J., Anda, R. F., Nordenberg, D., Williamson, D. F., Spitz, A. M., Edwards, V., Koss, M.P., Marks, J. S. (1998) 'Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults: The Adverse Childhood Experiences (ACE) Study'.

Fergusson, D., McLeod, G. and Horwood, J. (2013) 'Childhood sexual abuse and adult developmental outcomes: Findings from a 30-year longitudinal study in New Zealand'. Child Abuse and Neglect 37.

Goddard, A., Harewood, E. and Brennan, L. (2015) 'Review of Pathway following sexual assault for children and young people in London'. Kings College Hospital NHS Foundation Trust, NHS England (London).

Hackett, S. and Butterby, K. (2018) 'An independent evaluation of the Child Advocacy Centre (CAC) Project in Durham and Darlington'. Durham University and Child Advocacy Project.

Hailes, H., Yu, R., Danese, A. and Fazel, S. (2019) 'Long-term outcomes of childhood sexual abuse: an umbrella review'. Lancet Psychiatry 6, pp. 830-39.

Harewood, E. and Baine, H. (2018) 'Healthy London Partnership, London Child Sexual Abuse Services Learning Report'. NHS England.

Heeks, M., Reed, S., Tafsiri, M. and Prince, S. (2018) 'The economic and social costs of Crime'. Second edition. Research Report 99. Home Office.

Herbert, J L and Bromfield L (2016) 'Evidence for the Efficacy of the Child Advocacy Center Model: A Systematic Review'. Trauma Violence and Abuse 2016 Vol 17 (3) 341-357.

Herbert, J L and Bromfield L (2017) 'Better Together? A Review of Evidence for Multi-Disciplinary Teams Responding to Physical and Sexual Child Abuse'. Trauma Violence and Abuse 2017 1-15.

Home Office (2021) 'Tackling child sexual abuse strategy'. Home Office: London.

Khadr, S., Clarke, V., Wellings, K., Villalta, L., Goddard, A., Welch, J., Bewley, S., Kramer, T. and Viner, R. (2018) 'Mental and sexual health outcomes following sexual assaults in adolescents: a prospective cohort study', Lancet.

Landberg, A, and Svedin, C G (2013) 'Inuti ett Barnahus: a quality review of 23 Swedish barnahus'. Radda Barnen.

The Lighthouse (2020) 'The Lighthouse Annual Report 2019 – 2020'. Lighthouse. Available at

https://www.thelighthouse-london.org.uk/guidance-and-support-for-professionals/downloads-links-for-professionals/.

McNeish, D and Scott S, (2018) 'Key messages from research on intra-familial child sexual abuse'. DMSS Research and Centre of expertise on child sexual abuse.

Newberger, C., Gremy, I., Waternaux, C., and Newberger, E. (1993) 'Mothers of sexually abused children: Trauma and repair in longitudinal perspective'. American Journal of Orthopsychiatry, 63(1), pp. 92-102.

PWC (2015) 'The Costs of Eating Disorders. Social, Health and Economic Impacts'. PWC.

Sadler, S., Tosh, J., Rawdin, A., Squires, H., Sutton, A. and Chilcott, J. (2016) 'A model to evaluate the cost effectiveness of condom distribution schemes, developed for NICE public health guidance on condom distribution schemes and sexually transmitted infections'. PHAC 21.10 draft health economics report, University of Sheffield School of Health and Related Research.

Vaswani, N. (2018) 'Adverse Childhood Experiences in children at high risk of harm to others. A gendered perspective'. Centre for Youth & Criminal Justice.

Zarse, E.M., Mallory, R.N., Yoder, R., Hulvershorn, L., Chambers, J.E. & Chambers, R.A. (2019) 'The adverse childhood experiences questionnaire: Two decades of research on childhood trauma as a primary cause of adult mental illness, addiction and medical diseases'.

Appendices

Appendix A – Full list of criminal Justice coding framework variables and their frequencies, comparing Lighthouse with NEL

Variable	Lighthouse N	% of sample	Comparison N	% of sample
Victim/survivor characteristics				
Age at time of offence [incl. non-crime cases]				
Under 10 years	45	38%	8	11%
10-15 years	63	53%	46	64%
16 years and above	11	9%	18	25%
Age at time of reporting [incl. non-crime cases]				
Under 10 years	47	34%	8	10%
10-15 years	76	54%	49	62%
16 years and above	17	12%	22	28%
Gender [incl. non-crime cases]				
Female	115	80%	70	88%
Male	28	20%	10	13%
Ethnicity				
White	63	50%	40	56%
Black	43	34%	20	28%
Asian	10	8%	11	15%
Other	11	9%	0	-
Has mental health issue*	58	42%	14	21%
Has learning difficulty	20	14%	9	13%
Previous victimisation of sexual assault/DA	19	22%	7	10%
Suspect characteristics				
Age at time of offence [where known]				
Under 18 years	33	41%	27	48%
18-30 years	15	19%	16	25%
31-40 years	6	8%	5	9%
41-50 years	15	19%	5	9%
51-60 years	9	11%	3	5%
61+ years	2	3%	0	-
Gender				
Female	5	6%	5	7%
Male	84	94%	62	93%
Previous history of domestic abuse	11	13%	2	3%
Previous history of sexual assault/rape	9	10%	3	4%
Previous history of other offending*	19	22%	5	7%
Relationship to victim/survivor				
Stranger*	12	14%	18	27%
Current or former partner	9	10%	7	10%
Friend or Acquaintance [incl. family friend]	27	31%	25	37%
Familial*	35	41%	13	19%
Professional or Carer	1	1%	1	1%

Offence characteristics				
Location				
Victim's dwelling	14	16%	6	9%
Suspect's dwelling	14	16%	10	15%
Shared dwelling of victim and suspect	19	22%	8	12%
Other private dwelling	13	15%	4	6%
Outside	0	-	15	22%
Not domestic	19	22%	16	24%
Offence recorded or photographed	8	9%	9	13%
Procedural characteristics				
Time taken to report				
Same day	15	17%	12	21%
1 – 7 days	15	17%	24	41%
1 week – 1 month	21	24%	6	10%
1 month – 6 months	15	17%	6	10%
6 months – 1 year	2	2%	2	3%
Over 1 year	18	21%	8	14%
Reported to police by				
Victim/survivor	13	15%	15	23%
Third party	71	83%	51	77%
Third party description				
Family	35	48%	20	38%
Social Services	23	32%	10	19%
Education	10	14%	13	25%
Support services	0	-	7	13%
Medical	4	5%	0	-
Other	0	-	2	4%
Number of OICs				
One	5	7%	12	18%
Multiple	81	94%	55	82%
Victim/survivor attended Havens	17	20%	12	18%
Video recorded interview completed*	61	71%	22	33%
Multiple video recorded interviews	13	15%	13	19%
Location of 1st video recorded interview				
Police station	39	64%	19	86%
Lighthouse	19	31%	n/a	-
Other			2	9%
Location of last video recorded interview				
Police station	5	38%	n/a	-
Lighthouse	7	54%	n/a	-
Psychologist-led interview	9	15%	n/a	-
Police identify perpetrator	68	79%	49	73%
Perpetrator arrested*	38	44%	18	27%
Perpetrator interviewed under caution +3	32	37%	21	31%
Early investigative advice sought from CPS*	18	21%	4	6%
Early Evidence Kit administered	13	15%	12	18%
No forensic opportunities	47	55%	31	46%
Body Worn Video footage	12	22%	10	15%
Request for Lighthouse material made	17	20%	n/a	-
Request for other 3rd party material made*	43	50%	16	24%

Police reference delays in obtaining 3rd party material	16	19%	6	9%
Police reference high workload	18	21%	7	10%
Police reference delays due to Covid-19*	16	19%	4	6%
Victim referred to support services	n/a	-	14	21%

Appendix B – Comparison of NEL criminal justice cases sample with final comparison group

Table 13. Breakdown of Comparison group CRIS classifications

Classification	Wider comparison sample of 1869		Final comparison sample of 80	
	Number of cases	Percentage	Number of cases	Percentage
Sex Ass F	520	28%	21	26%
Sex Ass F U 13	255	14%	9	11%
Rape F U 16	223	12%	11	14%
Pen F U 16	155	8%	7	9%
Rape F O 15	154	8%	8	10%
No Pen F U 16	94	5%	7	9%
Sex Ass M U 13	81	4%	5	6%
Rape F U 13	80	4%	3	4%
No Pen F U 13	54	3%	2	3%
Sex Ass M	50	3%	2	3%
Pen F U 13	36	2%	0	0%
Pen Fem	28	1%	1	1%
Rape M U 13	20	1%	2	3%
No Pen M U 13	18	1%	0	0%
Pen M U 16	18	1%	0	0%
Pen M U 13	13	1%	0	0%
A/rape F U 16	11	1%	0	0%
No Pen Fem	10	1%	0	0%
No Pen M U 16	9	0%	0	0%
A/rape F O 15	7	0%	0	0%
A/rape F U 13	7	0%	0	0%
Rape M U 16	6	0%	0	0%
Rape M O 15	5	0%	0	0%
Pen Male	4	0%	1	1%
A/rape M U 13	2	0%	0	0%
A/rape M U 16	2	0%	0	0%
No Pen Male	2	0%	0	0%
Pen Fem	1	0%	0	0%
Rape MUO FU13	1	0%	0	0%
Rape MUO FU16	1	0%	0	0%
Sex Act U 13	1	0%	1	1%
Sex Act U 16	1	0%	0	0%
Total	**1869**		**80**	

Table 14. Breakdown of Comparison group gender

Gender	Wider comparison sample of 1869		Final comparison sample	
	Number	Percentage	Number	Percentage
Female	1624	87%	70	88%
Male	240	13%	10	13%
Undisclosed	2	0%	0	0%
Total	**1866***		80	

*(NB: The base numbers for demographics vary due to data completeness in CRIS)

Table 15. Breakdown of Comparison group ethnicity

Ethnicity	Wider comparison sample of 1869		Final comparison sample	
	Number	Percentage	Number	Percentage
White	839	51%	40	56%
Black	441	27%	20	28%
Asian	336	21%	11	15%
Other	23	1%	0	0%
Total	**1639**		**71**	

Table 16. Breakdown of Comparison group age groups

Age groups	Wider comparison sample of 1869		Final comparison sample	
	Number	Percentage	Number	Percentage
12 and under	534	29%	23	29%
13-17	1311	70%	55	69%
18 and over	24	1%	2	3%
Total	**1869**		**80**	

Appendix C - Supplementary Lighthouse performance tables

Table 17. Prevalence of ACEs (out of 222 CYP)

Type of ACE	No. of CYP	Percentage
Sexual abuse	183	82%
Parents divorced	102	46%
DV against mother or father	74	33%
Emotional abuse	70	32%
Emotional neglect	60	27%
Parent mental illness	55	25%
Physical abuse	43	19%
Parents alcohol or drug issues	36	16%
Physical neglect	33	15%
Parent in prison	15	7%

Table 18. Prevalence of disabilities among CYP

Disability	Service users	Percentage
Mild Learning difficulties	20	26%
Moderate Learning difficulties	19	24%
Autism	16	21%
Communication speech and language under therapy	12	15%
Mild physical disability	11	14%
ADHD	7	9%
Hearing with aids	3	4%
Blind	3	4%
Severe Learning difficulties	2	3%
Moderate to severe physical disability	2	3%
Total with disability	**78**	

Table 19. Prevalence of vulnerabilities among CYP

Type of vulnerability	Service users	Percentage
Anxiety/depression	121	41%
History of DA	110	37%
Other	106	36%
school/education problems	82	28%
History of self-harm	78	26%
Concerns over safety	55	19%
CSE	50	17%
Suicide risk	47	16%
Drugs/alcohol	34	11%
Risk of further harm	26	9%
Sexualised behaviour	26	9%
LA care order	25	8%
Missing from home	20	7%
Eating disorder	13	4%
Total with vulnerability	**297**	

Table 20. Onward referrals made by the Lighthouse into borough services, between Oct 2019 and March 2021

Borough	Local CAMHS	Local Sexual Health	GP	Other Paediatric Services	Counselling	Social Services	Voluntary Sector	A&E	Total
Barnet	3	0	1	1	2	6	7	0	**20**
Camden	1	1	0	0	3	2	5	0	**12**
Haringey	3	1	1	0	2	3	6	1	**17**
Enfield	4	0	1	0	0	7	8	0	**20**
Islington	7	0	0	1	1	6	3	0	**18**
Other	1	0	0	1	0	0	2	0	**4**
Total	**19**	**2**	**3**	**3**	**8**	**24**	**31**	**1**	**91**

Table 21. Quarterly levels of contact with CYP and families, between Oct 2019 and March 2021

Contact type	Oct - Dec 2019	Jan - March 2020	April - June 2020	Jul - Sept 2020	Oct - Dec 2020	Jan - March 2021	Total
Number of face to face sessions with CYP	N/K	N/K	15	161	231	102	**509**
Number of sessions with parent/carer	N/K	N/K	13	14	11	16	**54**
Number of sessions by telephone	388	476	398	573	902	705	**3442**
Number of sessions by video call	N/A	N/A	278	149	149	253	**829**
Number of professional meetings (excluding strategy and consultation)	152	125	123	124	219	193	**936**

Table 22. Quarterly Strategy discussions and signposting, by borough, between April 2020 and March 2021

Borough	Apr-Jun '20	Jul-Sep '20	Oct-Dec '20	Jan - Mar '21	Total
Barnet	2	1	1	5	9
Camden	15	21	14	14	64
Haringey	6	0	0	2	8
Enfield	5	4	1	1	11
Islington	6	13	10	16	45
Other	0	0		0	0
Total	34	39	26	38	137

Table 23. Quarterly consultations (delivered by SCLOs) by borough, between April 2020 March 2021

Borough	Apr-Jun '20	Jul-Sep '20	Oct-Dec '20	Jan - Mar '21	Total
Barnet	10	4	3	1	18
Camden	4	3	8	6	21
Haringey	9	7	4	2	22
Enfield	5	7	3	3	18
Islington	8	11	3	16	38
Other	0	1	0	0	1
Total	36	33	21	28	118

Time between reporting to police and being referred to the Lighthouse	**Number of cases**	**Percentage**
Lighthouse referral occurred *before* crime reported to police	3	3%
Within 1 week	30	35%
Over 7 days to 1 month	28	33%
Over 1 month to 6 months	16	19%
Over 6 months to 1 year	6	7%
Over 1 year	3	3%
Total	**86**	

Appendix D - Description of service provision in NEL

The Northeast London CSA Hub

In January 2018 a paper by the Healthy London Partnership (HLP) had been presented to the Joint Commissioning Committee established by the 7 NEL Clinical Commissioning Groups recommending the development of a Child Sexual Assault/Abuse Hub (CSA) for the NEL boroughs; Barking and Dagenham, Hackney, Havering, Newham, Redbridge, Tower Hamlets and Waltham Forest. There were two elements to the hub model.

1. an emotional support service (ESS) to work with CYP who had made disclosures of CSA that did not meet the criteria for the Haven sexual abuse referral centres.
2. CSA clinics for the medical assessment and treatment of CYP staffed by a rota of paediatricians from across NEL.

Provision of early emotional support
The contract for the emotional support service (ESS) was awarded to Barnardo's to provide the 'Tiger Light' model of trauma informed therapy and support. The service began on the 1st April 2019, delivering across the NEL STP boroughs. Initially it provided 6–8-week sessions of support including trauma-informed early help advocacy and case management, and symptom management, with safe and appropriate onward referral, when necessary, although the number of sessions was subsequently increased to 11 weeks. The support is provided directly to the child/young person and/or their safe parent/carer as appropriate with referrals coming from local Multi-Agency Safeguarding teams. Social workers can refer directly to Barnardo's if the young person or their family does not want a medical assessment or refer via the CSA medical Hub. The intention was for the CYP to be seen for the first ESS appointment at the same time as the medical assessment, but for logistical reasons (outlined below) this proved impossible. The emotional support service aims to provide early help, reduce the development of long-term mental health conditions such as PTSD, and thereby minimise the need for long-term support from CAMHS. The service was initially staffed with 1.7 fte practitioners and a part time team manager, although this was subsequently increased to 2.6 fte when the capacity of the service was increased by the CCG.

The programme is open to any child up to their 18th birthday. Referrals have to have been notified through Childrens' Social Care and are for abuse that has taken place outside the 3-week forensic window, the service manager described the abuse as typically being 'much more historical than that….[happening] 'probably six months to six years ago, it can be quite a long time'.

The Barnardo's referral form asked if they could make a referral to the paediatrician, but it was not always completed, so 'we tend to follow that up ourselves with the family'. Equally the paediatricians, if they get the referral through their route, whether it be via hospital or via a social worker, could refer CYP to Barnardo's for the early emotional support. The expectation is that a full-time worker would see 10 young people a week, their caseload might be slightly higher (possibly around 14) based on levels of anticipated non-attendance, cases starting and closing. The Tiger Light programme provides eight to eleven weeks of support – tending to be shorter for young children, but for some children, 'can feel that you're only getting to know them at 8 weeks, so the length of the support varies, something that the CCG recognised. While the focus of the model is on the child or young person, the parent might be offered 'one or two support sessions as well to help them understand what's happening for their child'.

The service manager described the referrals to the service as coming in 'peaks and troughs'. The target for Tiger Light initially was to see 72 young people a year, but within the first 4-5 months

of operation, they had already received more referrals than that, so NEL CCG provided additional funding to increase the numbers to 120 a year. There was a recognition that the potential level of demand in NEL far exceeded the number of places available. 2018/19 MPS data suggested that there were 705 cases of historic abuse reporting in the NEL STP area. Assuming a similar need for assessment to those cases as in NCL (60%), this would have required an annual capacity of around 400 new appointments – far beyond the current availability of services to deliver. As a result, the service had received more referrals than it had capacity for and had had a waiting list from 4/5 months into the start of the project. They had also had to put people on a 'holding list' during covid – not being seen because of COVID.

Barnardo's run a weekly referral and allocation meeting, attended by Tiger managers. The criteria for acceptance are age, living or under the authority of one of the NEL boroughs, and a strong suspicion or disclosure of abuse. Most referrals were accepted, decisions about priorities were taken on the basis of what the immediate risks were to the child, and whether the child was engaged with other agencies. This could also affect the way of working with the child; 'so we've got some examples where we work alongside CAMHS for example, we've just got one where we're alternating appointments for example now, so that the young person is still getting the support and we can work collaboratively'.

On the course's completion, Barnardo's made onward referrals to schools for counselling support, they also had volunteer 'buddies' who might be matched to the young person to offer them longer term support, but that was mainly around supporting the young person to attain goals; 'they want to get involved in like cadets or playing football or sports or something like that'. Generally, however 'a lot of young people at the end of support we don't identify that need any more support that point'. The service also did not generate many returns; while the offer is there 'to be honest with you, we've been operational for 2 years, we've only had two re-referrals and not very many young people end up coming back'.

In terms of how the Barnardo's service co-ordinated with the CSA clinic, it was described as running 'in parallel, maybe more in tandem' (Barnardo's staff member). The intention had been for there to be greater integration between the two services, with Tiger Light attending the clinic and making contact with CYPs there. In the event, as a result of working days that did not overlap and the impact of COVID, this had not happened.

In terms of the impact of Covid on service delivery, Barnardo's had done very little remote working pre-Covid, limited to phone contact with young people if they were unable to set up their session straight away. Otherwise, work was undertaken face to face, at a location chosen by the young person, normally school or college. When lockdown occurred, it took about 6 weeks for Barnardo's to migrate their model online, change consent procedures, make sure platform was safe, and address technical issues. The staff also had to start thinking about how they would change the structure of their sessions. As a result, a lot of young people were initially placed on hold, via phone contact.

Over time staff had become more proficient at delivering the work virtually, although, as with the Lighthouse, staff had identified the challenges of working from home. However, Barnardo's had always continued one-to-one support where it was safe and possible to do so, and some staff had been keen to do that from the outset, so they had developed a risk assessment process to allow them to do that (PPE equipment, risk assessment of the site, ensuring the CYP was fully aware of risks), although often it depended on the school granting access to their premises. At the beginning there had been a lot of issues with digital poverty, people not having access to safe, confidential spaces, but 'being a charity we were quite lucky. People donated like laptops and all sorts of things and we got some Vodafone, dongles, all sort of stuff that could help, but

it still doesn't take away the ability to have somewhere safe to sit and have a conversation without fearing that you're going to be overheard'. Most of the team were now out and about delivering sessions; 'we're offering we can come and see you, so we're much more out there now'.

At the time of writing, like the Lighthouse, Barnardo's were operating a hybrid model. It was accepted that remote working benefitted some young people, who would like to see elements retained (the absence of travel, and where home was a safe space) but for others, it did not work. Some children had not wanted to engage remotely during pandemic, for young children it was difficult to do the work virtually, and for children with learning needs or where the child had been abused online it did not feel appropriate.

NEL CSA clinic

The initial (2018) plan for the CSA clinic in NEL was that the seven NEL boroughs would contribute paediatric time to create a sector-wide paediatric rota, staffing a weekly CSA Hub clinic at two sites, 48 weeks of the year, CYP having open-access at either clinic. The two clinics would be offered on a four-week cycle; 3 weeks at the Royal London Hospital, the fourth a clinic for the outer London boroughs, probably located in Waltham Forest. Best practice standards indicated two paediatricians should be present and the intention was to offer improved referral and access to the emotional support service at the time of the medical appointment. The clinics would also enable training and support to paediatricians not currently able to provide this care and provide enough cases a year for them to maintain their competencies.

However, the planned model had never been implemented. While the Royal London Hospital introduced a weekly clinic for CSA medicals from April 2019, providing a service for three boroughs (Tower Hamlets, Newham, and Hackney), it proved impossible to develop the second clinical hub, largely due to 'very limited' paediatric capacity and expertise in NELFT.62 As a result, the initial proposal was eventually amended to a one-site model at the Royal London Hospital of CSA medicals paid for on a block contract with Barts Health Trust with costs shared across the 7 STP boroughs, beginning in January 2020.

As with Tiger-Light, the paediatrician described the number of referrals as 'lumpy, [I] can go some time with hardly anything and then suddenly 8 referrals in a week. I can see 2 kids in an afternoon clinic. Essentially two children a week, about 80 kids a year'. The clinic usually ran once a week, which the paediatrician described as being 'enough for current level of referrals I'm seeing' and there was no waiting list, although, as with the Barnardo's service there was a recognition that the level of CSA in NEL was much higher than the numbers being seen at the clinic; 'If you look at police data for NEL for reports of historic sexual abuse to police it's about 700 a year and I'm seeing a tiny fraction of those patients'.

All referrals had to be made by social care via a standard referral form which all local authorities had been sent. Referrals came via email into generic email address, which was vetted by the clinician 'as I'm still single handed here'. In most cases a referral would be accepted straight away, if there was not enough information on the form, or additional information required, the paediatrician would contact the social worker on the phone. Ideally the child would be seen within 2 weeks, but there was a recognition that this was not always the case, particularly if the paediatrician was on leave 'if I go on holiday that causes a problem. I'm not meeting the two-week standard sometimes I see them really quickly and sometimes they have to wait a bit'.

[62] The rota developed to support a two-site model required NELFT to provide 192 hours of paediatric time a year which equated to 18 hours per month - NELFT had a very small number of paediatricians qualified to undertake CSA medicals who did not have the capacity to support the Hubs as required. Additionally paediatricians from both Barts and NELFT raised logistical issues with a service offered across two sites operated by different organisations using different ICT systems, plus a concern about 'chain of evidence' arrangements which are not available in a community setting and which therefore could impact on the outcome of any criminal proceedings.

All appointments were undertaken face to face, something which had not changed during Covid, with the child being brought to the clinic by the social worker. Following the appointment, the paediatrician provided verbal feedback to the social worker, followed by a full written report. 'In majority of cases I don't need to see kid again, I may refer onto Barnardo's and follow up any investigations I've done during assessment, and if I need to give any treatment, I will contact GP to arrange that to be done. Occasionally I see children for follow up if something is abnormal'.

Other people involved in the clinic were the paediatrician's PA, supported by the play therapy team in the hospital, who the paediatrician described as 'effectively doing it free of charge, but without that support it would be really difficult for me to deliver the service as well as I do, they offer a lot of distraction and support for children during the examination. I bleep the on-call play therapist, I don't have an allocated play therapist, I bleep them and they are on a job and they are peeling off another job to help me, and if they are too busy they may not be able to come.'

Initially it was envisaged that the weekly clinic would allow for 2 new patients or 1 new and 2 follow up patients to be seen, and that the clinic would be staffed by a rota of paediatricians who would prospectively cover annual / study leave to ensure the clinic could be delivered 48 weeks a year. However, one of the major difficulties for the clinic has been obtaining paediatric support for the lead paediatrician (something which had also prevented the two-site model being implemented in the first place). While other paediatricians had attended the clinic, this had largely been for training purposes or to get experience, they had not been released from their jobs to spend allocated time at the clinic or been paid to do so. As a result, the clinic found itself in a Catch-22 situation; 'I can't pay for the extra resource without having the additional referrals and I'm only having a trickle of patients through. The service is entirely reliant on me to drive the improvements. I've got to be adaptable and flexible to allow it to grow'. It was recognised by the CCG that there was a need to develop the service gradually to support the growing competence and recruit additional staff to meet the likely required capacity.

Overall, the annual cost of the paediatric clinic at Barts is £60,390 pa (staffing costs of £59,640 as below plus £750 annually for the maintenance of the colposcope. Staffing costs include the costs of monthly clinical supervision and peer review to ensure emotional support for the team).

	Per Year	Rate	Total
Consultant Paediatrician	624 hours	84	£52,416
Hospital Play Specialist	216 hours	28	£6048
Psychologist	24 hours	49	£1176
Total			£59,640

Appendix E – Supplementary tables of comparisons between Lighthouse and NEL services

Table 24. Boroughs referring to NEL CSA Hub services between January 2019 and May 2021

	NEL Tiger Light		NEL Paediatrician		Total NEL	
Referring borough	**CYP**	**Percentage**	**CYP**	**Percentage**	**CYP**	**Percentage**
Barking & Dagenham	48	34%	6	7%	54	23%
Havering	30	21%	1	1%	31	13%
Redbridge	25	18%	2	2%	27	12%
Newham	13	9%	11	12%	24	10%
Waltham Forest	12	9%	9	10%	21	9%
Tower Hamlets	9	6%	37	41%	46	20%
Hackney	4	3%	24	27%	28	12%
Total	**141**		**90**		**231**	

Table 25. Comparison of service user age groups[63]

	Lighthouse		NEL Barnardo's	NEL Paediatrician	Total NEL	
Age group	**CYP**	**Percentage**	**CYP**	**CYP**	**CYP**	**Percentage**
12 and under	367	41%	85	74	159	60%
Age 13-17	505	57%	92	15	107	40%
18 and over	17	2%	0	1	1	0%
Total	**889**		**177**	**90**	**267**	

Table 26. Comparison of service user gender[64]

	Lighthouse		NEL Barnardo's	NEL Paediatrician	Total NEL	
Gender	**CYP**	**Percentage**	**CYP**	**CYP**	**CYP**	**Percentage**
Female	730	82%	133	75	208	78%
Male	155	17%	44	14	58	22%
Transgender	2	0.2%	0	0	0	0%
Total	**887**		**177**	**89**	**266**	

63 This includes the age data on all Lighthouse referrals, not just those who consented.
64 This includes the age data on all Lighthouse referrals, not just those who consented.

Table 27. Barnardo's Tiger Light wellbeing outcome measures[65]

Outcome	Good improvement	Some improvement	Stayed the same	Some decline	Total
Access to support services	1	10	11	2	**24**
Enhanced parent/carer/adult - child relationships	1	7	16	1	**25**
Increased confidence	1	10	11	3	**25**
Ability to express feelings	1	14	7	3	**25**
Improved mental health & well-being	1	16	5	3	**25**
Positive social/cultural/religious identity	0	9	14	0	**23**
Improved self esteem	1	13	9	2	**25**
Knowledge of sexual health strategies	0	1	1	0	**2**
Able to identify abusive/exploitative behaviour	0	2	0	0	**2**
Able to describe safety strategies	2	10	12	1	**25**
Reduction in level of risk/harm	0	0	2	0	**2**
Carers/staff aware of safety strategies	2	3	20	0	**25**
Reduction in impact of trauma	2	14	6	3	**25**
Family has access to support services	0	0	2	0	**2**
Link with reliable and supportive role models	0	8	15	0	**23**
Sustained progress on exit from service	1	7	14	0	**22**
Parents/carers active in working with service	0	0	2	0	**2**
Engaged in personal action planning	2	12	11	0	**25**
Grand Total	**15 (5%)**	**136 (42%)**	**158 (48%)**	**18 (6%)**	**327**

Table 28. Comparison of service user ethnic groups[66]

	Lighthouse		NEL Barnardo's	NEL Paediatrician	Total NEL	
Ethnic groups	**CYP**	**Percentage**	**CYP**	**CYP**	**CYP**	**Percentage**
White	140	47%	76	12	88	43%
Asian	23	8%	34	7	41	20%
Black	70	23%	34	3	37	18%
Other Mixed	20	7%	12	3	15	7%
Mixed White and Black	31	10%	8	4	12	6%
Mixed White and Asian	7	2%	3	2	5	2%
Other Ethnic group	10	3%	2	4	6	3%
Total	**301**		**169**	**35**	**204**	

65 'Good improvement' equals a change of -3 or -4 in scores, 'some improvement' equals a change of -1 or -2 in scores, 'stayed the same' means the score remained unchanged, and 'some decline' equals an increase of 1 – 2 in risk.
66 Lighthouse ethnicity data is only for those who consented.

Table 29. Lighthouse emotional wellbeing goal setting

Coded goals	**Achieved**	**Partially Achieved**	**Not Achieved**	**Total**	**No recorded outcome yet**
Support with emotions	13	10	1	**46**	22
Confidence & Identity	12	6		**28**	10
Parent support	11	2	1	**25**	11
Other	11	3	4	**25**	7
Healthy relationships		3	1	**20**	16
School support	5	4	1	**12**	2
Assessment of need	5		1	**11**	5
Health and wellbeing	4	4	1	**14**	5
Therapeutic support	4	1	1	**10**	4
Develop relationships	2		2	**5**	1
Further support	1	2		**5**	2
Safety advice	1			**3**	2
Total	**69 (59%)**	**35 (30%)**	**13 (11%)**	**204**	**87**

Appendix F – Calculations underpinning economic evaluation

RedQuadrant's (RQs) analysis deploys a Difference-in-Difference approach, a statistical technique often used in social science, that studies the differential effect of a treatment on a 'treatment group' versus a 'control group'. That meant:

- Collating data on key outcomes at baseline and after treatment from the Lighthouse Annual Report;
- Collating data on expected levels of improvements for these outcomes from the existing literature on the after-effects of CSAE for victim-survivors; and
- Reviewing the improvement for the Lighthouse versus that identified by the literature

The RQ model identifies the benefits that accrue compared against two hypotheses (a) treatment under non-specialist services; and (b) under a partly integrated approach. In drawing-up the benefits, a wide range of literature was reviewed, much of which is drawn from the international literature. In considering the benefits for inclusion, the criteria used were to consider whether they are:

(a) likely to be significant in terms of impact;
(b) measurable; and
(c) attributable to the interventions delivered at the Lighthouse.

The focus of the economic analysis is on the comparison of Lighthouse against standard forms of provision in London, in particular those considered in Harewood and Baine (editors) (2018) "*London Child Sexual Abuse Learning Report.* [67] This report examined three models funded by the London CSA Transformation Programme, all aiming to support CYP after experiencing CSA. These models were (1) the Children and Young People's Haven Service (CYP Havens) based within London's Sexual Assault Referral Centre, (2) the Lighthouse and (3) CSA hubs.

As well as the insights from Harewood and Baine (2018), useful data is available in the Lighthouse Annual Report on:

- Statistics on the proportion of goals met among C&YP (67% were achieved, 37% partially achieved and 4% not achieved), and
- Statistics on means and standard deviations on progress made towards individual goals for the parent course (which increased from an average of 5.4 to 7.8).

Attribution
Just as the measurement of outcomes is not straightforward, so too is attribution of causality of improvements in outcomes to the interventions offered at the Lighthouse. There is a complex relationship between the child's characteristics (such as their resilience and their pre-existing mental health); the family; and the quality and quantity of the therapeutic intervention. A key challenge is in establishing the counterfactual – determining what would have happened without the intervention. RQ have used two sources of information to assist in considering this point – insights into referral rates after intervention by the three different forms of support identified above; and information from the Lighthouse Annual Report and from Barnardos on the goals achieved by clients from the Lighthouse and from the NEL CSA hub respectively.

Taking referral rates first, the Lighthouse Annual Report 2019-20 cites that 63% of C&YP

[67] https://www.england.nhs.uk/london/wp-content/uploads/sites/8/2019/05/London-CSA-Services-Learning-Report-2018-v1.2-002.pdf

reported mental health conditions at initial assessment. However, this is highly likely to be an under-statement of the true rate of such conditions among the cohort, as the level of short-term support needs for the cohort is of the order of 80% to 90%. This suggests an impact of improving mental health issues of the following order:

- Lighthouse – 67% (calculated as 85% baseline rate of referrals - 18% referral rate after Lighthouse intervention = 67%)
- CSA South West London Hub – 54% (calculated as 85% baseline rate of referrals - 31% referral rate after CSA Hubs intervention = 54%). This represents a level that is proportionally 80% (since 54% ÷ 67% = 67% and
- C&YP Haven - 45% (calculated as 85% baseline rate - 40% referral rate after Havens intervention = 45%). This represents a level that is proportionally 67% of the impact of the Lighthouse (since 45% ÷ 67% = 67%).

A potentially useful cross-check is whether this pattern of referrals is upheld when examining more recent outcomes data. Ideally, this would compare Lighthouse and Havens data, as this is the scenario examined in relation to cost data. Unfortunately, however, outcomes data are only available for the Lighthouse and North East London CSA Hub. These data indicate 89% Lighthouse goals achieved or partially achieved, compared to NEL CSA Hub data showing improvements in 47% of outcomes. This suggests a relative level of improvement of 53% for North East London CSA Hub compared to the Lighthouse (since 47% ÷ 89% = 53%), considerably lower than the CSA South West London differential in relation to referrals.

In choosing which set of data to underpin their estimate of impact RQ have chosen to adopt the results from Harewood and Baine (2018), as this presents consistent data across the three types of provision. This implies an estimate of impact of 67% for the Lighthouse, and 45% for the Havens counterfactual, with the Haven's counterfactual in turn having an impact that is proportionally 67% of the Lighthouse impact but note that this estimate has to be treated with caution.

Review of benefits used in the RQ analysis

The long-term outcomes of child sexual abuse are known to be associated with a wide range of psychosocial and health outcomes. A recent review, Hailes *et al*. (2019), found the strongest links for two psychiatric disorders (post-traumatic stress disorder and schizophrenia) and one psychosocial outcome (substance misuse). Research by McNeish and Scott (2018), quoted by the UK-based Centre of expertise on child sexual abuse, finds CSA to be strongly associated with the following outcomes across the life course:

- physical health problems, including immediate impacts and long-term illness and disability
- poor mental health and wellbeing
- externalising behaviours such as substance misuse, 'risky' sexual behaviours, and offending
- difficulties in interpersonal relationships
- socio-economic impacts, including lower levels of education and income
- vulnerability to re-victimisation, both as a child and as an adult.

Decisions on which benefits to examine in the economic analysis is inevitably subjective. It is also important to note that there are some benefits on which it is difficult to place a monetary value, but which nevertheless command a high value. These include the benefits to wider society of supporting victims and survivors, both immediately and in later helping them to overcome the

effects of their experience; and the obligation to act in the best interests of the child. RQ's analysis incorporates three types of social value:

a) wellbeing to the client (such as the wellbeing value of less trauma);
b) useful savings from public sector spend (for instance, less need for mental health services);
c) more public sector spend on essential activity (such as more offenders going to prison).

These encompass the following domains:

- Health & wellbeing – sexual health, mental health, physical health, substance abuse, and
- client and family wellbeing
- Children's services and child protection – child taken into care, school support
- Employment – loss of earnings for client, loss of value for public sector
- Criminal justice system – improved prosecution rates
- System effects – closer co-ordination

In estimating social value for given categories, RQ have used two (roughly equivalent) methodologies, depending upon the data available. The first approach calculates the proportion affected by a given issue and multiplies it by the unit cost of that issue. So, for example, in relation to physical health, if it is known that 14% of child maltreatment cases require NHS treatment, and the average cost of such treatment is £850, then the unit cost is estimated at £120 (14% * £850) in respect of physical health for clients as the base case.

The second approach takes the average cost of a given issue to the cohort, and reduces it in line with the impact of the Lighthouse. For instance, if the average spend on mental health services (when required) is £11,450, and the Lighthouse has an effect which reduces trauma by 25%, then the public sector saving is 25% * £11,450, which equals £2,862.50

Health and well-being

Looking initially at **sexual health** RQ examined the proportion of cohort with a sexually transmitted infection (STI), proportions of different infections and the cost to treat. Khadr *et al.* (2018) found 12% of a sample of adolescents attending Sexual Assault Referral Centres had at least one sexually transmitted infection diagnosed 4 to 5 months after the assault. However, the Lighthouse Annual Report suggests that the prevalence of STIs requiring treatment is lower than this, as the Report indicates (p36) that 6% of prescriptions for the cohort involved antibiotics; further, it is highly unlikely that all of these prescriptions would be for STIs.

An additional factor is the high proportion of primary age children attending the Lighthouse compared with predominantly teenagers attending the CSA Hubs after sexual assaults. RQ therefore scale down their estimate of the impact of the Lighthouse on the prevalence of STIs to be of the order of 1% of the cohort (that is, 4 cases of STI out of 400 or so clients receiving both initial assessments and onward support between October 2018 and September 2020).

Turning to the issue of how much sexually transmitted infections cost to treat, they draw on Sadler *et al.* (2016). This provides an assessment of treatment costs for major sexual health issues – Chlamydia £120, Gonorrhoea £210, HIV £280,000 and Syphilis £210. Updating this in line with a 20% increase in the cost of GP appointments (and after equalising the unit cost so that it reflects the same amount of time per GP appointment) (PSSRU Unit Cost of Health and Social Care 2020, and PSSRU Unit Cost of Health and Social Care 2015), these rise to £144, £252, £336,500 and £252 respectively.

The next issue is creating a weighted average unit cost that reflects the relative extent to which these STIs occur in the age group(s) for the Lighthouse. Using the average rate on prevalence of infections from:

- Sadler *et al*. (2016) (p29), which gives data for the prevalence of those STIs in 2015 for the 0 to 12, 13 to 14, and 15 to 19 age range [in relation to HIV, RQ have taken the mid-way point for the population as a whole, and the "high risk" population];
- Public Health England (2020) (p10 to 11) 'STIs and screening for chlamydia in England, 2019: annual official statistics', which directly gives data for prevalence for chlamydia, gonorrhoea and syphilis in 2019 for the 15 to 19 age range, and which they have used to scale the estimates for other age ranges in Sadler *et al.* (2016) to 2019 levels, and
- Public Health England (2020) 'Key population HIV data tables number 2', (tables 1 and 4) on diagnoses of cases for those aged below 15 and those aged 15 to 24, which are used to scale the estimates for HIV by age range in Sadler *et al.* (2016) to 2019 levels.

Calculations are shown in the table below.

Age range	% Lighthouse cohort	Prevalence of Chlamydia by age	Prevalence of Gonorrhoea by age	Prevalence of HIV by age (adjusted)	Prevalence Syphilis by age
0 to 4	7.6%	0.000%	0.000%	0.000%	0.000%
5 to 12	38.4%	0.000%	0.000%	0.000%	0.000%
13 to 15	30.3%	0.111%	0.016%	0.007%	0.000%
16 to 17	21.7%	2.250%	0.287%	0.032%	0.004%
18	2.0%	2.250%	0.287%	0.032%	0.004%

When applied to an expected number of 4.5 among the Lighthouse cohort of 450 (1% * 450 = 4.5), these proportions imply 3.9 cases of Chlamydia, 0.5 cases of Gonorrhoea, and 0.1 cases of HIV. From these calculations, an average cost of £7,630 per client with STI then follows.

Much of this cost relates to HIV treatment, and hence to NHS costs. The table below shows a difference in NHS costs of £395 per client in respect of sexually transmitted infections (STIs). It should be noted, however, that this estimate is extremely dependent upon the prevalence of HIV infections for the cohort under consideration and is highly indicative.

	Proportion with issue	Cost per issue	Cost (£)	Proportion with issue	Cost (£)	Difference
	(Base case)			(After)		
Children with STIs	1.0%	7,630	75	0%	-	75

Turning to **physical health** and **substance misuse**, the table below shows no difference in respect of NHS costs for maltreatment costs, £75 improvement for obesity-related costs, and £30 improvement in respect of substance misuse treatment.

	Proportion with issue	Cost per issue	Cost (£)	Proportion with issue	Cost (£)	Difference
	(Base case)			(After)		
Physical health (maltreatment)	14%	850	120	14%	120	0
Physical health (obesity)	63%	880	555	54.6%	480	75
Eating disorders	2.4%	8,850	210	1.5%	135	75
Substance misuse (alcohol)	2.3%	4,000	95	2.0%	80	15
Substance misuse (drugs)	5.8%	4,000	230	5.0%	200	30

On **physical health**, RQ considered **maltreatment** and **obesity**. In relation to maltreatment, Conti *et al* (2017) estimates the proportion of maltreated children requiring treatment in hospital and cites £850 as the national unit cost of non-elective hospital admissions for paediatric injuries. For indicative purposes, the model assumes that the Lighthouse (a) increases the rate to which treatments are identified, so increasing costs; (b) decreases the rate that future treatment is required; (c) these two effects negate each other. In relation to obesity, RQ start with estimates of the unit costs to the NHS, and then consider the likely change in the proportion of the cohort with the issue after intervention. A starting point for unit costs is the estimate that the NHS spent £6.1 billion on overweight and obesity-related ill-health in 2014 to 2015; and the calculation that in 2015, 63% of adults in England were classed as either overweight or obese. Given that the adult population in England in 2015 was 54.8m, this implies a cost per person of the order of £177 per year, since £6,100m ÷ (54.8m * 63%) = £177. Over a five-year period, this amounts to NHS costs of the order of £880.

To assess the risk of adult obesity they use Hailes *et al.* (2019), which provides a meta-analysis of risks for a range of adverse outcomes for those who have suffered CSA, including the risk of obesity. Based on 26 studies involving more than 160,000 subjects in the UK, it identifies an Odds Ratio of 1.4 : 1.0 for those who experienced CSA.

Whether or not the Lighthouse may affect such risks depends on whether it can influence the driver(s) of that difference. Hailes *et al.* (2019) explains that this may be possible: "The association between childhood sexual abuse and physical health problems might also be partially explained by mediating psychiatric factors. For example, the effect of childhood sexual abuse on obesity might be due to depression or certain eating disorders". Assuming that this hypothesis is at least partly correct, RQ calculated the effect of the Lighthouse on reducing obesity as follows:

- Average proportion of obesity in adults = 63%
- Effect of increasing risk by factor of 40% = 0.40 * 63% = 25.2%
- Proportion of this increased risk among those who have had CSA that is attributable to depression or eating disorders is assumed to be half
- Impact of the Lighthouse on mental health = 67%
- Impact of the Lighthouse on obesity by improving mental health = 25.2% * 50% * 67% = 8.44%

Around 0.75 million people in the UK are estimated to have an **eating disorder**, according to PWC (2015) "The Costs of Eating Disorders. Social, Health and Economic Impacts" (p21). which represents a level of approximately 1.1% among the UK population. The report calculates an average health cost per sufferer of £8,850. RQ apply the same methodology as for obesity, using the Odds Ratio of 2.2 for eating disorders shown in Hailes *et al*. (2019).

The calculations are as follows:

- Average proportion of eating disorders = 1.1%
- Effect of increasing risk by factor of 120% = 1.2 * 1.1% = 1.3% increase, to 2.4% prevalence
- Impact of the Lighthouse on mental health = 67%
- Impact of the Lighthouse on eating disorders = 1.3% * 67% = 0.9%

Turning to **substance misuse**, RQ apply the same methodology as for obesity, using the Odds Ratio shown in Hailes *et al.* (2019) since that study states that high quality studies show a strong link between substance misuse and CSA, and calculates an Odds Ratio of 1.7 : 1.0 for this issue. The calculations are as follows:

- Average level of drugs dependency in adults (taking a Class A drug) = 3.4%, according to NHS Digital, Statistics on Drug Use (2019)
- Average level of alcohol dependency in adults = 1.37%, according to Public Health England
- Effect of increasing risk factor by 70% = 2.4% in relation to drug use, and 1.0% in relation to alcohol dependency
- Impact of the Lighthouse on drug use after (1) scaling for impact on mental health and (2) assuming that proportion of this increased risk among those who have had CSA that is attributable to mental health problems is assumed to be half = 2.4% * 67% * 50% = 0.8%
- Impact of the Lighthouse on alcohol dependency after (1) scaling for impact on mental health and (2) assuming that proportion of this increased risk among those who have had CSA that is attributable to mental health problems is assumed to be half = 1.0% * 67% * 50% = 0.3%

The estimated annual cost to the NHS of **alcohol dependency**, per year per dependent drinker is some £2,000, updating NICE guidance for inflation (RQ assumed treatment applies for two years, and also assumed the cost of treatment for substance abuse is the same as for alcohol).

Mental health is considered from the perspectives of (a) the NHS and local authority; (b) for the individual themselves, (c) for their family. In doing so, RQ make a distinction between costs and trauma incurred during childhood, and as an adult. Conti *et al.* (2017) (p31) provides an estimate of the cost of treatment per case during childhood for hyperkinetic disorders, conduct disorders and emotional disorders to be £11,450. The report further estimates a cost of around £950 in respect of anxiety and £5,145 in relation to depression as an adult (p32). These values are calculated in present value terms (costs up to 30 years from the age of 6 are discounted using an annual rate of 3.5%; and by 3% p.a. for costs incurred between 31 and 74 years).

In relation to costs during **childhood**, RQ have scaled the estimate of cost per treatment by the impact that the Lighthouse has on the need for future referrals. As noted previously, the level of mental health disorders that the cohort has on entry into the Lighthouse is of the order of 80% to 90%; following Harewood and Baines (2018) impact is estimated to be of the order of 67%. This is in line with the outcomes reported in the Lighthouse Annual Report 2019- 20, which states (p64) that "During the year 2019/20, 276 goals were agreed with children and young people and 67% were achieved, 37% partially achieved and 4% not achieved."

In the long-term, the effects of Lighthouse on **adult mental health** are not known, and consequently RQ have used the same methodology on the Odds Ratio of adverse effects that was applied earlier.

- Average proportion of anxiety in adults (in 2014 Adult Psychiatric Morbidity Survey) = 7% in females and 5% in males. For a cohort that is 80% females and 20% males, the benchmark level is 6.6%.
- Average proportion of depression in adults (in 2014 Adult Psychiatric Morbidity Survey) = 3.8% in females and 3% in males. For a cohort that is 80% females and 20% males, the benchmark level is 3.64%.
- Odds Ratio of 2.7 for anxiety and depression in Hailes *et al.* (2018) implies that effect of CSA is to increase expected prevalence without intervention by 11.2% and 6.2% respectively.
- Impact of the Lighthouse on mental health = 67%, and so expected impact of the Lighthouse on anxiety = 67%* 11.2% = 7.5%, and expected impact on depression = 67% * 6.2% = 4.1%.

Based on these calculations, the table below shows a reduction of £7,670 on NHS/LA spend in respect of mental health for the client up to age of 18, and further reduction of £455 spend as an adult.

	Average cost per client (£ NHS/LA spend)	Reduction in proportions	Cost per client (£) after intervention	Difference
Mental health (up to 18)	11,450	67%	3,780	7,670
Adult anxiety	950	7.5%	880	70
Adult depression	5145	4.1%	4,930	215

In relation to **client wellbeing**, RQ have used the estimate in Home Office (2018), of a wellbeing loss from rape of £31,450. Their assumption is that there is an improvement in wellbeing (or more precisely, an avoidance of some of the loss of wellbeing) in line with the estimate of a 67% improvement in mental health. This equates to a value of £21,100 per client.

Family members – parents and siblings – can also experience "profound harm" as a secondary trauma due to sexual assault on a child. The disclosure of CSA can be a major life crisis for the non-abusing parent or carer. This possibility is exacerbated if the parent has experienced abuse in childhood themselves. Research findings are limited, however. Newberger *et al.* (1993) in a study of 44 mothers and 2 maternal care givers found 55% of them initially in the clinical range of traumatisation, with symptoms diminishing over a year but still present for many. RQ have assumed that the extent of this trauma is on a par with violence with injury, at a level of £11,200 (according to Home Office 2018). They further assume that this applies to, on average, one parent and one sibling, so making a potential loss of wellbeing of 2 * £11,200 * 69% rate of secondary trauma as a proportion of primary trauma = £15,400.

The impact of group-based interventions for non-abusing parents have been found to be significant in achieving positive outcomes for children and in reducing carers' stress. Evidence shows that parents who participate in such groups report increased wellbeing and confidence, reduced stress, and greater ability to care for their child and deal with professionals. In particular, the Lighthouse Annual Report 2019-20 cites outcomes in the parents' psychoeducation course that attendees made progress in 69% of their goals and 31% stayed the same (see page 10).

Using the previous estimate of impact of 67%, RQ calculate a wellbeing improvement of £10,320 in relation to family wellbeing (on the basis of the calculation 67% * £15,400 = £10,320).

	Average adverse effect (£)	Reduction in effect (%)	Adverse effect after intervention	Difference in adverse effect
Client wellbeing	31,500	28%	22,640	-8,860
Family member wellbeing	15,400	28%	11,070	-4,330

Children's services and child protection

In examining Children's Services RQ have looked at:

- Formal child protection action due to Lighthouse investigations
- School support (child behaviour and/or learning difficulties).

The table below shows no identifiable saving for local authorities in respect of children taken into care per Lighthouse client, but a £1,200 saving for them in respect of additional school support.

	Proportion with issue	Cost per issue	Cost (£)	Proportion with issue	Cost (£)	Difference
	(Base case)			(After)		
Formal child protection action	8%	217,000	17,585	8%	17,585	0
School support	22%	32,200	8,190	16%	5,880	-2,300

The Annual Report (p47) cites that 16 out of 198 clients were subject to a Local Authority Care Order, a rate of 8%. In addition, 12 cases were referred onward to Local Authority children's services (p62 – although this may be an under-estimate, but does not affect the results for reasons explained below).

Since the average age of the Lighthouse cohort is 11.8 years, this would imply additional protection action for 6.2 years; either in the form of a 6 month Child Protection Plan (at an indicative cost of £922 according to Holmes (2021) (p41) 'Children's social care cost pressures and variations in unit costs') and/or the cost of placement, which PSSRU unit costs data imply would be around £26,000 per year for foster care, and £86,000 per year for residential care, with an overall cost of £217,000 per case over 6.2 years for the proportions of support outlined in DfE statistics on children in care. However, RQ feel that volumes are unlikely to be reduced by the Lighthouse (indeed, some CAC research suggests an increase in the numbers of children taken into care), and in line with the view that spending that is required but not previously undertaken should not be included in the analysis, and have set the difference in costs between the Lighthouse and the alternative to zero.

Turning to school support, Conti *et al* (2017) (p35) provides an estimate of the cost of additional school support as some £32,200 over a ten-year period, with the proportion of children requiring such support rising by 22% due to maltreatment. RQ assume that the Lighthouse proportionally reduces this cost by 67% - that is, from 22% to 7.3% - as per previous assessments.

Employment

The table below suggests that the Lighthouse is able to reduce losses of earnings by £6,600 per client, and loss of taxes / increases in benefits by £1,300 per client.

	Proportion with issue	Cost per issue	Cost (£)	Proportion with issue	Cost (£)	Difference
	(Base case)			(After)		
Employment losses (client wellbeing)	100%	50,875	50,875	87%	44,270	-6,605
Employment losses (DWP/HMRC)	100%	10,170	10,170	87%	8,850	-1,320

Direct ONS data on the issue is not available, but survey results for adult victims of crime suggests that the effect of sexual assault in hampering employment can be substantial. Drawing on data from the 2020 Crime Survey, analysis set out in 'Nature of sexual assault by rape or penetration, England and Wales: year ending March 2020' (see table above) cites 5.6% of respondents "lost job or gave up work", and 33.2% of respondents took a month or more off work. Conti *et al*. (2017) (p36) calculates loss of earnings into adulthood for those affected by child maltreatment based on a 5% effect on wages, drawing on Daro (1988). RQ have adopted a 13% figure, taking the average of this study, Barrett & Kamiya (2012) (p18), which indicates a 12% effect, and Fergusson *et al.* (2013) (p670), which suggests a 22% figure. Note also that a 13% figure is close to the expected impact of a 12% reduction in the level of adult anxiety among the cohort.

Over a 30-year period, set against average earnings for a group that is 80% female and 20% male, this amounts to some £50,875 in terms of lifetime loss of earnings. The DWP / HMRC loss is assumed to be equal to 20% of this loss of earnings. The savings to these Departments due to the Lighthouse vary in line with changes in earnings, which also are assumed to vary in line with changes in mental health.

Criminal justice

Criminal justice issues relate to observed patterns of increased criminal activity by child abuse victims when they reach adulthood. Other possibilities that were considered were a reduction in cracked trials, and effects on reductions in reoffending by the perpetrator. Both of these were excluded on the grounds of lack of good data. RQ have also excluded costs in relation to charitable funds of ISVAs, as broadly speaking the same amount of money is spent on per ISVA whether they are funded by the public sector or by charity. The table below shows an estimate of a reduction in CJS spend due to future criminal behaviour by the victim of some £1,775; and an increase in CJS spend on crimes prosecuted and convicted due to an increased willingness to testify by victims.

	Average cost per client (£)	Change in proportions	Cost per client after intervention (£)	Difference
Criminal behaviour by victim when an adult	7,100	-67%	2,340	-4,760
Crimes prosecuted and convicted	32,110	+5%	33,715	+1,605

Conti *et al*. (2017) (p32) cites average costs of criminal behaviour by victims as £7,100, and (p34) cites average costs per case of £32,110 (£11,750 on courts, £20,360 on convictions). Then the assumption is that the Lighthouse reduces additional criminal behaviour of victim in line with their mental health improvement of 67%; and that a small effect (5%) relates to extra cases brought to light; a small proportion is used given the mixed research evidence, and the strong

possibility that there would be a reduction in reoffending by the perpetrator which would lower the costs for the CJS.

System effects

Turning to the last domain of social value, the table below shows an estimated productivity improvement due to better co-ordination between agencies of some £1,720 per client.

	System cost per case (£)	Improved productivity	Difference (£)
Co-ordination effect	28,625	6%	-1,720

The source for the scale of improved productivity is Nat Cen (2012), a study of an integrated approach to drugs offenders, which estimates improved co-ordination improving efficiency by 6%. Clearly, this is only one example and not directly equivalent, so can only represent an indicative figure. The system cost per case derives from:

- court costs of £11,750 in respect of maltreated children);
- police & CPS costs (at least 50% of court costs, according to NAO data on cost of young offenders);
- Local Authority investigation costs £10,400 based on PSSRU unit costs data; and (d) NHS costs (based on consultant paediatrician and psychotherapy appointments).

Appendix G - Summary of Early Emotional Support (EES) Services commissioned in London

(FY 2020/21).

STP	Boroughs	ESS service	Provider
NEL	Barking & Dagenham, City & Hackney, Havering, Newham, Redbridge, Tower Hamlets, Waltham Forest	The CSA Hub service (TIGER Light) offers early emotional support to children, young people and their families being seen for a CSA medical examination at the newly established CSA Hub in Royal London. The paediatricians providing CSA paediatric assessments in the hub work with the emotional support practitioners, providing a holistic health review focused on the needs of the child/young person and their family.	Barnardo's
NWL	Brent, Ealing, Hammersmith & Fulham, Harrow, Hillingdon, Hounslow, Kensington & Chelsea, *Westminster	TIGER Light is a trauma informed early emotional wellbeing service provided by Barnardo's. TIGER means Trauma Informed Growth and Empowered Recovery. The approach builds on the expertise Barnardo's has developed over the past 25 years to improve the lives of sexually exploited children	Barnardo's
SEL (LSL)	Lambeth Lewisham Southwark	Safer London offer dedicated support to children, young people and their families who have experienced CSA. They champion their voices to ensure they receive the best possible support, and offer specialist consultations and advocacy. The paediatricians providing CSA paediatric assessments in the LSL boroughs will work with the Safer London practitioners, providing a holistic health review focused on the needs of the child/young person and their family.	Safer London
SEL (BBG)	Bexley, Bromley, Greenwich	Family matters confirmed providing a service in Bexley but no further information was received. No information received for Bromley and Greenwich	Family Matters (Bexley)
SWL	Croydon, Kingston, Merton, Richmond, Sutton, Wandsworth	The NSPCC provides up to 6 sessions to the child or young person and their family in order to support them through the initial difficult stages following a disclosure. During the sessions the worker will get to know the child, and together with the child and family make an assessment of their needs, which will inform the focus of the support sessions. In addition, an assessment of longer-term therapeutic need will be completed.	NSPCC

NCL	Barnet, Camden, Enfield, Haringey, Islington	The Lighthouse offers early and long-term support is offered through CAMHS, the NSPCC's LTFI and Protect and Respect services. This additional emotional support and therapy helps CYP to recover. The Lighthouse model is different to the rest of London. It offers emotional support as part and parcel of its CSA services and does not offer EES as standalone service.	NSPCC, CAMHS
All	Across London	The CYP Havens is a specialist sexual assault referral centre (SARCs) that provides immediate services to reduce the risk of long term problems. In addition to providing FMEs and post assault follow-up care they provide counselling therapy and clinical psychology treatment for up to one year post-assault (Up to 20 sessions of EES post abuse for under 18s; 16-18 yrs. access to SARCs for up to one-year therapeutic support post abuse). CYP Havens also make referrals for EES support to the services described above.	The CYP Havens