Barnahus Ireland Therapeutic Mapping
April 2025

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Executive Summary

The European Union-Council of Europe Joint Project "Support the implementation of the Barnahus project in Ireland" commissioned a mapping of the therapeutic support available to children and families within and outside of the Barnahus in 2024. Child sexual abuse (CSA) is a pervasive issue, with an estimated 15% of girls and 5% of boys experiencing abuse before the age of 16. Yet, the majority of these cases remain unreported or unsupported, highlighting a significant service gap. In Ireland, while CSA referrals in 2024 exceeded 3,400, this report found that only a 24% (844) of affected children accessed specialized services, such as the Barnahus and only 15% (514) access therapeutic support. This discrepancy underscores the urgent need for effective, accessible therapeutic interventions tailored to the needs of CSA victims and their families.

The objectives were to identify therapeutic services available to children and their families following CSA; detailing the service offer, referral criteria and wait times and map the services available in a visual map. With the support of an Expert Reference Group, the methodology included: 71 survey responses; four focus groups with 29 attendees from Tusla therapy team, voluntary sector providers and CAMHS; 21 interviews including Barnahus, The Alders Units (CHI), Rape Crisis, CARI, ASSC and Jigsaw, frontline CAMHS, family resource centres, Community Therapy Ireland and therapeutic hubs; and a focus group with 5 members of the Child Advisory Board (CAB). Despite widespread Barnahus across Europe, there is limited evidence of the effectiveness of therapy and variations in therapeutic approaches. The methodology explored the various Barnahus therapeutic models, includes a literature scoping review of the evidence base and references a synthesised model referred to as the "Continuum of Recovery" to guide best practice in therapeutic service delivery.

The mapping sought to understand the predicted number of children experiencing child sexual abuse and coming to the attention of statutory services, those who access support at Barnahus and those who may need to access early help or long-term therapeutic support after child sexual abuse in local services. There was limited data available as many of the statutory and voluntary sector services do not record data about child sexual abuse in their case management systems and some do not directly ask children if they have experienced child sexual abuse. Whilst the demand and capacity modelling suggested that theoretically there may be sufficient capacity to meet the needs of those children attending Barnahus and requiring therapeutic support by 2025, there were a number of caveats. Barriers included Barnahus therapy team not fully staffed and trained, services only available in a limited geographical location of services, limitations on age of children that can access services or waiting lists of up to 12 months.

The mapping identified specialist CSA support services available for children at Barnahus West and South, The Alders Units (CHI), CARI and three of the Rape Crisis Centres that deliver an adolescent model for children over 12 years. These services were accessed by 514 children in 2024. These services offer a range of therapeutic interventions available including psychotherapy, art, play and systemic family therapy; parent/caregiver support; and, in some services, groups for young people and parents. Stakeholders spoke highly of these services and identified them as the place they would refer a child to if they identified as having experienced child sexual abuse.

Other local therapy services included Therapy Hubs in Family Resource Centres; some voluntary sector specialists like Daughters of Charity in Dublin and West Cork Beacon Sexual Violence Support Services; and some case specific Tusla therapy services like Area based therapy teams, for children new into care and the Complex case and therapy team, to support a group of siblings in the Mid-West. However, each of these services only supported one or two children after CSA each year and often described referring onto independent play therapists and adolescent psychotherapists. CAMHS provide evidence-based interventions to treat moderate to severe mental health disorders. CAMHS practitioners interviewed felt that their expertise was in the area of treating disorders, such as depression, suicide, anxiety, PTSD; and some in the team may not have the skills to address the impact of trauma from child sexual abuse.

A surprising number of stakeholders spoke of procuring independent/private practitioners to provide therapy when services like Barnahus, Alders, CARI or Rape Crisis lack capacity or where families in more rural areas may prefer to be seen closer to home. Stakeholders reported that confidence varies significantly across independent practitioners; while some play therapists may feel confident supporting trauma, not many have CSA-specific trauma training. Concerns were raised by professionals and the CAB about the lack of a structured clinical supervision system, lack of multi-agency working and the practitioner isolation.

Gap and barriers to accessing specialist CSA services included:

- Large areas of Ireland with limited or no access to specialist CSA support services.
- Lack of training and confidence in trauma support services in local therapy services.
- Reliance on independent practitioners, who work in isolation with limited governance.
- Specific barriers based on time since trauma/specialist interview, age of perpetrator, language and culture.
- Lack of awareness of current therapeutic services available in Ireland.

Stakeholders described the ideal service as local, flexible in length to meet needs and with a wide range of therapeutic support options for a child and their family to choose from. Support for the child, their parent/caregiver and wider network, ideally for the length of the criminal investigation. They suggested co-location of specialist CSA support services like Barnahus, The Alders Units (CHI) and CARI in local satellite sites; and where independent practitioners are used in rural situations, there should be a governance process to support them and bring quality assurance.

There were 20 recommendations for commissioners and funders; specialist CSA support services; local therapy and support services; and for communication and awareness raising. The broad themes include:

- Expansion of Specialist CSA support like Barnahus, The Alders Units (CHI) and CARI to satellite sites in all Tusla regions in Ireland, co-located with existing hubs and resource centres.
- Consideration for all Rape Crisis Centres to adopt the adolescent framework to extend support to children 12 years and older.
- Request for Tusla to introduce a robust governance process and national database for independent practitioners.

- Building on the expertise of Specialist CSA support services; development of a programme of training, consultation, and quarterly learning spaces for local therapy hubs and independent practitioners.
- Ensuring all three Barnahus provide holistic therapy, support services and participation in line with the Barnahus Therapy Framework and the Continuum of Recovery.
- Raising awareness of all support services using the National Children's Therapy Services Map and accompanying spreadsheet.

1. Introduction

The European Union-Council of Europe Joint Project "Support the implementation of the Barnahus project in Ireland" commissioned a mapping of the therapeutic support available to children and families within and outside of the Barnahus in 2024.

1.1 Context

Ireland has been party to the Lanzarote Convention since 2020, and as such has been developing the Barnahus Model. Barnahus, meaning 'Children's House' in Icelandic, has been developed throughout Europe as the core model of response where there are concerns about child sexual abuse. The Council of Europe is a leading organisation in promoting and implementing the Barnahus model, the aim of which is to 'operationalise children's rights to receive adequate support and protection and to have access to child friendly justice' by offering community-based, multi-disciplinary, child friendly services, under one roof.

The European Union-Council of Europe Joint Project "Support the implementation of the Barnahus project in Ireland" aims to strengthen the country's response mechanism to child sexual abuse, to ensure that undue delays in the treatment of such cases is diminished, and that all children who are victims of sexual violence benefit from a child-friendly access to justice. The project is co-funded by the European Union and the Council of Europe and is implemented by the Council of Europe's Children's Rights Division in close co-operation with the Irish Department of Children, Equality, Disability, Integration and Youth (DCEDIY) from 12 August 2022 to 11 April 2025.

In 2017, Ireland implemented the Children First Act 2015, which introduced mandatory reporting for suspected cases of child abuse. It was followed by the development of a pilot Barnahus project in Galway in 2019, which began receiving referrals in November 2020. The goal of the European Union-Council of Europe project is to address the challenges encountered during the pilot project and to facilitate the opening of two additional centres: Barnahus South in Cork and Barnahus East in Dublin.

1.2 Roll Out of the Barnahus Model in Ireland

The roll out of the Barnahus model in Ireland is being supported by the Council of Europe, is anchored in the Council of Europe strategy for the Rights of the Child, (2022-2027), and is part of the Council of Europe programme, 'Building a Europe for and with Children'.

The Inception Report (Council of Europe 2023)[i] sets out a clear pathway for the development of Barnahus in Ireland. The aim is to provide wraparound services, in one facility, to which children and their families can go in order to get help and support following CSA, including medical examinations, joint interviews, advocacy and therapeutic support. To date, two Barnahus facilities are operational in Ireland: Barnahus South, based in Cork, and Barnahus West, based in Galway. Barnahus East, based in Dublin, is expected to open in 2025. The Alders Units (CHI) and Laurels Forensic Examination Clinic have provided specialist CSA support for children in some parts of the East for up to 30 years.

The Barnahus Network which supports the implementation of the Barnahus model across Europe is centred on Barnahus Quality Standards (PROMISE 2019)[ii] which were 'formulated to ensure transferability and adaptability, recognising that they will be implemented in different political, legal, judicial, socio-economic and cultural contexts.' These standards ensure Barnahus work in the best interests of the child, enable multi-agency collaboration and case management, provide a child friendly space for medical/interviews processes and enable access to therapeutic support. Standard 8: Therapeutic Support describes assessment and treatment for the child, as well as crisis support for the child and family/care-givers if needed. This should be provided by mental health staff with specialised training and expertise. As well ensuring children and family/care-givers receive adequate information regarding available treatments and can influence the timing, location and set up of interventions.

The Barnahus National Therapy Group (including Tusla representatives from Barnahus West, South and East; the HSE and CHI) developed the Barnahus Therapeutic Framework (Lacey 2023)[iii] to provide guidance on how children and families who attend a Barnahus in Ireland should be individually screened and assessed for therapeutic need; and to ensure that the services offered in response to those needs can be delivered in a timely and proportionate way.

1.3 Scale of the Problem and current challenges

Child sexual abuse (CSA) is a pervasive issue, with an estimated 15% of girls and 5% of boys experiencing abuse before the age of 16. Yet, the majority of these cases remain unreported or unsupported, highlighting a significant service gap. In Ireland, while CSA referrals in 2024 exceeded 3,400, this report found that only a 24% (844) of affected children accessed specialized services, such as the Barnahus and only 15% (514) access therapeutic support. This discrepancy underscores the urgent need for effective, accessible therapeutic interventions tailored to the needs of CSA victims and their families.

The Outline Draft for Victims of Domestic Violence (TUSLA 2023)[iv] identified that therapeutic services for children under the age of 14 are centred in larger cities, and while some outreach is available, this is often for over 14s and not always available in more rural areas.

Barnahus offers an integrated model for addressing the needs of children that have experienced CSA; through multi-disciplinary interagency teams providing forensic interviews, medical examinations, advocacy and therapeutic services under one roof, aiming to minimize trauma while supporting recovery. Despite widespread Barnahus across Europe, there is limited evidence of the effectiveness of therapy and variations in therapeutic approaches. This highlights the need for a cohesive, evidence-based framework of therapeutic support in Barnahus.

2. Methodology

2.1 Objectives

The objectives of the Mapping Exercise were initially broad in Stage 1 but limited to the following key objectives in Stage 2:

- Identify therapeutic services available to children and their families following CSA (within Ireland and excluding private providers)
- Detail the service offer including therapy and support services that are general or specific to CSA, therapeutic support available, referral criteria and wait times
- Map the services available in a visual map, by 26 regional areas in Ireland
- Consider accessibility including geographical availability; children under 14 years and 14-18 years; children with a physical / learning disability; children identifying as LGBTQIA+; migrant children/asylum seekers; and children from minorities e.g. children from the travelling community.

2.2 Expert Reference Group

The objectives were developed with an Expert Reference Group which was established during Stage 2 in response to some gaps in stakeholder engagement.

The purpose of the Expert Reference Group was to advise on the design and implementation of Stage 2 of the Therapy Mapping Report in Ireland and enable an effective mapping through:

- supporting the development of a complete stakeholder list
- reviewing the Key Lines of Enquiry and scope - ensuring it will consider the needs of children and families, especially those with specific needs
- co-designing a briefing for stakeholders including an update on the national Barnahus roll out and success to date
- escalating and enabling contact with hard-to-reach stakeholders

Invited membership included: Chair of IDG, National Barnahus Lead, HSE Child and Youth Mental Health Office and Children's Mental Health Leads, CHI Directors from The Alders Units (CHI), Voluntary sector representation from CARI, Child Advisory Board and a Primary care lead. The ERG met three times to agree the methodology, stakeholder list and KLOE; for a progress update and to provide comment on final draft report.

2.3 Mapping process

During Stage 1, 35 people were interviewed (during August/September 2024) from statutory services including Barnahus, The Alders Units (CHI), An Garda Síochána and Tusla; other commissioned provider services; independent social workers; guardian ad litem (GAL) and other key stakeholders such as Ombudsmen for Children (see Appendix 1). The interviews sought to gather data on the availability and accessibility of therapeutic services to children and families in Ireland within and outside of Barnahus. Feedback on the draft report identified gaps in the interview schedule including primary care mental health services, frontline CAMHS practitioners, family resource centres and therapeutic hubs. Limited quantitative and service specific capacity data was secured, leading to Phase 2 of the mapping exercise.

Stage 2 included a broader reach using a mixed methodology approach:

- Survey sent to over 300 providers of therapeutic support to children after child sexual abuse including Barnahus, voluntary and charitable sector providers such as Rape Crisis Centres, CARI, ASSC and Jigsaw, primary care mental health services, frontline CAMHS practitioners, family resource centres and therapeutic hubs
- Focus group for Therapy Hubs and Family Resource Centres; Voluntary and charitable sector providers; CAMHS; Area based therapy teams and NIAPP
- Interviews with key providers of therapy services including Barnahus, Rape Crisis, CARI, ASSC and Jigsaw, frontline CAMHS practitioners, family resource centres, Community Therapy Ireland members and therapeutic hubs
- Clarification interviews with key stakeholders and respondents to the draft report

The mapping ensured that all commissioners and funders of support services were included:

- HSE – Jigsaw, primary care mental health services, CAMHS, The Alders Units (CHI)
- Tusla – Family resource centres, Therapy hubs, CARI, Barnahus, Area based therapy teams
- Cuan – RCC, ASSC

Stakeholders for the survey and focus group invitations were initially identified using the three existing mapping of services for each region.

- Mapping Report of Therapeutic Services for CSA available to Children & their Families across the regions of Dublin Mid Leinster - Tusla
- Audit of Therapeutic Services in Tusla Western Region – Marie Gibbons, Tusla
- Audit of Therapeutic Services in Tusla South – Helen Barnes, Tusla

This enabled a broad and representative set of survey responses and interviews, capturing feedback from all regions in Ireland. Stage 2 included a total of:

- 5 clarification interviews
- 71 survey responses
- 4 focus groups with 29 attendees
- 21 individual interviews
- A focus group with 5 members of the Child Advisory Board

Survey results were analysed using built in Google Forms frequency graphs, as well as thematic analysis of exported qualitative responses with the assistive use of AI software as a research assistant, to enable triangulation with findings from interviews and focus groups.

Interviews were transcribed using transcription software (where consent was secured in advance) and summarised around the themes in the standardised interview questions. Additionally, the full transcripts were reviewed with the support of AI software to identify themes which were triangulated with the manually coded data and to draw out quotations to illustrate practitioners' views.

Other sources of evidence included annual reports from CSA providers and national representative bodies, feedback from Child Advisory Board and website reviews.

3. Therapeutic approaches for child victims of child sexual abuse and exploitation – including intrafamilial abuse, sibling abuse and harmful sexual behaviour

3.1 Context

CSA Centre research estimates that at least 15% of girls and 5% of boys are sexually abused before the age of 16 [v] which, if applied to the population of Ireland [vi], equates to 130,000 children having experienced sexual abuse by the age of 16. However, research suggests that very few children come to the attention of the police or children's social care, potentially as low as one in eight children [vii].

In the Sexual Violence Survey of Childhood Experiences (2022[viii]) there were even higher rates of non-contact sexual violence, with 25% of women reporting experiencing non-contact sexual violence as a child, compared with 16% of men. Almost three quarters of those aged 18-24 who experienced contact sexual violence as a child reported that a person under 18 was the perpetrator. One in ten (10%) men reported that they were made to look at unwanted pornographic material when they were a child. Bisexual people reported over double the level (49%) of non-contact sexual violence as a child compared with heterosexual/straight people (20%).

In 2024, Tusla received 3,483 referrals relating to Sexual Abuse and yet only 24% (844) of children were referred to the Barnahus West/South/The Alders Units (CHI), and only 15% (514) were able to access therapeutic support. This highlights a significant gap between the numbers of children actually experiencing child sexual abuse, the numbers of children who report this and those children and families who are able to access specialist help. There has not been any research or mapping to date to identify the reason for these low levels of access to support in Ireland. However, similar issues are seen in other jurisdictions.

This chapter will consider what evidence there is in research and grey literature for therapeutic models of support for trauma in mental health literature and triangulate this with evaluations into what children and young people say they need, as well as evaluations of therapeutic provision in the Barnahus settings.

3.2 Learning from the 'Continuum of Recovery' in Barnahus

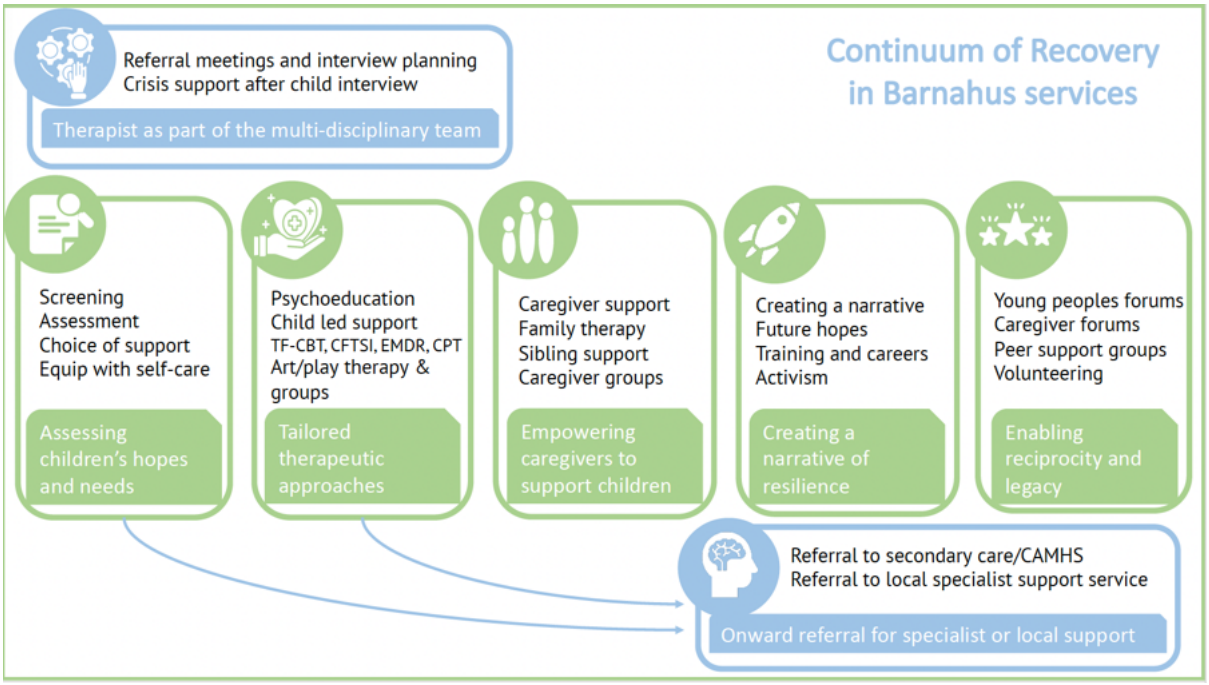
The cross-European learning review "Creating a Continuum of Recovery" (Harewood 2024[ix]) is a rapid review of good practice which brings together examples from across eight European countries to synthesise a model that integrates multidisciplinary collaboration, trauma-informed therapy, empowering families and participation for children and young people. The Continuum of Recovery model synthesizes international best practices, providing a framework to guide Barnahus service development and enhance child-centred support. Despite widespread Barnahus across Europe, there is limited evidence of the effectiveness of therapy, variations in therapeutic approaches and a lack of clarity of the components of each therapy service. This highlights the need for a cohesive, evidence-based framework of therapeutic support in Barnahus.

The Continuum of Recovery Model

The model emphasises a staged, holistic approach to therapeutic support for CSA victims; with a particular focus on participation to ensure children's hopes and needs are heard and shape their support; to create a narrative of resilience and strength through their story; and to enable reciprocity to leave a legacy of gratitude after their journey at Barnahus has ended.

The model in Figure 1 below summarises the stages of therapeutic support that Barnahus services usually consider and this chapter details the evidence base for the Continuum of Recovery model.

Figure 1: The Continuum of Recovery in Barnahus Services



The Continuum of Recovery Model©

Key components include:

Assessing children's hopes and needs

Central to the Barnahus model is Barnahus Quality Standard 1.2 (Lind Haldorsson 2017)[x] which seeks to ensure that children's voices shape their support plan. At Barnahus, therapists conduct assessments and screenings to understand children's hopes and contextual needs, enabling personalised care plans.

Tailored therapeutic interventions

The international research does not identify a single intervention that is universally effective; but instead speaks of therapy that is child-centred and flexible (O'Doherty 2022[xi], Warrington 2017[xii], McElveney 2023[xiii], Beckett 2022[xiv], Mitchell 2024[xv]). Evidence-based approaches such as Trauma-Focused Cognitive Behavioural Therapy (TF-CBT), Eye Movement Desensitisation and Reprocessing (EMDR), psychotherapy and narrative therapies are used alongside creative therapies like play and art therapy.

Empowering caregivers to support children:
Parallel work with non-abusing caregivers is integral (Mitchell 2024, Parker 2021[xvi]), including psychoeducational sessions, parent groups and systemic family therapy. For example, The Bairns Hoose evaluation found that support for parents reduces their sense of isolation, which is particularly important when navigating the complex processes following CSA disclosures; supported them to support their child's emotional recovery; and strengthen the child's protective environment.

Creating a narrative of resilience:
Therapeutic approaches should aim to help children understand that what happened to them is not their fault and that their identity and future are not defined by the abuse they experienced. Practitioners work with children to build confidence, develop coping strategies, and create a future-oriented narrative. Barnahus offer practical support aimed at improving children's future outcomes including support around returning to education, engaging in positive activities, and rebuilding peer and family relationships; all which help children imagine a positive future beyond the abuse.

Enabling reciprocity and legacy:
Many Barnahus create opportunities for children to participate in service development or advocacy. This reciprocity fosters a sense of belonging and counters isolation as identified in the 'Participation as Protection' model (Warrington 2024). This can include service user forums enabling young people to shape the services that supported them, enabling feedback to the criminal justice system, participating in research/evaluations, well-being sessions, vision board creation, young people's recruitment panels for Barnahus staff or peer led parent forums for continued support after therapy.

3.3 Introduction to the evidence base

There is a lack of published research specific to the multi-agency Barnahus context, about therapeutic models of support. However, much of our learning about the types of support that matter to children and young people after child sexual abuse, is often found in smaller studies, service evaluations, peer-led research and grey literature. A review of these evaluations detailed below, identified similar messages from children who were asking for relational support from one consistent worker, a sense of choice and control, a broad range of support options, and one safe place to be heard and to belong.

For children who have experienced sexual abuse and require therapeutic support for associated mental health difficulties, including trauma-related mental health concerns, child and adolescent mental health providers recommended that this is provided by clinicians with recognised core competencies in the assessment, formulation and treatment of children's mental health difficulties. A variety of evidence-based frameworks exist, which recommend an assessment and formulation approach, which we will discuss later.

Where there is evidence of trauma after sexual abuse, particularly against a background of complex needs, research evidence suggests approaches such as Eye Movement Desensitisation and Reprocessing (EMDR), Narrative Exposure Therapy (NET), Trauma

Focussed Cognitive Behavioural Therapy (TF-CBT) or systemic family therapy are effective; as well as therapy for specific issues such as depression, an eating disorder or anxiety.

In Ireland, the National Therapy Group has developed a Barnahus Therapeutic Framework to provide guidance for Barnahus in Ireland to screen and assess the therapeutic needs of children and families attending Barnahus. This framework, informed by research evidence, aims to ensure that services are consistent, timely and meet therapeutic needs. (See section 4.1)

We will explore below the evidence for therapeutic models in the mental health literature and triangulate this with research and evaluations into what children and young people say they actually need.

3.4 Evidence base for therapeutic support

3.4.1 A child-centred approach with choice and control

A **Cochrane review** [xvii] of children and adult survivors experience of therapy and support interventions after sexual violence found that there was not one specific intervention, after experiences of sexual abuse, that was most effective. In fact, it was the content, format, location and the way that interventions were delivered that had the most significant impact on efficacy. Survivors needed a consistency of practitioner to maintain a trusted bond within the intervention, they valued meeting the practitioner in a range of community-based venues and valued choice around content, pace and intervention type. They also noted the importance of preparation for the intervention and good endings with onward support.

"Survivors valued a sense of choice and control within the intervention, which they considered essential when sharing sexual abuse and violence narratives. Having the ability to determine pace, co-produce content and treatment modality was identified as central to healing. Young people particularly valued this in the context of making their own decisions about which tasks or activities they wanted to engage with, and they felt supported if they knew the practitioner would stop, take a break, or support them whenever they were distressed." Finding 10, Cochrane review

The most effective interventions provided an understanding of the abuse and trauma they had experienced, provided reassurance that they were not the only ones and developed future skills such as boundary setting. Group-based interventions helped young people develop their communication skills, build trust, develop gratitude, and grow in confidence; improving relationships with family members and developing new healthy relationships. Trusting relationships developed with peers participating in the group intervention which was seen as central to the healing process. In the review, this was noted as especially important to survivors from ethnic and minority groups.

Family members valued interventions that were available close to home, and the review noted that support from family and a peer network outside of the intervention facilitated change. Some parents noted feeling at times excluded from the trusting relationship between the practitioner and their child. Children who are dependent on parents/carers to access

interventions can face difficulty if engagement from parents/carers is inconsistent or resistant.

This approach is supported in the **WHO Clinical Guidelines**[xviii] for responding to children and adolescents who have been sexually abused; which recommends children who have been sexually abused should be offered first-line support that is child or adolescent centred and gender sensitive. This includes listening respectfully and empathetically; inquiring about worries and needs and offering a non-judgmental response. They recommend providing information about what will be done and making the environment and approach appropriate to age, disability or sexual orientation. Additionally, they recommend taking actions to keep them safe; facilitating access to psychosocial services; and empowering non-offending caregivers with information to understand symptoms and behaviours that their child may show.

Choice should also be extended to confidentiality and control over information sharing. When supporting a child with an open criminal investigation or whose case is awaiting trial (Pre-trial therapy), it is important to remember that therapy notes could form a valuable part of evidence for the case. However, it is equally important to remember that therapy notes are a child's voice and it should be the choice of the child and their family whether to share their notes. The Bluestar project[xix] advises that children and families should always be asked for their agreement to share their therapy notes, as they have a right to say no to sharing their data under the Article 8 of Human Rights Act: Right to Privacy.

Currently in Ireland, prosecution and criminal courts can request to access children's therapy notes under guidance from the Office of the Director and Public Prosecutions, Sexual Offences Act 2017 and Irish Data Protection Act 2018 for the purposes of legal, public interest and criminal proceedings. However, this right of access is restricted under Article 60[xx] where the health and mental well-being of the child might be affected by obtaining access to the data. Children's notes should reflect their voice and they should have a choice about whether to share them and enable their voice to be heard in court. Bluestar Project advise sharing only the sections of therapy session notes that are relevant to the offence being investigated or demonstrate the impact of the trauma on the child.

3.4.2 What children and young people say they need in evaluations

Whilst there is a range of research evidence for individual interventions and therapeutic models; this next section will consider what the children and young people say works, in line with the strong child participatory approach[xxi] in Ireland. There is a consistency of messages across young people's evaluations of CSA services which identify some key themes of what they say they need.

What children say matters and they ask for:

- **All professionals under one roof so they can work together to keep the child central in all their decisions**
- **A safe space where they can trust that they will be believed and not judged**
- **A sense of choice and control about the therapy and support they need**
- **Being seen as themselves and not just a victim**
- **A sense of belonging that counters isolation and blame**

- **A broad range of support that includes how to *'do life'*[xxii], build confidence and create coping strategies**
- **Care for the whole family affected by the abuse**
- **Caring and compassionate workers, who are welcoming and consider good endings**
- **Consistent relationship with workers and good communication**
- **Optimism and hope for the future**

The 2017 **Making Noise**[xxiii] report, interviewed 53 children and young people who had experienced child sexual abuse and they said what was most important to them was a safe space in which to process what had happened; knowing others have comparable experiences; being believed; countering stigma, isolation and self-blame; the development of coping strategies and wider confidence and resilience building. While these benefits could be achieved in other therapeutic services like CAMHS, school counsellors, IAPTs; there was a clear message from some interviewees that specialist CSA services, like Barnahus, are particularly helpful in countering stigma and isolation and understanding the complexities of CSA in the family environment. Children and young people identified ten key aspects that they valued in support services: being believed, choice and control, optimism, safety, non-judgement, active listening, care and compassion, understanding, advocacy and trustworthiness.

A study by **McElvaney** [xxiv] explored 16 young people's experiences of psychotherapy after child sexual abuse. McElvaney found that young people spoke of the importance of choice; not feeling pressured in both initially attending and in how the therapy unfolded; how helpful it was to talk; the centrality of the relationship with their therapist; the benefit of attending a specialist service; how helpful it was when the therapist explained things; and finally, the coping skills they learned in the therapeutic work. A key learning from the study was respecting young people's choice. The author noted the importance of this choice when young people's trust may have been broken as part of the abuse and therefore not replicating that through therapy was essential.

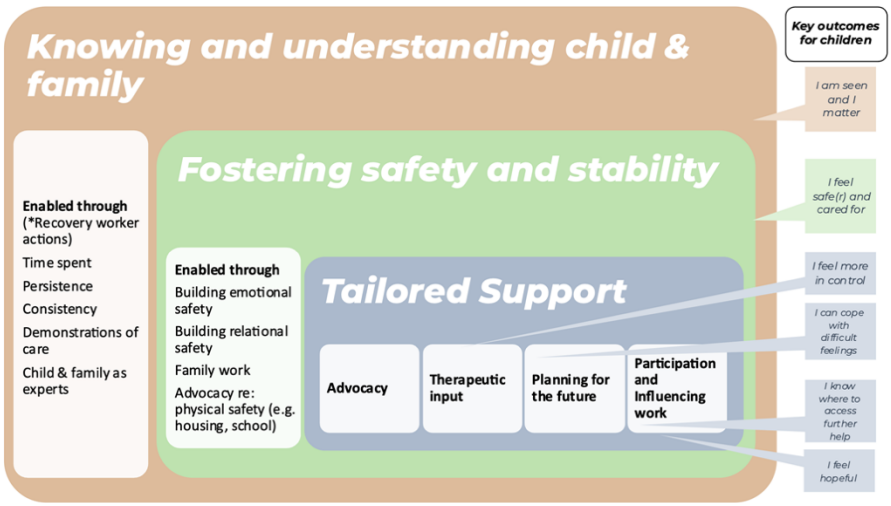
The Lighthouse evaluation 'There's something there for everyone'[xxv] described the service from the perspective of 11 young people and found five key features that young people valued. The unique feature of the Child House model being all under one roof, reduced the need to retell their experiences and enabled all practitioners in the team to support the young people in an integrated way. They felt like young people were held at the centre of decisions, with authentic and caring staff who listened to them and tailored their approach. The physical environment made them feel safe and cared for, with a warm welcome when they arrived and consideration for good endings. They valued the broad focus to recovery, helping them to do life as well as meeting wellbeing and physical health needs. This extended to creating a hope for the future, advocating for them in education and offering opportunities for activism. The pilot allowed a flexible and unrestricted approach to the content, pace and length of therapy and support services; with a commitment to be 'open to return' if young people needed to come back for support later in their recovery journey. The main areas for improvement that were identified were about communication and information sharing, with young people noting just how hard it is to process all that is happening with them after a traumatic event.

The Bairns Hoose evaluation – Phase 2 report[xxvi] interviewed nine children and eight parents, exploring the impact of the child-led and family inclusive approach seen in Recovery Model at Bairns Hoose (see Case Study 2). The children said *"I feel seen and I matter".* The Children 1st model at Bairns Hoose is non-manualised and gives permission for practitioners to take time to know and understand the child and their family. During the initial stage of fostering safety and stability, they felt safe and cared for, and noticed the absence of pressure to talk about the abuse. They were not seen just as a victim, with some describing a feeling of a 'friendship' developing in the informality of the work. The family inclusivity was particularly valued with examples of care for a single father or an adult sibling who themselves has experienced many years of abuse. Key outcomes from the flexible tailored support enabled children to feel in control, to cope with difficult feelings, to know where to access further help and to feel hopeful. The evaluation also described emerging evidence that advocacy provided by recovery support can buffer children and families from wider impacts of engagement in justice and welfare processes.

Figure 2 below visualises the three-stage recovery model:

- Knowing and understanding child and family - developing a relationship
- Fostering safety and stabilisation
- Tailored support - responding to individual needs

Figure 2: Visualising the Children 1st Bairns Hoose recovery model.



3.4.3 Evidence-base for therapeutic treatments in children's mental health literature

The **World Health Organisation** identified sexual abuse of children and adolescents has both short- and long-term mental health consequences. A systematic review found that children can experience depression, anxiety, post-traumatic stress, dissociation, eating disorders, sleep disorders, low self-esteem, anger, externalizing symptoms, ideation and behaviours related to suicide and self-harm, interpersonal problems, and engagement in high-risk behaviours (e.g. substance use, unsafe sexual behaviours, alcohol misuse) later in life. Children or adolescents presenting with such symptoms or disclosing sexual abuse need to be provided both immediate psychological support as well as longer-term mental health care."

Less than half (40-50%) of children who have been sexually abused develop **Post-Traumatic Stress Disorder** (PTSD) (Passarela 2010[xxvii]). A meta-analysis[xxviii] by Alisic and Zalta et al identified the best evidence-based treatment for PTSD as individual TF-CBT between 10 and 20 sessions. This recommendation is supported by the WHO Clinical guidelines[xxix], NICE Guidance for Child Abuse[xxx] and NICE Guidance for PTSD[xxxi] that note, although the evidence is low, best practice is to consider CBT with a trauma focus for both children and adolescents who have been sexually abused and are experiencing symptoms of PTSD; and their non-offending caregivers.

Cohen (2012[xxxii]) recommended a phase-based approach for youth with complex trauma with additional time and focus on problematic domains such as attachment security, affect regulation, biological regulation, dissociation, behavioural regulation, cognition and self-concept. She also noted that the total treatment length for youth with complex trauma may need to be extended, sometimes up to 30 sessions.

Carr (2009[xxxiii]) suggested that services which support families after abuse, including sexual abuse, should begin with a comprehensive network assessment and include systemic family therapy sessions, as well as separate parent-focused and child-focused interventions over at least six months, according to the families' needs. Therapists should carry small caseloads of fewer than ten cases.

McElvaney and Moorhouse (2022[xxxiv]) noted that there is no consensus on one therapeutic approach over another and summarised the researched benefits of a variety of ways of working. These include:

- creative therapies to stimulate right brain thinking and can facilitate processing of trauma,
- art therapy to reveal the inner world of the child,
- child-centred therapy to build self-esteem,
- psychoanalytical psychotherapy to consider past relationships and make sense of what has happened to them,
- somatic experiencing and body psychotherapy to understand how stress is carried in the body as a reaction to trauma and to learn to release this

CAMHS providers recommended that support is provided by clinicians with recognised core competencies in the assessment, formulation and treatment of children's mental health difficulties. A variety of evidence-based framework exist, such as the **CAMHS framework** developed by UCL[xxxv] and The Matrix: A guide to delivering evidence based psychological therapies in Scotland[xxxvi]. The UCL guide recommends an '*Assessment and Formulation'* approach that includes comprehensive assessment, risk assessment, child's functioning in multiple systems, a formulation of presenting clinical needs and feeding back the findings and treatment plan to the child and family – summarised on a competency map[xxxvii]. The Matrix offers an 'explore the interventions section' detailing treatments for children and young people effected by trauma including; TF- CBT, EMDR, NET, Child and Family Traumatic Stress Intervention (CFTSI) and Prolonged Exposure (PE).

Although the **NICE guidance** provides a collation of the evidence base for TF-CBT; it does alert practitioners to explain to children and young people that there are other options available,

if they would prefer. Reinforcing the need to enable choice for the child. Other therapeutic options outlined in the NICE guidance are child led interventions (such as 'Letting the Future In' LTFI) that emphasise the importance of the therapeutic relationship between the child and therapist. Child led interventions are tailored to the child's needs; draw on a range of approaches including counselling, socio-educative and creative; and can extend for up to 20-30 sessions, with parallel work with non-abusing parents or carers. TF-CBT, LTFI and Emotion Focused Therapy for Trauma (EFTT) are all described as integrative approaches, draw on underlying theories and techniques from different schools of psychotherapy.

In addition, NICE highlight psychoanalytic therapy (up to 30 sessions) or group psychoeducational sessions (up to 18 sessions) for specific emotional or behavioural disturbances. In all these interventions NICE recommend separate supportive sessions for the non-abusing parent or carer, helping them to support the child's attendance at therapy, as well as addressing issues within the family. This parent/caregiver support can be 1:1 or in group settings, with further information on parent/caregiver groups is available in the South London CSA Support Services - Guide to Running Groups[xxxviii].

Limited access to services and increasing waiting times, has led to some services offering **Group Interventions** prior to individual work or as part of a programme of support to the child and family. A recent meta-analysis[xxxix] of group interventions found group programmes are a valuable therapeutic resource, particularly TF-CBT based groups, with better outcomes for children and adolescents with depression. The 'Best Practice Guide for Running Groups' developed by South London CSA Services (Harewood 2024[xl]) found they provide a non-judgmental space to share similar lived experiences, can reduce isolation through a sense of community and enable caregivers to be empowered with the skills and confidence to support their child's healing and recovery. For example, The Green House[xli] Nature Based group is a 12-week therapy group that uses art making, movement, drama and writing to explore feelings. Being in nature can be calming and grounding, and it has been proven to improve wellbeing, boost confidence and reduce trauma symptoms. Group work provides survivors the choice to explore alternatives to speaking about difficult things and being surrounded by nature can feel more comfortable than working in a therapy room.

Parent/caregiver support is integral to supporting children and their siblings after sexual abuse. Child House and Bairns Hoose evaluations found key benefits of supporting parents and caregivers: emotional regulation, knowledge and confidence, reduced isolation, better child outcomes and help navigating the system. *Evaluators found "Parents and carers spoke about the trauma they themselves experienced when their child disclosed sexual abuse and the challenges of navigating the complex processes that followed."* (Mitchell 2024 p.39). They described how *"providing parents and carers with advice, reassurance, and information about the process was found to reduce their anxiety, enabling them to better support their child."* (Parker 2021 p.22[xlii])

Supporting parents helps them process their own trauma, reduces stress and isolation, and ensures they can provide the stable, nurturing environment their child needs to heal. Services like Bairns' Hoose and Lighthouse demonstrate that embedding parent and caregiver support into child sexual abuse responses creates better outcomes for children and families alike.

Table 1: Benefits of parent/caregiver support

Benefit	Description
Emotional Regulation	Parents process their own trauma and emotions, enabling them to be emotionally available for the child
Knowledge and Confidence	Parents feel equipped to support their child's recovery
Reduced Isolation	Parents feel less alone, knowing others experience similar struggles
Improved Child Outcomes	Children feel safer and more supported at home when parent/caregivers are calm, informed, and able to create a safe home environment
System Navigation	Parents better understand the justice, health, and child protection systems and so are better equipped to advocate for their child

For younger children who have caused sexual harm, and are often victims of abuse themselves, Hackett[xliii] recommends child-focused and holistic therapeutic interventions for **Harmful Sexual Behaviour**, targeting both abuse specific and more generalised areas of unmet need. Research[xliv] [xlv] points to a move away from punitive models designed for adult offenders and towards interventions that are based on behavioural or cognitive behavioural approaches, but are multisystemic in nature, intervening at both the level of the child and the child's wider family. Allardyce and Yates[xlvi], recommend approaches for pre-adolescent children with problematic sexual behaviours that focus on recognising, understanding and expressing feelings; promote prosocial behaviour and coping skills; teach methods of relaxation; raise children's understandings of maintaining interpersonal boundaries; focus on safe touch; and educating children on sex and sexuality. Currently NIAPP (National Inter-Agency Prevention Programme) support children 3-18 years old with a community-based treatment programme for young people.

Children with learning difficulties may be better supported with adapted versions of therapeutic models, including availability of more sessions to allow a slower pace and more time to build trusted relationships before the intervention could begin. A review of therapeutic provision in England and Wales by the CSA Centre in 2019 found that there are few services nationally who specialised in offering support to children with learning difficulties. Adapted services in England and Wales include the NSPCC Letting the Future In model adapted for children with learning difficulties (LTFI-LD[xlvii]), a paper on adapted models of TF-CBT from BILD network (Hoover 2024[xlviii]) and support services offered by Respond[xlix].

The most recent systematic review of **national clinical care guidelines** for childhood sexual abuse in Europe in 2024 [l] found there is considerable variability across Europe, with no national guidance in 50% of eligible countries and where there was clinical guidance, it often lacked evidence for safety and risk assessment, interactions with caregivers, and mental health interventions. The authors advocated for a multidisciplinary team to develop a pan-European CSA guideline to ensure quality care for survivors, that involves children and caregivers in its development.

Finally, **Herman** recommends that whatever psychological technique is right for the child, it should sit within a three-stage sequence of trauma treatment and recovery. She describes first establishing safety for the child, which not only assumes safety from abusive relationships but also creating a safe space for the trauma recovery[li]. This theme is also reflected in what children and young people say they need (Section 1.5.3). The second phase is the psychological treatment itself to process and respond to the trauma. The final stage Herman describes as *'an advance to a new post-traumatic life, possibly broadened by the experience of surviving the trauma and all it involved'.*

3.4.4 Therapeutic provision in international Barnahus settings

The Barnahus Network (formerly PROMISE) created Barnahus Quality Standards and a range of reports and webinars to assist Barnahus services as they establish therapeutic services. The **Barnahus Quality Standard 8** recommends that mental health services and treatment are provided by professionals with specialised training and expertise, that assessment and treatment is routinely made available for child victims and that interventions both for the child and child's caregivers start as soon as possible. A two-part series of Barnahus Network webinars on international therapeutic approaches detail the approaches in Norway (Part 1[lii]) and Iceland (Part 2[liii]). Therapeutic services in Barnahus are recommended to take a role throughout the child and young person's journey starting with involvement in the MDT referral meeting and planning for the investigative interview; as well as providing crisis support immediately after interview, if the child came alone to their interview without parents.

In Part 1, the Norwegian Barnahus teams detail the process of assessment of hopes and needs for therapy, as is recommended in the research literature, followed by a choice of four routes of support: no therapy needed at that time; referral to local services such as child protection school nurse, family doctor; support from the Barnahus therapy team including one to one sessions, groups and parent support; and a referral to secondary care if long-term support is needed for mental health conditions.

In Part 2, the Icelandic Barnahus explores further the process of assessment of therapeutic needs, recommending this is undertaken over three or four sessions with a child and their caregivers to identify the needs and develop a formulation. This should include a genogram and trauma history, strengths and weaknesses, parenting skills and ability to support child, parent/child interaction and attachment relationships. As a team of clinical psychologists, they recommend the use of standardised measures and diagnostic assessment tools for PTSD, depression and anxiety scales.

The therapeutic model at Barnahus Iceland includes trauma processing models such as TF-CBT with parents/caregivers as part of the treatment, EMDR or Cognitive Processing Therapy (CPT); as well as creating space for psychoeducation, family support, play and sand therapy. The Barnahus also offers groups for children and young people to focus on self-esteem, self-respect and regulatory skills.

The **Barnahus Quality Standard 5** recommends there is one consistent support person that oversees the case management and support of each child. They can include the child protection specialist in the team, the psychologist/counsellor or an advocate and practice varies internationally based on capacity and capability in the Barnahus team. A key benefit of one consistent support person for child and family, is that one person is able to create a trusted relationship with them, and can help navigate their whole journey through the Barnahus. It is clear that the therapeutic support is not always provided by a mental health practitioner, but encompasses a broad range of support needs.

The support that is recommended includes one consistent case worker for the child, supporting and liaising through their recovery journey and ensuring the voice of the child is at the centre of Barnahus services. The practitioner can provide direct trauma-informed work with the child and family ensuring their voice is heard by professionals throughout the process and they are kept up to date. This is particularly important when it is time to end their journey with the Barnahus and move to local community-based services. The practitioner plays an important role to smooth the transition and ensure local community-based services are equipped to support them.

Finally, **Barnahus Quality Standard 2** recommends multi-agency collaboration. Evidence from international Barnahus demonstrates the interconnected role of therapists throughout the child's journey including being part of the multidisciplinary triage and screening process, leading or advising on interviews, consultation to the wider team and external agencies, and direct provision of 1:1 and group therapeutic support. This multi-agency collaboration with therapist is seen most clearly in the Lighthouse model of a joint assessment process – See Lighthouse Case Study.

Table 2 summarises the models of therapeutic support in Barnahus, including the workforce and therapeutic support available.

Table 2: International models of therapeutic support in Barnahus

Barnahus Albania	Psychologists provide crisis support after interview and specialised psychological counselling and therapeutic interventions
The Lighthouse (Child House), England	A team of psychologist, psychotherapist and play specialist provide a unique joint assessment with health and advocacy colleagues, followed by a range of therapeutic support options including TF-CBT, EMDR, psychotherapy and sleep work. As well as access to Letting the Future In from the local NSPCC team.
Barnahus Helsinki, Finland	Psychosocial support workers provide support at referral in and on the day of the interview. After an assessment, children can access TF-CBT at the Barnahus or are referred to local therapeutic support services if there are long travelling distances.
Barnahus Reykjavik, Iceland	Psychologists use trauma processing models such as TF-CBT with parents/caregivers as part of the treatment, EMDR or Cognitive Processing Therapy; as well as creating space for psychoeducation, family support, play and sand therapy. The Barnahus also offers groups for children and young people to focus on self-esteem, self-respect and regulatory skills.

Bairns Hoose, Scotland	Barnahus practitioners come from a range of backgrounds (social work, art therapy and IDVA) and offer child led support services focusing on psycho-education, self-esteem, coping mechanisms, healthy relationships and family relationships. Children and young people are referred to local counsellors or CAMHS teams for therapeutic interventions.
Barnahus Slovenia	Psychologists or counsellors undertake preparatory meetings with the child, to explain the interview process and listen to their hopes and wishes. They bring the child's views into the booking process for the hearing and a psychologist undertakes the hearing interview. They offer crisis support, psychosocial support and appropriate therapies including TF-CBT or Gestalt therapy weekly for 6 months. Gestalt therapy is a form of psychotherapy that is centred on increasing a person's awareness and self-direction; noticing the present moment rather than past experiences.
Barnahus Linköping, Sweden	Psychologists offer a joint assessment with the social worker at referral in and assistance with preparation for the interview, as well as observing the interview and offer advice to the interviewer. After the interview they offer crisis support using the CFTSI model and after assessment can go onto to provide combined parent/child CBT for 20 weeks.
Barnahus Tarragona, Spain	Psychologists and social workers work as a pair to undertake a joint assessment after the MDIA meeting, with the psychologist assessing the child and the social work assessing the parent/caregiver's needs and capacity to respond to their child. Therapy dogs are available to assist with children that are reluctant to attend Barnahus, meet professionals or undertake a forensic interview/court attendance. The psychologist and social worker offer a range of therapies including TF-CBT, integrative therapies, EMDR, sand play and parent/child attachment sessions. There is no limit on how long they can support a child and family, often up to one year.

3.4.5 Workforce

There are various therapeutic practitioners seen in Barnahus internationally ranging from CAMHS psychological professionals, social workers trained in trauma informed approaches, art therapists and play therapists. Often the professional background of the team will shape the therapy and support services available to children and families, with some Barnahus only providing crisis support and short-term interventions, and referring out to local services for long-term therapeutic support, psycho-therapeutic treatments, play and art therapies.

The CSA Centre identified a range of staffing in services in England and Wales in their Support Matters mapping report, including: therapists, counsellors, social workers trained in CSA support models, multidisciplinary teams with clinical psychologists as part of the team, trainees and volunteers. The Lighthouse in England provides the most comprehensive range of specialities in a team with CAMHS clinical psychologists and psychotherapists, play specialist, access to psychiatry and a lived experience consultant; as well as opportunities for

trainee psychologists to develop skills holding a small caseload. The Lived Experience Consultant is a paid member of the team and co-facilitates the parent course, as well as providing training and consultation to the professional network. This role significantly benefits the parent course bringing a sense of belonging and understanding. For more information, see the Lighthouse case study.

Volunteers are used by some support services, most frequently in the charitable sector, but not for the provision of direct work. Volunteers can safely assist with administrative or technical support, fundraising, staff wellbeing and service promotion.

Peer-led support is only just beginning to be seen in Barnahus services, due to safety and risk concerns for the young people; as well as the need to consider their readiness to participate and the potential emotional impact. The Bairns Hoose in Scotland is developing a model of young people's groups that will be jointly led by one of their 'Changemakers' and a Bairns Hoose practitioner. The Changemakers are a group of young people who have been supported and trained to participate in the co-design of the Scottish Bairns Hoose model and the local Children's 1st service at the Wee Hoose. For more information, see the Bairns Hoose Case Study.

Case Study 1: The Lighthouse (Child House) in England

Trauma informed child focused support to children, young people and families affected by sexual abuse; where there is need for holistic mental health support alongside health and criminal justice needs.

Referral criteria Live in North London Children that have experienced sexual abuse Must report to social care/police No need for an active police investigation	**The team** CAMHS – clinical psychologists, child & adolescent psychotherapists, assistant psychologists and trainees, child & adolescent Psychiatrist, play specialist Lived Experience Consultant NSPCC Social workers (LTFI team) Child and family practitioners including independent sexual violence advocate (ISVA)
Screening Triage by case management team MDT Intake meeting to consider assessment or consultation to professional network Case manager completes screening - CATS Case manager supports child with social story/letter and discussing options for MDT assessment	**Assessment** Unique MDT assessment with paediatrician, clinical nurse specialist, play specialist, CAMHS, child and family practitioner - including assessment, clinical formulation, goals/hopes and collaborative care plan. MDT de-brief at the end of the morning to complete measures: Current View and CGAS Joint assessment letter to child/family/referrer
Therapeutic support CAMHS Trauma-focused practice (TF-CBT, EMDR, CATT, NET) Child & Adolescent Psychotherapy Letting the Future In (LTFI) Other support including: sleep work with play specialist, advocacy, health and sexual health	**Parent/caregiver support** Individual sessions parallel to CAMHS or LTFI – can be joined by Lived experience consultant Psychoeducational Parent Course for 10 sessions - co-led by Lived experience consultant and psychologist
Hopes for the future Ongoing review of routine mental health outcome measures and use of goals-based outcomes ISVA support can continue after therapy Additional CAMHS support as justice progresses Consultation provided to professionals by Lighthouse CAMHS team e.g. schools	**Participation** Young people can join interview panels and contribute to service development Participation events in school holidays with a focus on contributing to therapeutic recovery For example: well-being sessions, creating vision boards for the service
If not Barnahus where …. Refer onto local CAMHS teams or third sector services where the focus is not on the impact of sexual harm Refer to CAMHS where there are high mental health risk concerns that need to be prioritised	**Evidence of what works** MDT complete outcome measures with CYP and family – CATS, RCADs, Goal based outcome Parent course and psychology led VRI evaluations Annual reports during four year pilot 'Learning about the Lighthouse'- Young people's perspectives on London's Child House. 2022

"We see functionally and statistically significant reduction in reported symptoms of trauma, depression and anxiety for young people before and after their therapeutic support."

Case Study 2: Bairns Hoose (Children 1st), Scotland

A broad trauma informed socio-ecological recovery model, based on the work with an emphasis on building stability and safety through trust, choice and empowerment of the child/young person and their family.

Referral criteria Children after any type of abuse or trauma – not just sexual abuse - including harmful sexual behaviour, domestic abuse, neglect	**The team** Bairns Hoose team made of practitioners with a background in social work, art therapy or advocacy (IDVA)
Screening Trauma recovery model purposefully broad and outside a clinical approach. Triage and case allocation based on need. Regular phone, letter or text contact prior to allocation, to ensure children and families have support immediately after forensic interview and know they are 'held in mind' while waiting. Designing a process of check-ins to identify when Bairns Hoose support would be helpful e.g. impact of the justice process.	**Assessment** Based on a holistic and ecological approach including: hopes and needs, history of abuse, wellbeing, friendships, school, family, parents and siblings needs. Assessment led by Bairns Hoose worker and informed by safety needs, stabilisation, stage in child protection and justice processes. Information from other agencies: police, CAMHS, pastoral care teacher, social work. No clinical diagnostics as no mental health practitioners.
Therapeutic support - a four stage process: *Access and engagement *Developing a relationship *Fostering safety and stabilisation *Tailored, overlapping support options Including: psycho-education, self-esteem, sexual health and healthy relationships, peer relationships, family relationships *See Recovery Support model page 40 of phase 2 evaluation	**Parent/caregiver support** 1:1 support for parent/caregivers/couples Whole family support sessions 1:1 Sibling support *See Bairns Hoose recovery model page 48 of phase 2 evaluation
Hopes for the future *Reflections of what they have learnt *May not have 'recovered' but celebrate the journey travelled *Restorative family conversations *Developing coping skills *Additional processing support after court	**Participation** The 'Changemakers' group (13-19 yrs)have shaped: *National Scottish Bairns Hoose Standards *Co-design the brand for the Bairns Hoose *Feedback on the interior design of the house Young people have undertaken training to become volunteer co-leaders of psychoeducation groups.
If not Barnahus where …. 1/3 decline Bairns Hoose support initially 1/3 refer onto CAMHS or local support, if there is a strong and trusting support relationship 1/3 access Bairns Hoose support	**Evidence of what works** North Strathclyde Bairns Hoose Evaluation – Phase one report. March 2023 North Strathclyde Bairns Hoose Evaluation – Phase two report. Sept 2024

In 2022, the Bairns Hoose created the Children 1st 'Changemakers'. They have a significant role in informing the design and development of Bairns Hoose, working alongside partners to co-produce important aspects of the design and development. Participation requires meaningful and inclusive choices, so the group is supported to make choices, share ideas and feedback their views.

Case Study 3: Barnahus Reykjavík, Iceland

A wide range of trauma informed support for children, young people and families affected by sexual abuse, physical abuse or domestic violence; delivered close to the child's home.

Referral criteria Children aged 3-18 years old after any sexual or physical abuse or domestic violence. Service available in Reykjavík, a satellite site in North of Iceland or the child's hometown.	**The team** A team of clinical and forensic psychologists (8), social workers (2) and forensic interviewers Plus, a new team offering child/parent combined CBT after domestic violence (and accountable perpetrator)
Screening All children are eligible if they are referred by child protection services If there are no trauma symptoms, then child protection services lead on psychoeducation	**Assessment** Assessment and psychoeducation of 3 to 4 sessions; including child development, protective factors, parent skills and support needs, trauma history. Formulation of therapeutic need and std measures Consider child/parent interactions, parental ability to support child, attachment
Therapeutic support TF-CBT, NET, child and parent CBT EMDR and cognitive processing therapy (CPT) Psychoeducation Play and sand therapy Group therapy	**Parent/caregiver support** 1:1 work during CPT and TFCBT Family support - child/parent child relationship Onward referrals for parents' own support NEW – support for the child that caused sexual harm but not in the Barnahus.
Hopes for the future Sessions include reflections on progress, what is different now and hope for the future At final session the children choose a parting gift Celebrate last session with wider family	**Participation** Children enabled to feedback to Icelandic government ministers and Ombudsman for Children Participation group – but noted risk of young people knowing each other as Iceland is a small community
If not Barnahus where …. Child protection can refer on for long-term mental health conditions – child protection psychologist, private practice, youth healthcare centre	**Evidence of what works** Research evaluation Feedback from parents underway Outcomes measures collected: Trauma reaction index, CATS, RCADs, DASS 21, PTSD scales, depression and anxiety scales

'Importance of long term therapy is crucial for the victims and their families' Ólöf Ásta Farestveit, Director of The National Agency for Children and Families

Case Study 4: Barnahus Tarragona, Catalonia, Spain

Referral criteria Children that have experienced sexual abuse	**The team** Child protection psychologists (3) Social workers (3) Health team psychologists (3) Justice social worker (1) Therapy dog team from Affinity Foundation
Screening Triage by local social worker who ensures child safety first and then refers to multi-disciplinary interagency (MDIA) meeting at Barnahus Barnahus social worker contacts child to discuss options, provide leaflet and brings their voice into MDIA assessment MDIA meeting plans therapeutic assessment after medical examination/forensic interview	**Assessment** Child protection psychologists and social workers work as a pair to undertake a joint assessment - psychologist assesses the child and social worker assesses the caregiver's needs and capacity. Therapy dogs are available to assist with children that are reluctant to attend the Barnahus or meet professionals. MDIA de-brief to make decision about therapy
Therapeutic support Health team psychologists offer a range of therapies including TF-CBT, integrative therapies, EMDR, sand play. No limit on length of support - up to one year **Therapy dogs** can help children to express emotions, for calming, used as a mirror to explore touch and build the bond between practitioner and child.	**Parent/caregiver support** 1:1 support for parent/caregivers/couples Parent/child attachment sessions No groups
Hopes for the future Coordination and psychoeducation from psychologists; and consultation to schools. Additional support from a justice social worker as the investigation progresses.	**Participation** Children are supported to write a letter at the end of their time with Barnahus, that can be shared with another child starting their Barnahus journey.
If not Barnahus where …. For children already supported by a psychologist outside of Barnahus, they continue to access support locally. Barnahus offer consultation to build confidence in local practitioners and monthly supervision.	**Evidence of what works** Barnahus Tarragona evaluation (2025) is in progress by Save the Children and University of Catalonia. Therapy dogs have been found to empower children with confidence to speak in therapeutic interviews

'Supporting a child to train them to be able to work with the therapy dog, empowered them to feel confident enough to go to the forensic interview.' *Maribel Vila, Affinity Foundation*

4 Current Barnahus services and the Barnahus Therapeutic Framework

4.1 Barnahus' Therapeutic Framework

The National Therapy Group in Ireland developed a Barnahus Therapeutic Framework to provide guidance for existing and developing Barnahus services. The Barnahus Therapeutic Framework aligns with the Barnahus Quality Standards and was informed by evidence-based research prepared by members of the Barnahus National Therapy Group including Barnahus practitioners, BNASC, CHI and HSE representatives. The Framework relates to services provided within Barnahus, and will be updated following the Barnahus Therapy Mapping to include a framework for longer-term therapies outside of Barnahus.

This Therapeutic Framework recommends a **Screening** process to gather information from the referral, joint investigative interview, forensic medical and discussions with parent/caregivers and professionals. The screening should enable a decision about which children and young people could be supported at the Barnahus. At this point some children may not meet the criteria for assessment and therapeutic intervention. This could include children whose primary need is for psychological support in relation to other mental health issues, where there is a pre-existing relationship with a suitable therapeutic support service, where there is an immediate need for child and adolescent mental health services (CAMHS), where long-term support is predicted or because no support is wanted at that time. The Therapeutic Framework states *"When it is clear from the therapeutic screening process that a child would benefit from a longer-term specialised intervention, or from modalities not available within a Barnahus framework, they will be referred to other child sexual abuse specialist services such as a Rape Crisis Centre (depending on age), Children at Risk Ireland (CARI), The Alders Unit CHI, and/or primary are psychology, CAMHS, or other psychologists/psychotherapists in private practice."*

The screening is followed by an **Assessment** process, undertaken by Barnahus practitioners over one to two sessions, which should include a clinical interview and standard assessment tools. The following assessment domains can be used during the clinical interview to create a unique picture of the child and family: (i) trauma history, including the trauma symptoms experienced by the child and family and exposure to other forms of abuse; (ii) observations of a child and their caregivers; (iii) contextual history, biopsychosocial development and attachment, family relationships, caregivers response to disclosure, and parenting styles; (iv) interviews with caregivers to assess their coping ability, level of parental support, mental health functioning, and ability to fully participate in the intervention process. Standard assessment tools that are recommended include a trauma measure, such as Trauma Symptom Checklist (TSCC/YP) and a broader assessment of emotional needs such as Strength and Difficulties Questionnaire (SDQ).

Following the assessment, children and families can access a **range of therapeutic support** such as psychoeducation, crisis intervention, Child and Family Traumatic Stress Intervention (CFTSI), Trauma Focussed Cognitive Behavioural Therapy (TF-CBT), psychotherapy or creative therapies, as available. Children may be referred onto local specialist support services for long-term therapy, such as play or art therapy, family work or psychoanalytical therapy.

Caregivers may be referred to primary mental health services or the National Counselling Service for their own mental health needs or specialist support if they have disclosed their own experiences of sexual abuse for the first time.

CFTSI is an evidence-based, prevention and early intervention programme, designed to reduce traumatic stress reactions and prevent the development of PTSD in children and adolescents (7-18 years). Commencing within 45 days of a traumatic experience or disclosure of sexual abuse, CFTSI aims to help children and their caregivers understand their post-traumatic experiences, recognise traumatic stress reactions, communicate these trauma symptoms, and apply coping skills and techniques to address trauma stress reactions. Lasting five to eight sessions, CFTSI has been associated with significant reductions in PTSD symptoms, anxiety symptoms, and reversal of PTSD diagnosis.

TF-CBT is an evidence-based treatment approach shown to help children, adolescents, and their parents (or other caregivers) overcome trauma-related difficulties, including child maltreatment. The programme can last up to 24 sessions and include parenting, psychoeducation, relaxation, affect expression and modulation, cognitive coping, creating trauma narratives and processing, in vivo mastery and conjoint sessions.

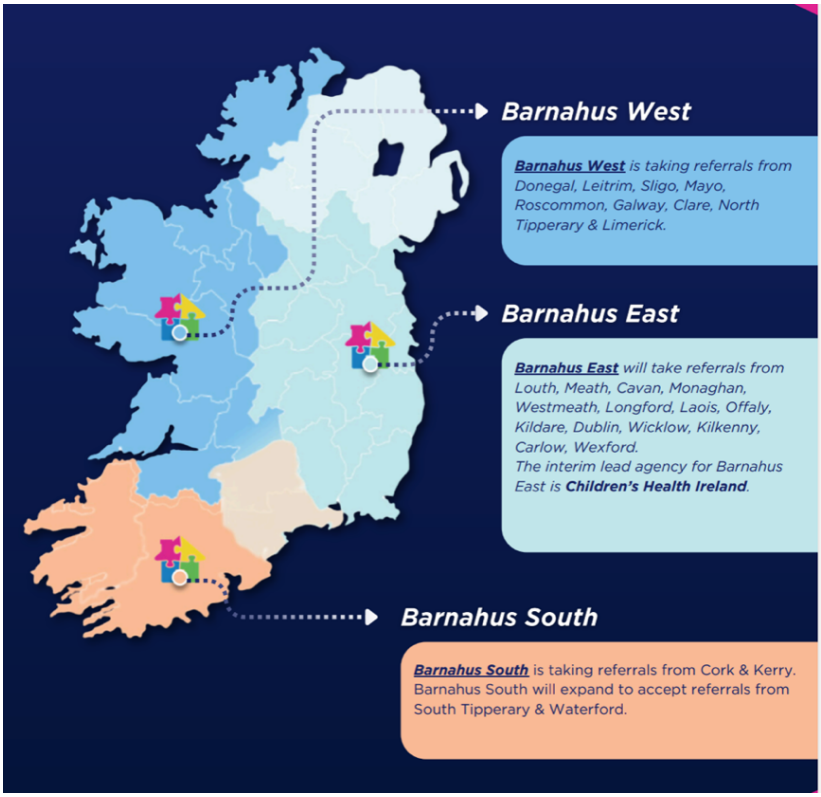
4.2 Current Barnahus Therapeutic Provision

Barnahus West and Barnahus South provide all the elements of a Barnahus model of multi-disciplinary interagency assessment, with one consistent support person for the child, enabling forensic specialist interviews, child friendly medical assessment and a therapeutic screening to identify the hopes and needs of the child. Barnahus West opened in 2019 with a core team of Barnahus manager, social worker, psychologist and administrator, police lead and working alongside the child and adolescent sexual assault treatment service (CASATS). Barnahus South opened May 2024 and both services have been rapidly expanding their teams over the last 12 months to be able to offer therapeutic support and joint intererviews.

Barnahus East is in the final stages of implementation, and The Alders Units (CHI) will provide the therapeutic service at the Barnahus East when it opens. The Alders Units (CHI) therapeutic services are detailed in this section, however it should be noted that they are also a Specialist CSA Support Service in their own right, who will remain available to provide long-term support after Barnahus East opens.

Barnahus locations
The three Barnahus are, or will be, located in Galway, Cork and Dublin as detailed below in Figure 3.

Figure 3: Barnahus Locations



The Barnahus West team commenced a three pilot projects in 2023:

- **Child and Youth Advocate**[1] – an advocate from ASSC joined the team two-three days a week (2023 – 2025). The aim of the child and youth advocate is to ensure that the child's voice is heard so they can be involved in decisions about the support they receive; as well as offering support through the criminal justice interviewing process.
- **Child and Family Traumatic Stress Intervention** (CFTSI) - two practitioners from CARI joined to provide CFTSI for children after Barnahus screening (2023 – 2025)
- **You are Enough** Parental Peer Support Groups – as part of the 2KNOW[liv] project Barnahus/CARI piloted the You are Enough model alongside Barnahus in Finland. The evaluation revealed that the child victims' symptoms closely mirror the parents' own symptoms of trauma, stressing the urgent need to enhance systematic support systems for families that acknowledge the far-reaching impact of OCSEA. (2024)

Significant Tusla funding in 2024 has enabled Barnahus West and South to recruit an in-house team of senior psychologists, senior social workers and social care leaders who are being trained to deliver therapeutic support, including CFTSI and TF-CBT, in line with the National Therapeutic Model; in addition to the existing CARI practitioners in Barnahus West. The workforce and exact staffing make-up differs across the two sites and is detailed below. From 2025, agency partners will see a significant increase in the Barnahus capacity to not only

[1] **Child Advocate Purpose:** To act as a dedicated support for the child, upholding their rights under Article 12 of the UNCRC, which says that every child has the right to express their views, feelings and wishes in all matters affecting them, and to have their views considered and taken seriously. Ensure that the child is provided with space, voice, audience and influence in order to allow their views and feelings and wishes a communicated to relevant professionals and that their views are considered and taken seriously.

screen and offer early help through CFTSI, but also to support children and families after child sexual abuse with TF-CBT for up to 24 sessions, and other modalities as local workforce allows.

Barnahus Capacity
Table 3 below shows the activity in Barnahus West in 2024 and Barnahus South since opening (10 months); with 59 children accessing therapeutic support at Barnahus West or South in 2024, which is less than 18% of those referred to Barnahus. In Barnahus West in 2024, 35 children accessed CFTSI (CARI 34, Barnahus 1) and four accessed TF-CBT. During their first 10 months of service, Barnahus South supported 20 children, with 17 children accessing CFTSI and three accessing TF-CBT

Barnahus team:
The Barnahus team when fully staffed will include social care leaders and senior social workers (both who could be therapeutically trained to deliver CFTSI/TF-CBT) and senior psychologists or family therapists at each Barnahus in the West and South. In addition to their therapeutic role, approximately three of the social care team will also be trained to be joint interviewers with An Garda Síochána officers.

Current staffing includes:

- Barnahus West team: Social work team leader, three senior social workers (Sligo, Galway and Limerick), two social care leaders, two family therapist – with one remaining social care leader post to be recruited. Plus two therapists from CARI and a youth advocate from ASSC under service level agreement.
- Barnahus South team: Social work team leader, three senior social workers, 1.4 senior psychotherapist – with three remaining social care leader posts to be recruited.

The team is spread across the core Barnahus sites in Galway and Cork, as well as the recent expansion to trial outreach in Limerick and Sligo for Galway, and Kerry and South Tipperary (also covering Waterford) in the south. Currently the trial of outreach consists of a Tusla office space for the practitioners and access to CARI child friendly therapy rooms by mutual agreement with CARI Ireland or rented rooms in Family Resource Centres. The model of therapeutic support is developing based on the National Therapeutic Framework and expanding at the rate at which posts can be filled and staff established.

Table 3: Barnahus West and South activity

Activity	**Barnahus West 2024 (12 mths)**	**% of referrals**	**Barnahus South May '24 – Feb '25**	**% of referrals**
CYP referred	218		137	
CYP screened	98	45%	38	28%
Therapeutic support with CFTSI or TF-CBT	39	18%	20	15%

Referred to another service	38	17%	22	16%
Did not need support at that time	32	15%	13	9%
Consultations offered	17*	8%	68	50%

*BW – consultations underreported due to lack of data capture beyond early 2024

Therapeutic pathway through Barnahus:
Figure 4 below summarises the journey of the child and family through the therapeutic pathway at Barnahus West and South, noting the differences in practice where identified.

At referral into Barnahus the child's voice is gathered through close work with local professionals and discussion with parents to really ensure they understand the hopes and needs of the child. In future, it is hoped to add this to the referral form. In Barnahus West this is enhanced by the child and young person's advocate who ensures that the voice of the child is central to all MDIA meetings and discussions at the Barnahus. Although concerns were raised by one interviewee that the screening process focused only on the child's needs and not those of the parent/caregivers.

Barnahus West and South are developing their localised approaches to how therapy is to be delivered in the context of an expanding team. The approaches include a review of the screening process to ensure that it is up to date with evidence-based practice and the child participation strategy, review of assessment for therapy readiness and building relationships with external stakeholders in the community to improve referral pathways.

At the MDIA meeting, the team consider which children would benefit from therapeutic screening (28-45%), those who can be supported via consultation (17[2]-50%) where an existing practitioner is supporting them locally, or those children that do not need or want any therapeutic support at that time (9-15%) – remembering that children and families should be able to return at a later stage for support if needed. The Barnahus provide support to existing local practitioners through a one-off consultation, offering further support on an ad hoc basis, as required.

28-45% of children attend for therapeutic screening and/or psychoeducation. The screening gathers their hopes and assesses the need for therapeutic support, as well as providing psychoeducation, coping skills to the parent/caregivers and children. In Barnahus South the screening takes place in person and includes the child and parent/caregiver, whilst in Barnahus West the screening is currently undertaken over the phone with parent/caregivers. For some children, the therapeutic screening alone is enough, and they do not require further therapeutic support from Barnahus. For others, referral onto another specialist CSA provider,

[2] Note: Barnahus West 17% consultation under reported due to lack of data but anecdotally similar level to Barnahus South 50%

local support service or child and adolescent mental health service is identified. In 2024, an estimated 16-17% of children went onto access another support service outside of Barnahus.

In 2024, 15-18% of those children referred to Barnahus were able to access therapeutic support within the Barnahus, with the majority accessing CFTSI from the CARI team and small number accessed support from the Barnahus psychologist. As the Barnahus continue to recruit a combined team of psychologists and social workers who have been therapeutically trained to deliver CFTSI and Trauma focused CBT, this capacity will increase. **See Section 10: Demand and Capacity mapping** for more details. Children under 7 years are usually referred outside of Barnahus to CARI or local play and art therapy, but the Barnahus can offer support to their parent/caregivers as required. While TF-CBT and CFTSI can be adapted for younger children, the Barnahus team have not undertaken this training.

Barnahus West piloted the You are Enough model of parent support group in 2024, but there are no young people's groups available at either Barnahus site - although both are currently considering what group support might look like as capacity allows. Guidance for running groups in CSA support services for children (Harewood 2024[lv]) and running those groups pre-trial (Harewood 2023[lvi]) are available as reference points when designing the future groups model.

Both Barnahus sites are considering how to work therapeutically when children's cases are pre-trial (for those children that still have an open investigation with AGS), with a national sub-group considering note keeping pre-trial and developing pre-trial therapy leaflets and consent forms for clients.

Ensuring a child's voice is heard

Reflecting on the international best practice, as synthesised in the 'Continuum of Recovery Model', the child's voice is captured through conversations with parents, during the MDIA assessment and at therapeutic screening. In Barnahus South, the child's voice in heard in screening which takes place in a series of face-to-face sessions with the child and parent/caregivers. In Barnahus West, the child advocate ensures the child's hopes and needs are very clearly present during the MDIA and therapeutic screening process. However, it is rare for the rest of the Barnahus team to make direct contact with the child during the MDIA and Screening process. Barnahus West described how occasionally young people that are in care have been brought to the Barnahus for a visit in advance of their referral into the process, which gives an opportunity to capture their hopes and needs during the assessment process.

Once a child reaches the Therapeutic Support stage at Barnahus, it was clear that there is a choice of interventions, and the children and therapist work jointly to identify whether CFTSI, TF-CBT or another type of support is better for them.

Child participation for children that have attended a Barnahus is currently limited due to capacity, although there is good evidence of the CAB being actively involved in the service design. The children in the CAB are not children that have already attended a Barnahus, but they have experienced other support from statutory services, such as CAMHS and Tusla. There were some examples of good practice in Barnahus with children being supported to

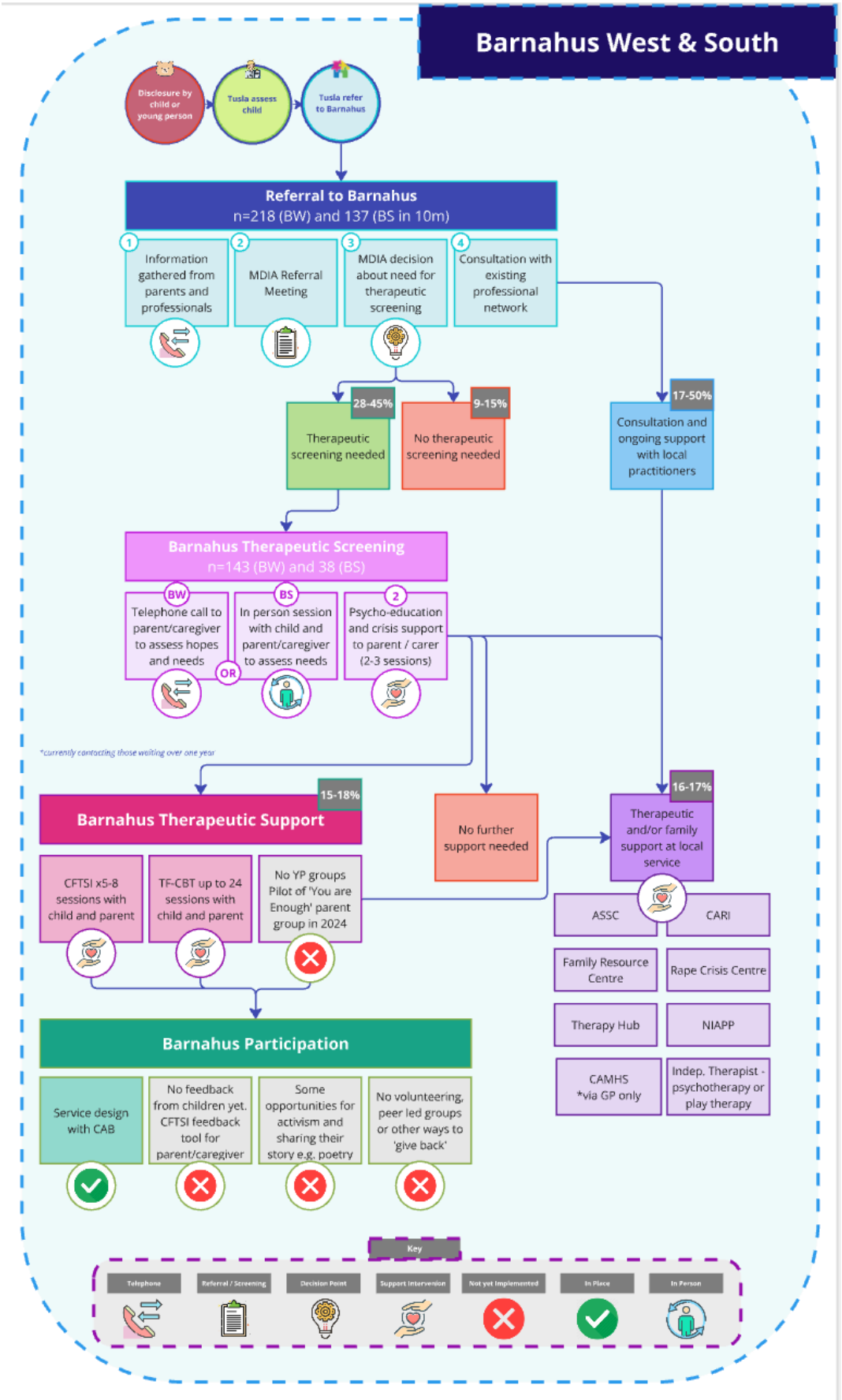
make sense of their narrative and through creativity such as writing poetry and creating a story of their experiences to share with another child.

Issues identified from stakeholders

- There is currently no evaluation or feedback captured from children and families that have used the Barnahus, apart from ad hoc compliments and built in CFTSI parent feedback.
- In terms of creating reciprocity and legacy through connection to Barnahus, there are currently no opportunities for young people to return to the service to volunteer such as on recruitment panels, peer led groups or YP forum to feedback on service design.
- The CFTSI model is designed children who have experienced or reported the trauma of sexual abuse in the last 45 days. This means that some children are not eligible to access support as more than 45 days has passed.
- Children that have experienced sibling sexual abuse from a sibling that is under 10 years do not currently meet Barnahus criteria, as this is classed as sexualised behaviour by Tusla and not considered child sexual abuse. It was noted that these referral criteria are currently being reviewed, and The Alders Unit do already accept these referrals.

One interviewee said *"There is that funny fragmentation of families that can happen. [I have a] family at the moment and they're thinking they need private therapy for each of the parents. They need NIAPP for the boy who harmed his siblings. They're looking at getting some other private therapy for the two younger siblings who are harmed."*

Figure 4: Barnahus West and South Referral Pathway



4.3 Current therapeutic support at The Alders Units (CHI)

The Barnahus East service is developing local procedures for their future as a multi-disciplinary interagency team, but there is currently no funding for the Barnahus manager, administrative support or advocacy provision. As such, the Barnahus East has not yet opened. This section will focus on The Alders Units (CHI), that will provide the staffing for the "Therapy Room" at Barnahus East once it is open.

The Children's Health Ireland (CHI) service 'The Alders Units (CHI)' have been supporting children and families through the aftermath of sexual abuse for over 30 years. This long-established, child-led therapeutic support service is based in Dublin at two healthcare sites in Tallaght and Connolly, Blanchardstown; previously known as St Clare's Unit and St Louise's Unit. Nearly all interviewees were aware of the service, with several accessing advice, consultation and/or clinical supervision from the team. As the Barnahus East progresses through to implementation, The Alders Unit are working closely with other agencies to develop the 'therapy room' of the Barnahus model.

The Alders Units (CHI) therapy team comprises social workers, psychologists, psychotherapists, art therapists and play therapists. Various modalities are represented including psychoanalytic therapy, systemic therapy and play therapy. Psychiatry is provided on a sessional basis to children who present with mental health difficulties. The Alders Units (CHI) therapeutic teams of 9.1WTE at Tallaght and 11.7WTE at Connolly (Blanchardstown) (excluding non-clinical facing time), include highly experienced practitioners who are active in the field of academic research. The therapeutic service at The Alders Units (CHI) is co-located and works closely with the Laurels Clinic (CHI), which provides medical intervention including forensic medical examination after sexual assault or disclosure of child sexual abuse. In addition, the Alders Units (CHI) work closely with the SATU at Rotunda Hospital for children 14 years and over. When Barnahus East opens, a proportion of The Alders Units (CHI) practitioners will join the Barnahus East team.

Referrals are accepted from professionals in Tusla social work teams, as well as other statutory services such as GPs, primary care, CAMHS, An Garda Siochana and the Laurels Clinic; when there has been a disclosure of child sexual abuse or there are reasonable grounds for concern that sexual abuse has occurred. Additionally, the team noted referrals can be accepted following the presence of significant sexualised behaviour which raises concerns about possible child sexual abuse. The Alders Units (CHI) supports any child 0-18 years and their family where there is an indication that specialist therapeutic supports are required in the context of child sexual abuse. Professionals working with children/families can also seek consultation where there is a concern of child sexual abuse. Most of the support is provided face to face in Connolly (Blanchardstown) or Tallaght with children travelling into Dublin from their home counties; as well as outreach from Tallaght in Wicklow/Kildare, Naas and the Dublin D18 area; and plans for outreach from Connolly (Blanchardstown) into Cavan and Louth.

The therapeutic team undertake an intake process and capture any additional needs of the child at referral in. Across Connolly (Blanchardstown) and Tallaght 158 (33%) of the 473 children referred in for therapeutic support, were offered a therapeutic assessment in person with their parent/caregiver. The purpose of the assessment is to provide the child with a safe

space and opportunity to talk about the sexual abuse concerns and to identify any therapeutic needs for the child and family. The assessment of their therapeutic needs can last three to four sessions and include support and psychoeducation tailored to the needs of the parent/caregiver. Sometimes the assessment alone is enough intervention to support the child at that time.

Recommendations are made in relation to therapeutic needs and supports identified as helpful for the child. Referral can be made from assessment to the therapy team in The Alders Unit or to another agency, as appropriate. On completion of assessment, a report may be provided to Tusla and An Garda Siochana if appropriate. Table 4 details the activity during 2024.

Table 4: The Alders Units (CHI) activity

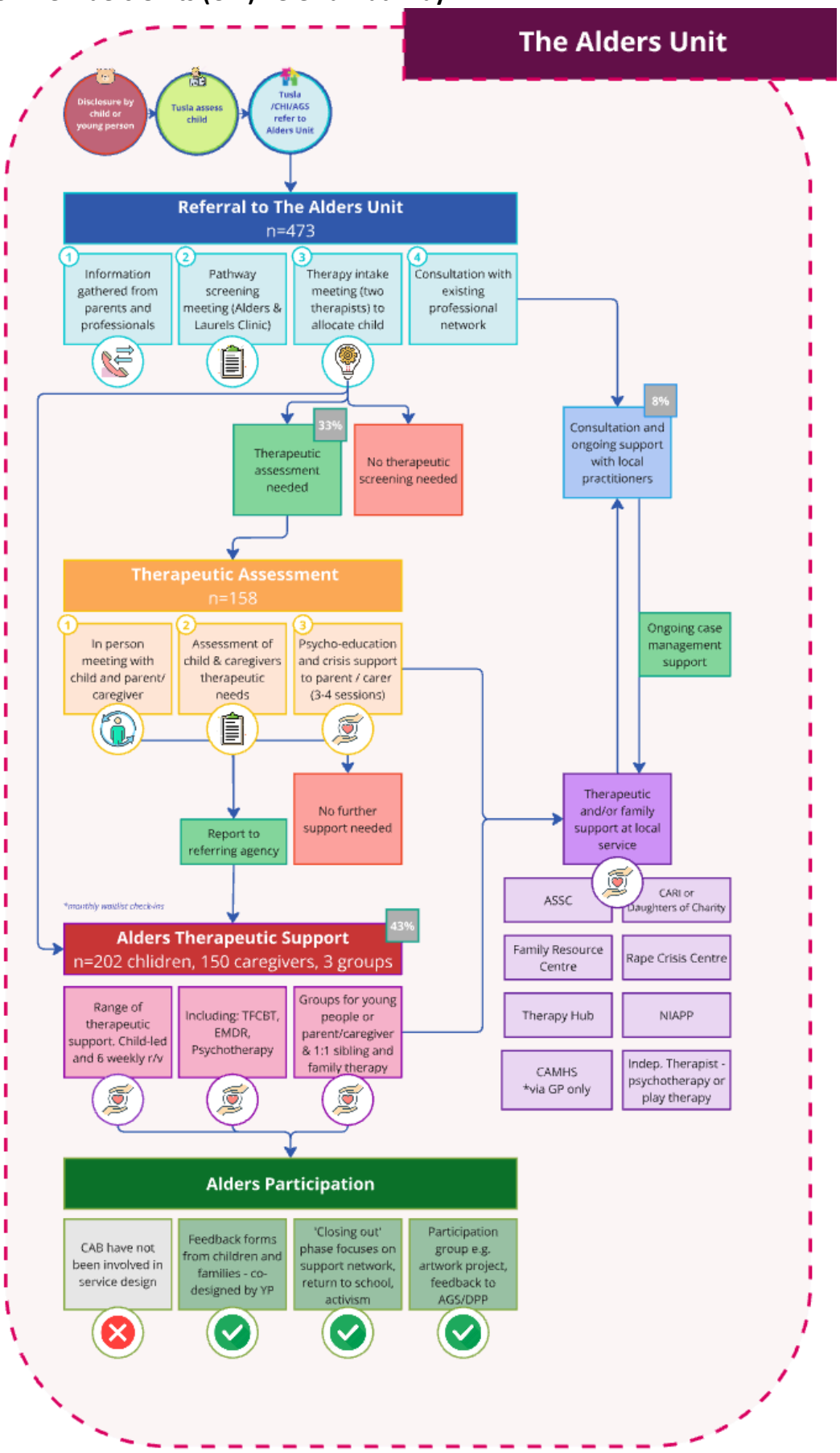
Activity	Alders Connolly 2024	Alders Tallaght 2024	Combined % of referrals
CYP referred	190	283	
CYP assessed	76	82	33%
Therapeutic support	73	129	43%
Groups	22	18	8%
Consultations offered	19	19	8%

Children requiring therapeutic support can join the waiting list of three to six months immediately or are referred after the assessment process, with 202 (43%) of referrals in 2024 requiring medium to long term therapeutic support; ranging from short term (six up to 12 sessions), medium term (up to 25 sessions) and long-term support of a year or more. Children are supported with monthly check-ins while they wait and support can be provided for parent/caregivers in distress. There are a range of therapeutic interventions available including: various types of psychoanalytic therapy, art, play and systemic family therapy. There were three groups for young people and parents in 2024 and access to psychiatry support when needed through the wider team at CHI. Support through the criminal justice process is available and children under 12 years with harmful sexual behaviour can be supported, as well as parallel work with specialist provider NIAPP (see section 7).

Consultation is provided by The Alders Units (CHI) to other agencies and professionals. For example, when children are attending a therapy service in the community their practitioner can access support through an initial consultation and ongoing consultation/support from the expert practitioners at The Alders Units (CHI).

At the end of child's journey with The Alders Units (CHI) there are opportunities for participation. For example, children from the cross-site Youth Participation Group have been involved in co-designing feedback forms, an artwork project and providing feedback to An Garda Síochána. Their therapeutic intervention ends with a closing out phase that focuses on creating a secure support network, returning to school and opportunities for activism.

Figure 5: The Alders Units (CHI) Referral Pathway.



5 Early help after child sexual abuse and local knowledge

Through interviews, surveys and focus groups, the mapping identified considerable variety in the range of local services commissioned by the HSE, Tusla and provided by independent practitioners in each county. Local support services include Jigsaw (HSE), Family Resource Centres (Tusla), Therapy Hubs (Tusla), Therapeutic Family Centres (Daughters of Charity), Area based therapy teams (Tusla) and independent therapists, both Tusla funded and self-funding.

Support services, such as Family Resource Centres and Jigsaw, are well known locally and provide community based early help, counselling, family support and advocacy. They have a good knowledge of local independent services, smaller charities and specialist support. Many of these services assess children and refer onto a specialist service after disclosure of child sexual abuse, such as Barnahus, The Alders Units (CHI), Sexual assault treatment units (SATU), Tusla, RCC or local independent therapists. Even after the investment of a million euros in 2022/23, the services that responded to the mapping reported they did not have the specialist expertise needed to support after the impact of trauma and abuse. In 2023, Tusla piloted nine Therapy hubs, who are able to offer in-house play therapy and adolescent psychotherapy, with pilot outcomes expected in July 2025.

5.1 Jigsaw and other primary care mental health services

Jigsaw are HSE funded primary mental health services based in 15 locations around Ireland - Galway, Dublin, Laois, Meath, Offaly, Wicklow, Cork, Kerry, Limerick, Tipperary, Donegal, plus satellite sites. They offer stabilisation, grounding techniques and psycho-education to children and young people referred by their health colleagues including GPs, CAMHS, the Gardaí, school or by self-referral.

Jigsaw teams are multi-disciplinary health teams typically comprising a mental health nurse, occupational therapist, psychologist and social worker. Although Jigsaw are working towards being a trauma informed organisation, they reported current gaps in their 100 practitioner's knowledge of child sexual abuse, responding to the impact of trauma, responding to new disclosures of sexual abuse and myths about working pre-trial.

The teams typically offer brief interventions for issues such as self-harm, sleep or school refusal and then refer onto other specialist services as needed. They said they *are* often the first service that a young person discloses their experiences of sexual assault/abuse to and so rather than being a support service to refer onto after Barnahus, they are often a child's route into support from Tusla and Barnahus for an estimated 20 children per year. Jigsaw also typically refer onto RCC for young people 14 years and older, although noted the long wait times; and primary care child and family psychology, CAMHS or CARI for younger children, again noting a wait time of two years or more.

No data was recorded on the Jigsaw system about child sexual abuse, but anecdotally they estimated supporting one to two children who have experienced child sexual abuse in the past at each of their services each year.

We did not receive any responses in the mapping survey from primary care mental health services. However, we did hear from more specialist services that, like Jigsaw, primary care psychologists may hear children disclose during their eight sessions of support, and then they alert Tusla and may refer to RCC to more long-term support of 12-24 sessions.

5.2 Family Resource Centres (FRC)

Tusla has worked with many community and voluntary services for 25 years to establish 121 Family Resource Centres (FRC). The aim of the FRC programme is to support children and families from disadvantaged backgrounds and involving local communities in tackling local problems. This can create successful partnerships between voluntary and statutory agencies at community level. It is a needs-led model and so each of the 121 FRCs has a local flavour and is rooted in the community; with some focused more on children and families than others. There is no national standard for an FRC and so a wide variation in levels and types of support and resources is seen nationally, with details of locations and how to access them on the FRC National Forum[3],[4] and the map below. 121 are members of FRC National Forum, with 108 providing primarily adult counselling.

Nine of the FRCs have a clinical lead and host a Therapy hub (see Section 6.3 below) while the remainder provide a range of universal and targeted services including:

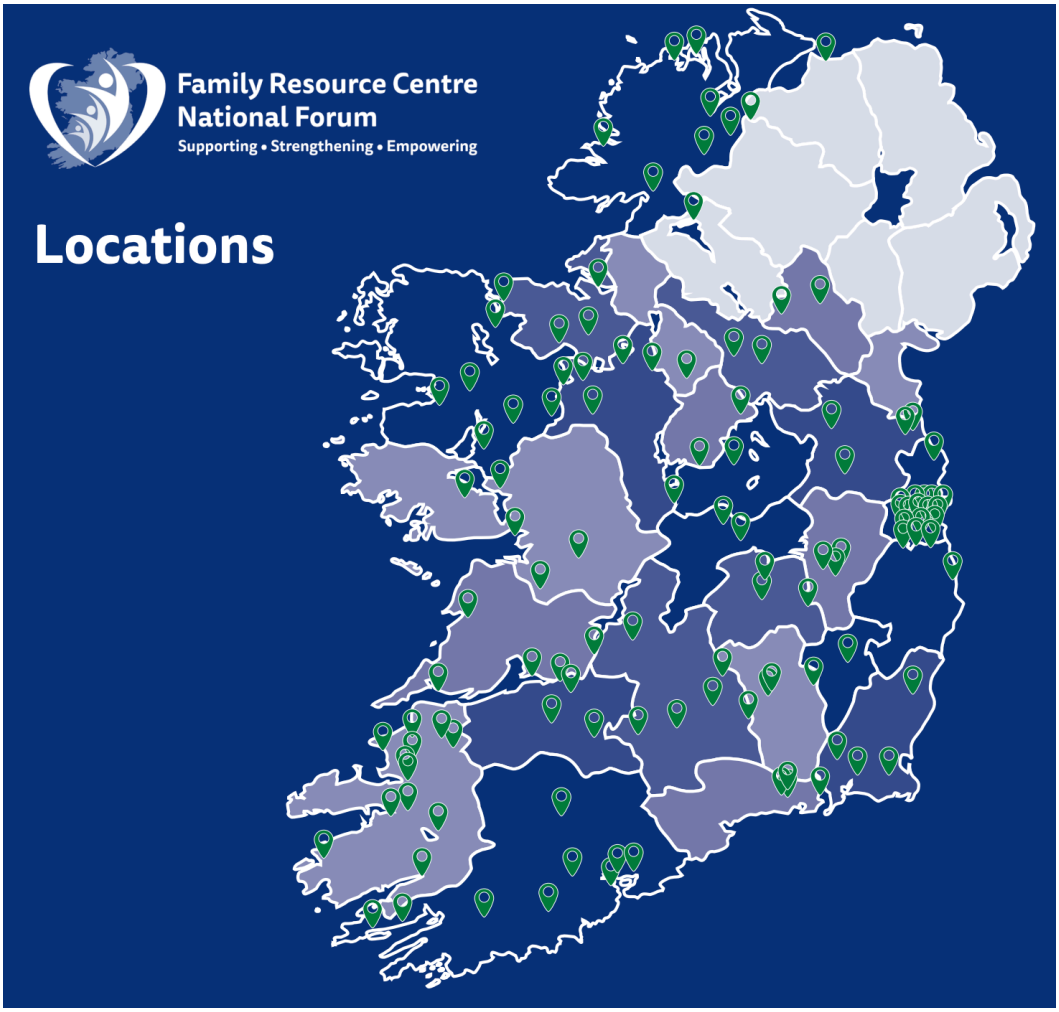
- Information and advice
- Education courses and training opportunities
- Meeting local needs such as childcare facilities, after-school clubs, men's groups
- Counselling and support to individuals and groups
- Developing capacity and leadership within communities
- Access to information technology and office facilities
- Supporting existing community groups and networking

However, being placed at the heart of 121 communities across Ireland (see Figure 6) and well known locally, they could be approached to host specialist CSA services delivered at a local level or the network of Therapy hubs could be expanded. For example, Barnahus could run parent sessions or parent support groups there, with the added value of access to other local support. The national FRC forum said *"For someone unfamiliar with an FRC and its services, coming in for one particular support—such as a support group—can open the door to discovering the whole range of wraparound supports available. FRCs offers support across the entire lifespan, from birth to old age, regardless of background or circumstances, so anyone entering is likely to find something that meets their needs."*

Out of the 121 FRCs, we heard back from those that provide support services for children and families with 19 responding to the survey and 10 representatives from Therapy Hubs attending a focus group.

[3] https://www.familyresource.ie/family-resource-centres-ireland.php
[4] https://www.familyresource.ie/regional-forum.php

Figure 6: Locations of Family Resource Centres:



Respondents from many of the FRCs only provide local advice for referral onto independent play therapist or adolescent psychotherapists in the region. The Three Drives Family Resource Centre in Tipperary said *"Our counselling and therapy supports are not specifically for children or parents who have experienced sexual abuse. We have not got that specific expertise to hand."*

Connect FRC in Louth said *"Our service offers short-term interventions so we may refer to a more specialist service for child sexual abuse as would see this needing more long-term supports. We see a far higher number of children/young people accessing our service for support around anxiety, parental separation, emotional resilience, impacts of criminality/intimidation within the community, bereavement, breakdown of family relationships within the home."*

Whereas the Northside Family Resource Centre in Limerick, felt able to support some families after sexual abuse. *"We are a universal support service, with seven therapists contracted in for our therapeutic support, who offer support across broad spectrum of mental health issues including child sexual abuse."*

5.3 Therapy Hubs

The pilot of nine Therapy hubs are being hosted in FRCs and provide counselling psychotherapy and play therapy for children. Only two are members of Community Therapy Ireland (see section 5.8) a membership body providing some assurance and governance standards, but all have a clinical lead.

The Therapy Hubs are:

- Boyle FRC, Roscommon
- Fatima FRC, Dublin
- Mountview FRC, Dublin
- Ballincollig FRC, Croom
- Croom FRC, Limerick
- Teach Oscail FRC, Cavan
- Portlaoise FRC, Laois
- Teach na Daoine FRC, Monaghan
- Curragh FRC, Kildare

Those that responded to the survey/focus group, reported supporting children and adults of all ages being supported; with a focus on parent/caregiver support, advocacy and group work for those families affected by child sexual abuse. Where counselling was available, the support focused on play therapy, art therapy, counselling and psychotherapy; with one or two offering CBT, EMDR or equine therapy. Only one Therapy Hub that responded has expertise in TF-CBT. Most respondents described short term support of 6-12 sessions; with longer term therapy available at the Curragh Family Resource Centre in Kildare. Over 50% (11/19) had a short wait time of less than three months, but many reported referring onto local independent practitioners with expertise in play therapy or adolescent psychotherapy.

Established referral pathways were identified between Barnahus or The Alders Units (CHI) and the Therapy hubs in Cavan and Limerick and FRCs in Wexford, Tipperary, Westmeath.

Boyle FRC reported long waiting lists and only sees a few children after sexual abuse each year. They noted the value of consultations from The Alders Units (CHI) team if CSA emerges alongside the therapeutic support they are offering a child and family.

The was no recorded data available on the number of children supported after child sexual abuse, but anecdotally respondents noted only one to two children per year supported out of 50-300 children per year attending the FRC.

The Therapy hubs represented in the focus group described the average number of sessions of therapeutic intervention last year as 13 sessions, with a few very long-term outliers, but noted the importance of being child-led and approaching the therapy as *"open-ended*".

5.4 Daughters of Charity

Daughters of Charity run several services in Dublin and have been established for 40 years. Their centres include:

- Early childhood development – six early years centres in Dublin and Meath. These centres are increasingly supporting children from asylum seeking families and they often hear about sexual abuse and exploitation on the journey.
- Therapeutic family centres – seven therapeutic family centres in Dublin and Wicklow that accept referrals from TUSLA, GP, CAMHS and self-referrals. They support children and families after child abuse, neglect, anxiety, bullying, parent support, school refusal, parental mental health – including child sexual abuse.
- Assessment centres - these centres in Dublin, Louth and Meath carry out Signs of Safety assessments on behalf of Tusla, and often identify child sexual abuse, domestic violence and neglect. They report CSA into TUSLA, who then refer into Barnahus or back to FRCs for support.

They offer parenting support, individual support, group work, family work and advocacy. Their teams of play therapist, child and adolescent psychotherapist and family therapist, have extra training in CBT and trauma and those interviewed reported staff felt confident about working with families after CSA. They use non directive play therapy, art therapy, sand trays, adolescent psychotherapy; and access regular supervision. The team are also aware of working pre-trial when there is an ongoing criminal investigation, carefully note keeping conscious of court process and redacting notes when requested. They are confident about referring on for psychiatric support, if needed, and accessing consultation from The Alders Units (CHI) when working with child sexual abuse.

They estimated that The Alders Units (CHI) refer approximately five children a year to their Therapeutic family centres:

- Aistear Beo Connaught St. Family Centre
- Arklow Family Centre
- Balbriggan Family Centre
- Connaught Street, Phibsboro, Dublin
- Cherry Orchard Family Centre
- Lisdeel Family Centre
- Jobstown Mary Mercer Centre
- Turas Family Centre

5.5 Area Based Therapy Teams (ABTT)

In 2023, Tusla commenced a two-year pilot of in–house therapeutic services to meet the psychological and therapeutic needs of children and young people in newly into care, who have been harmed or abused. This project sought to reduce the cost of and dependence on local independent therapists for play and adolescent psychotherapy by creating in-house expertise. The Area Based Therapy teams work in collaboration with the professional network to ensure early identification of children's therapeutic needs as they enter the care of Tusla.

The six ABTTs are in Galway/Roscommon, Mid-West, Kilkenny/Carlow/South Tipperary, Cork, Louth/Meath and Midlands. These multi-disciplinary teams typically include psychotherapist, psychologist, play therapist, clinical nurse specialist, social workers and sometimes speech and language or occupational therapist. They offer stabilisation and grounding techniques, psychoeducation, parent/caregiver support and systemic family

support. Some of the hubs also have the expertise in the team to offer groups for young people and for parent/caregivers. The teams have adopted AMBIT (Adaptive Mentalization-Based Integrative Treatment) as their model of care, and some teams additionally use play/creative therapies, Marte Meo and CBT. The teams do not work with children who are not in the care of Tusla, and children newly admitted to care are prioritised. The final outcomes of this project are expected in July 2025[lvii].

The Midlands ABTT said *"We support the adults in a child or young person's life to develop a trauma informed understanding of the child or young person and their behaviour and presentation. We emphasise supporting the child or young person's recovery from trauma through building safety for the child or young person through attuned connections with the important people in their life. We identify what services the child would benefit from and what developmental assessments are required" and then they refer on.*

The Waterford and Wexford ABTT and the Kilkenny, Carlow and South Tipperary ABTT support children 12-18 years old that have demonstrated harmful sexual behaviour; whereas the others refer to NIAPP.

The ABTTs are accessible for children in care, with 30% (3/9) of the survey respondents reporting less than three month wait and over 50% (5/9) reporting a three to six month wait. Once in service, the support was described as *"open-ended"* with child-led sessions of support of 30 or more and cases being open for three months to two years. Those children accessing creative and play therapy were offered up to 18 and 25 sessions respectively, with their parents receiving six months of support.

Children usually come to the ABTT through Tusla, but the Galway ABTT did report accepting referrals direct from the Barnahus West; and in the focus group the ABTT's were open to exploring trusted assessments from Barnahus South without the need to repeat the assessment and ask a child to repeat their story again. This was encouraging and in line with the principles of Barnahus services. Potential barriers to accessing support included the geographical limitations of the pilot hubs, the requirement to be subject to a care order and the requirement for a child to be in a stable home with a caring adult who is capable of supporting a child to attend therapy. As the ABTTs are limited to supporting children in care, any referrals received from Barnahus will be referred onto local independent practitioners for Tusla funded therapy.

There was no accurate data available in the number of children supported after child sexual abuse, as this is not captured on the Tusla case management system, but ABTTs estimated supporting only one or two children each year who were known to have experienced child sexual abuse.

5.6 Tusla Regional Therapy managers

In each region, the Regional Therapy Managers in consultation with local management and teams are assisting social workers to refer onto to voluntary sector providers and independent providers of counselling and therapy where specialist support is required. Tusla has in place a live register of approved psychologists who have completed the Tusla registration process. The next step is to create national list of play therapists, psychologist and adolescent psychotherapists for social workers and procurement to call off for Tusla

funded work. This register of practitioners will seek assurance and governance checks regarding AGS vetting, evidence of qualifications, professional indemnity insurance, professional registration, Children First training, GDPR training, privacy statement, etc.

In the meantime, some regional therapy managers are creating local lists and requesting evidence of governance and compliance, but this puts an additional administrative burden on regional managers. One regional manager described how the more stringent requirements and standards have reduced a list of over 260 psychologists to 73 independent practitioners who have completed and passed the assurance process.

A principal SW said "We don't know what psychologists to approach. So, we've been wanting this for a good while."

5.7 Complex Case and Therapy Team (CCTT)

A specialist team was set up in the Mid-West in response to the need to support a group of 17 children (from three sibling groups) with specific needs resulting from exposure to the Mid-West organised child sexual abuse case. They have the expertise to provide in-house play therapy, therapeutic life story work, psychotherapy and psychology; and support approximately 40 referrals each year, although most are for other complex needs and not following CSA.

The team can offer multiple type of support including 1-1 psychological support, creative therapy with young person, psychotherapy, play therapy, carer support, stabilising and grounding, therapeutic life story work, advocating on behalf of young person, psychoeducation, sex education and supporting social workers.

However, in 2024 they only supported one child who had been to Barnahus, and described redirecting to CARI for support after sexual abuse or CAMHS services for specialist support with ASD or ADHD.

5.8 Community Therapy Ireland

Community Therapy Ireland (CTI) is a membership organisation with 25 organisations around Ireland providing counselling services that support children. Community Therapy Ireland offers assurance to Tusla and other statutory agencies that members have high standards of clinical governance and corporate governance. All members undergo clinical and organisational governance to join and which is refreshed annually.

There are currently 20 independent counselling services supporting children and adolescents and six of the 121 FRCs who are members of CTI and have a clinical lead in place. The following services confirmed their commitment to supporting children and families after sexual abuse, at the point of mapping:

- Curragh Family Resource Centre
- Beacon of Light Counselling Centre
- Southwest Counselling
- Dundalk Counselling Centre

- Kerry Adolescent Counselling Service
- Knock Counselling Centre
- Limerick Youth Service
- Candle Community Trust
- Croom Family Resource Centre

CTI members reported a national average of 13 weeks for psychotherapy and 17 sessions for play therapy, with a plea for a national understanding of the need for "open-ended" therapeutic support.

5.9 Independent practitioners

Stakeholders across TUSLA services (ABTT, CCTT, FRCs and therapy hubs) all spoke of commissioning independent/private practitioners to provide therapy where Specialist CSA Support Services lack capacity or capability. We heard they are also commissioned where there is no local service, and families may prefer to be seen closer to home. Independent therapists are sourced by regional managers from locally held lists and funded by TUSLA through a procurement route. However, practitioners gave examples of some families feeling pushed into private practice at their own cost when statutory services were at capacity or the wait for their child to access support is too long (see NIAPP example); or when their child was no longer open to Tusla. This could create inequity, with wealthier families being able to access support quicker.

We heard from Tusla staff that confidence varies significantly across independent practitioners. While some play therapists may feel confident supporting trauma, not many have CSA-specific trauma. It was not possible to confirm this view as there is currently no national database to contact all independent providers and no mandatory CSA-specific training requirement for independent practitioners being procured by Tusla.

Tusla staff said:
"Play therapist turn back if they do not feel confident to work with CSA."
"Some play and art therapists do not have all the qualifications and work alone."
"If they're not confident, they either refer back to Barnahus or to a more specialist service like CARI."

Particular concerns were raised about the lack of a structured clinical supervision system and the practitioner isolation. Tusla colleagues were aware that local independent practitioners are not embedded in multi-disciplinary teams, so their work with the child is disconnected from wider safeguarding/MDIA processes.

Some Tusla staff had heard from independent practitioners who were worried about how their notes would be used in court, and some were overly cautious about engaging in trauma work for fear of compromising evidence. One Tusla practitioner said *"We heard that some are unsure if they are even allowed to take notes pre-trial."* As above it was not possible to confirm this view directly with independent practitioners.

6 Specialist CSA Support services

The mapping identified a smaller number of specialist CSA support services that are commissioned to offer therapeutic and support services to children and their families after child sexual abuse. These specialist services include Children at Risk Ireland (CARI), Rape Crisis Centres (RCC), Accompaniment and Support Service for Children (ASSC) and the National Inter Agency Prevention Programme (NIAPP). This is in addition to **The Alders Units (CHI)** described in section 4.3.

These services all felt confident and equipped to deliver trauma informed therapeutic and support services to children and families, with capacity being the only limiting factor. Many of the stakeholders interviewed spoke highly of these services, often describing them as their go-to service to refer to and calling more of them to be available nationally.

6.1 Children at Risk Ireland

CARI is a national service, funded by Tusla, offering:

- **Support for children affected by child sexual abuse –** long-term psychotherapy for children affected by sexual abuse, with support ranging from 23 to 46 sessions (15 sessions accessed on average). CARI use a range of modalities in weekly sessions, including talking, play and art therapy; and group work.
- **Support for parents/caregivers** - parental support sessions for the non-abusing parents, siblings and extended family members who may assist in the child's recovery. If the child is in the care of the TUSLA, CARI will work with the foster parents, residential care staff and social worker responsible for the child. Parental sessions offer a space for parents to discuss their fears and worries about their child or adolescent; and to develop ways to support their child in everyday life. Parenting workshops while on waiting list.
- **Support officer** – after the helpline closed in 2024, a support officer is now available as a first point of contact and support for any person or professional who has concerns about or is affected by child sexual abuse or sexualised behaviour. This can include professionals who are seeking practical advice about what they should do in relation to a disclosure, to make a referral or who want to talk about their own feelings and the impact of the work.
- **Boundary Project** - for children from 3 to 12 years who present with sexually harmful behaviours.

CARI's team of 7.5WTE therapists (play, music, art, talk and family therapy, and adolescent psychotherapy) are now only based in Limerick and Dublin; with two of CARIs team being co-located at the Galway Barnahus to provide CFTSI. The Barnahus based team supported 34 children with CFTSI in 2024 and delivered one group. As the new therapeutic social workers are being recruited into the Barnahus West team roles are still being agreed, but despite this CARI's strong alignment with the trauma-informed approach of Barnahus have established it an effective partner agency in Barnahus.

CARI supported 67 children (33 children and 34 adolescents) and 128 parents nationally in 2024 (outside of Barnahus West). The service is accessible to a high number of boys, with a ratio of 60% girls:40% boys in the under 12s and 79%girls:20% boys:2% transgender in the 12

years and over. However, children and young people continue to have a long wait of 24 months on average to access CARI services and there are currently 76 children waiting. The service has worked hard to reduce this from 140 children waiting in December 2023, although CARI had to close to new referrals for much of 2024 due to limited funding. Currently children on the waiting list are supported with regular check-ins and parents are invited to join a two-day parenting workshop to equip them with skills and confidence to support their child. Once on the waiting list, young people can access group therapy

Stakeholders in interviews and focus groups spoke highly of the CARI service, and it was clear that they are valued as a trusted partner in delivering trauma-focused work. However, many stressed the need for additional resources to extend CARI's reach; noting the long waiting lists of up to two years and the service temporarily closing to new referrals in 2024. Once a child is accepted for support, its psychotherapy services can extend up to two years for more complex cases. However, there are regional gaps in availability and calls were made by several interviewees for an expansion to ensure nationwide coverage.

One of their peers in the voluntary sector focus group said *"In perfect world there would be a CARI in every city!!"*

The CCTT manager in the Mid-West said we need more teams like CARI. More opportunities for them to work with older children, and more of the Boundary project. *"For a 16-year-old survivor of sexual abuse ... they may allocate their art therapist, or they may do some creative therapy, or more recently, they've set up self-support groups for 16 plus young people who've been who've experienced sexual abuse."*

CARI reported that there are barriers to children accessing therapeutic support pretrial, with AGS police officers sometimes advising children and families not to access therapy during the investigation stage and asking CARI to only support children after the specialist interview has been completed. It was not possible to determine in the mapping how many children were being denied access and for how long, noting that the time to trial can stretch to years in Ireland. CARI therapy case notes are often called for and have been used as evidence in court. The team only record factual case notes with no hypothesis, in line with Bluestar Pretrial Guidance, and are child-led in any processing and narrative work about what has happened.

6.2 Rape Crisis Centres

The RCCs in Ireland offer long-term support to children aged 14-16 years and three of the RCCs also offer an adolescent pathway with access to support for children aged from 10-12 years old and their parent/caregiver. They use a trauma informed approach and are open to children of all genders. Currently there is not a national membership organisation for RCC, although many belong to the RCC forum.

Prompted by research into the needs to children after sexual abuse in 2018, the RCCs in Kilkenny, Wexford and Tipperary created an adolescent framework to support young children. Initially supporting just the children, the service has now extended this support to parent/caregivers also. Using the experience of McElvaney's research and RCC expertise, the three sites have developed a model of person-centred counselling in the context of the family, with a range of psychotherapy and other modalities available including: support after

sexual, domestic or gender-based violence, assessment, counselling 1:1, parent/caregiver support, play therapy and creative tools. The number of sessions is child-led and can range from six to 80, on average lasting for six to eight months of weekly sessions. More information is available in RCCs annual report Nov 2023. Cuan[5], the statutory agency dedicated to tackling and reducing domestic, sexual and gender-based violence, are currently mapping service delivery of services across the RCCs and will be exploring how the adolescent framework model fits with their national strategic plan to ensure adolescent therapy is available nationally.

The three adolescent RCC services have a workforce ranging from one to five part-time counsellors, psychologists and support workers. They offer weekly check-ins while the child is on the 10-12 week wait list. Like other therapy and support services, they noted how hard it is to recruit suitable trained staff in Ireland, with skilled practitioners being tempted to work independently for better financial reward. Increasing the capacity for the younger adolescents may require a shift to recruit more play therapists or art therapists.

The RCCs hold limited reportable data but estimates from seven of the RCCs for 2024 included:

- Kilkenny, Tipperary and Wexford – 96 (12 years and over)
- Limerick – 12 (16 years and over)
- Sligo – 10 (14 years and over)
- Laois and Offaly – 25 (14 years and over)

When the RCCs do not have capacity to support children and young people they refer to independent adolescent psychotherapists – ensuring they are Masters level trained and accredited through IACP (Irish Association of Child Psychotherapy) or IHIP (Irish Humanistic and Integrated Psychotherapists) or another RCC. If parents need additional support for the impact of the abuse of themselves, they refer to parent support services such as family resource centres, private practitioners. If children have moderate to severe mental health conditions or need a psychiatric assessment, the RCCs refer to CAMHS. They did note that often the young people do not meet CAMHS criteria, but those who do report a good experience, with the majority starting on medication.

RCC never refer to primary care mental health services but often receive referrals from primary care child and family psychology. When children have accessed eight sessions in primary care or disclosed during therapy, they are often referred to RCC to more long-term support of 12-24 sessions. RCCs also receive referrals from CAMHS after assessment, if sexual abuse related trauma is identified alongside a mental health diagnosis.

6.3 Accompaniment and Support Service for Children

ASSC is a national service providing four support services:

- **Forensic Accompaniment for children** – supporting children under 14 years old attending sexual assault treatment units (SATU) with emotional support during the forensic examinations. This is provided at the SATU in Cork, Dublin and Galway.

[5] An Ghníomhaireacht um Fhoréigean Baile, Gnéasach agus Inscnebhunaithe

- **Court Accompaniment** – any child witness aged five to 18 years can be provided advocacy support, pretrial court visits and court accompaniment at the time of the trial. In addition, they offer post-trial support and the offer of accompaniment if open to any child, not just those experiencing sexual violence.
- **Phone support** – after a forensic examination, children and families are offered phone support from an ASSC advocate to support by phone the child in the weeks and months after their examination
- **Child and Youth Advocate at Barnahus West** – a three-year pilot (2023 – 2025) of youth advocacy in line with Barnahus standard 1.2 and the UNCRC.

The Child and Youth Advocate at Barnahus West has been piloted as part of the Journeys project, Barnahus Network, and has grown organically since May 2023. The post holder is available three days a week to support any child attending the Barnahus. She brings the voice of the child into MDIA meetings, case reviews meetings and six weekly case management meetings; challenging the Barnahus team to ensure they are listening to the voice of the child and being child-centred in all their thinking.

The Journey project evaluation found, the Child Advocate role had set out to listen to the child's voice without agenda, bring the child's voice into Barnahus multiagency meetings and reviews and to advocate on behalf of the child, ensuring their views are heard across the process. While the role does not provide therapeutic support, the child advocate does provide tailored, needs-based support before, during, and after engagement with Barnahus and ensures children understand the processes they are part of. The role draws from the Lundy Model[lviii] framework (Space, Voice, Audience, Influence) and during 2024 supported the development of practical child-friendly tools, such as the app and log, within the Journeys Project.

There is evidence of emotional support, enabling choice and empowering the children; which are all key elements of the wider 'Continuum of Recovery'. For example:

- Supported a young person to attend Barnahus to decide to participate in a Specialist Interview - something they had initially been reluctant to do
- Supported a return to school for a child after disclosure trauma
- Provided online safety education during a case where sexuality and online risks were factors
- Assisted families in navigating multi-agency processes, ensuring they were not overwhelmed by the complexity of the system

Children felt more confident knowing they had someone to speak for them when they found it difficult to speak directly; and parents appreciated having a single trusted advocate to guide them through unfamiliar processes.

6.4 National Inter Agency Prevention Programme

NIAPP provides support for children and young people who have exhibited harmful sexual behaviour to others, as well as support for their parents or caregivers. Set up in 2016 this service provides provide training, consultation, assessment, and age-appropriate intervention for any child or young person aged 3-18 years who has exhibited sexually harmful or abusive

behaviours and does not have any learning needs. Their goal is to help the child or young person return to a more normal developmental path, to reintegrate with family (if appropriate) and become safe and productive members of society. The team use a number of structured assessment frameworks including bespoke psychometrics, NIAPP interview frame, the AIM Assessment Intervention and Moving on. A range of interventions are available, depending on staffing levels, discipline and other qualifications; with the addition of group programmes available in Dublin North East.

The teams include: NIAPP Dublin North East, NIAPP Southside (South Dublin, Kildare, Wicklow), NIAPP Louth/Meath, NIAPP Cavan/Monaghan, NIAPP Sligo/Leitrim, NIAPP Galway/Roscommon/Mayo, NIAPP Midlands, and NIAPP Donegal. NIAPP North Dublin East is staffed with a team of 2.8WTE. The remaining regional teams comprise a small number of local staff (30 in total) each released half to one day a week, under the support of the four national team leads.

NIAPP support the harming child and parent as long as needed, and in 2024 they supported 132 children and parents. However, they noted that while they can support the child with the harmful sexual behaviour, the harmed child often only receives six sessions of play therapy, may not meet Barnahus criteria and can wait on long waiting lists for support; often driving parents to seek support from independent practitioners.

NIAPP national team said *"something that's very upsetting for our team... is if we can provide the service and we're in a position to take this family, but maybe they [the harmed sibling] have to wait a year on a waiting list for service somewhere else, because there are waiting lists. It was devastating for a NIAPP client that their sister's kid has not been able to access help."*

7 Support for moderate/severe mental health difficulties

7.1 CAMHS

CAMHS provide evidence-based interventions to treat moderate to severe mental health disorders. Many children who experience sexual abuse are not diagnosed with a mental illness immediately after the trauma of sexual abuse and, as a result, do not meet the criteria for CAMHS.

CAMHS staff are open to working with children and young people in their service who have experienced childhood sexual trauma, in the context of them experiencing a moderate to severe mental health disorder. In these cases, they can provide a wide range of therapeutic interventions including:

- Stabilisation and grounding techniques
- Mindfulness Wellbeing Teaching techniques
- TF-CBT, DBT, FBT
- Psychotherapy
- EMDR and narrative approaches such as NET
- Parent and caregiver support and attachment-based family work

- Decider skills
- Brief solution focused therapy
- Groups for young people
- Creative therapies such as art therapy, music and equine therapy
- Medication

We heard that CAMHS is under resourced following recruitment restrictions within the HSE over the last 18 months, which has particularly impacted the disciplines within CAMHS which provide therapy. The wait time for support was reported as ranging from 3 months to more than a year. The CAMHS focus group described how they have to prioritise the children and young people who present with the highest risk and this may not be those recovering from the trauma from CSA.

One CAMHS practitioner said "Our remit would not be to take on cases of child sexual abuse because if we did do that, we would not be able to treat the children that are presenting with suicidality with depression or moderate severe anxiety disorders."

"I think most CAMHS services are operating at a maximum of about 50% [capacity] at the moment ... if somebody has experienced child sexual abuse and they're referred for a moderate severe mental disorder, we will treat that moderate severe mental disorder. But we may not have the expertise on the team to address the sexual abuse."

Staff in CAMHS services have not all been equipped or trained to support families around the wider support needs that are required when supporting recovery from CSA. For example, we heard in the focus group that there is limited knowledge about the legal process, working pre-trial, and the impact of the legal process on children and the wider family system. CAMHS practitioners interviewed felt that their expertise was in the area of treating disorders, such as depression, suicide, anxiety, PTSD; and many in the team did not have experience in addressing the impact of trauma from child sexual abuse.

One CAMHS practitioner said *"How could we take on all child sexual abuse, as then we couldn't treat the high-risk children? We are not specialised in CSA trauma – no one is trained in trauma."*

Some in the focus group raised concerns *"Because we're not trained. If notes are pulled for court cases and you have done or said or whatever, something that could jeopardise the case, all that kind of stuff. So, we would always say that, you know, the referral needs to go to specialist people."*

The practitioners described how they used to refer children to a specialist HSE service for sexual abuse which has now closed and reported feeling unclear about getting involved in pre-trial support as the rules have changed recently. Most described referring onto The Alders Units (CHI) who supported the child through the trauma and then CAMHS treat the PTSD disorder. Others were familiar with the support available through specialist CSA services like CARI and RCC.

One practitioner said *"If a child comes in and we're assessing them for depression and treating them for depression. And something comes up in relation to child sexual abuse. The team will go to the ends of the earth to try and support that child in any way they can or, and also to link them in with the appropriate services. Now we would always link in with Tusla, that would usually be the way that we would work. You know, if a child reported child sexual abuse .... we would usually make the referral then to the likes of St Claire's or St Louise's."*

All referrals have to be made by a primary care GP, so if a Barnahus psychologist wanted to make a referral to CAMHS it would need to be made in conjunction with child's GP to provide the medical and family history

Data is not collected in CAMHS under the category of CSA, as all cases are coded by their ICD-10 primary mental health diagnosis, so it was not possible to determine how many children CAMHS support who have concurrently experienced CSA. Some teams estimated anywhere up to five open cases on the whole team caseload may have experienced CSA.

In summary, CAMHS teams provide evidence-based interventions to treat moderate to severe mental health disorders. In most instances, practitioners felt more confident referring children and young people to specialist CSA support services. This was noted as being due to a lack of training in working with trauma and working pre-trial.

8 Insights from the Child Advisory Board (CAB)

We met with five members of the Child Advisory Board (CAB) from the Cork area and asked them about the types of service they felt might be helpful for children experiencing sexual abuse and needing someone to talk to about how they were feeling. We acknowledged that the Barnahus services they had been working to co-design are only available in three areas and we thought about what a more local service could look like.

We talked with the CAB about location and travel

- ☺ Less than an hour away for regular appointments - they thought older teens could travel up to 3 hours for occasional sessions
- ☺ Must be on a bus route so teenagers can get there themselves if needed
- ☺ Online sessions don't work well because therapists might miss important body language and because rural Wi-Fi is too unreliable. Losing connection mid-session would make them feel bad

We talked about Barnahus satellite sites and outreach to other local areas. This is what they said the places should be like?

- ☺ Not too clinical or obvious
- ☺ Best option is a private, welcoming, safe space that feels normal and doesn't scream 'something bad happened'
- ☺ CAMHS buildings were seen as okay — everyone there is for therapy, so you don't feel singled out and people in the waiting room won't ask way you there
- ☹ Rape Crisis Centres could feel too obvious, making some young people feel embarrassed – especially for boys

- ☹ Family Resource Centres could feel too public because you might bump into people you know and it could be awkward

Only a couple of the CAB has accessed therapy themselves, but we talked about what they thought might be important?

- ☺ Therapy should help both the child and parent — not just the child alone
- ☺ Should cover more than just the abuse. It's good to talk about school, friendships, future jobs and life skills
- ☺ Should go at the child's pace, not rushed
- ☺ Creative therapies are great even for teenagers, but only if the therapists are properly trained and supported
- ☺ Children understand that therapists sometimes have to tell social workers or the police, even if the child doesn't want them to
- ☺ Independent therapists working alone need clear rules and support for how to handle it when someone talks about abuse for the first time, so everyone knows what to expect — no *"lone wolf"* therapists

We thought about how young people, their families and professionals would know where to find out about services. They liked the idea of creating a map and had some suggestions for the colours. They also suggested that therapists should all be part of a national network so they can learn from each other and improve the service.

"Therapy should feel safe and local — somewhere you could be going for any reason, not somewhere that screams 'something bad happened'. It should help with your whole life, not just the abuse. And there should be a proper map so everyone knows where to go."

9 Support services summary by region

This section provides a summary of the available therapy and support services for children and their parent/caregivers after child sexual abuse; including location, service offer and referral criteria. The table below is accompanied by an interactive spreadsheet for Barnahus and Tusla teams to search by county for locations of specialist CSA support services and therapy services.

A full map and interactive spreadsheet of all the national therapy services for children in Ireland is available to accompany this mapping report. Figure 7-9 below are snapshots of the areas served each Barnahus.

Figure 7: Map of Therapy and support services for CSA in Barnahus South region

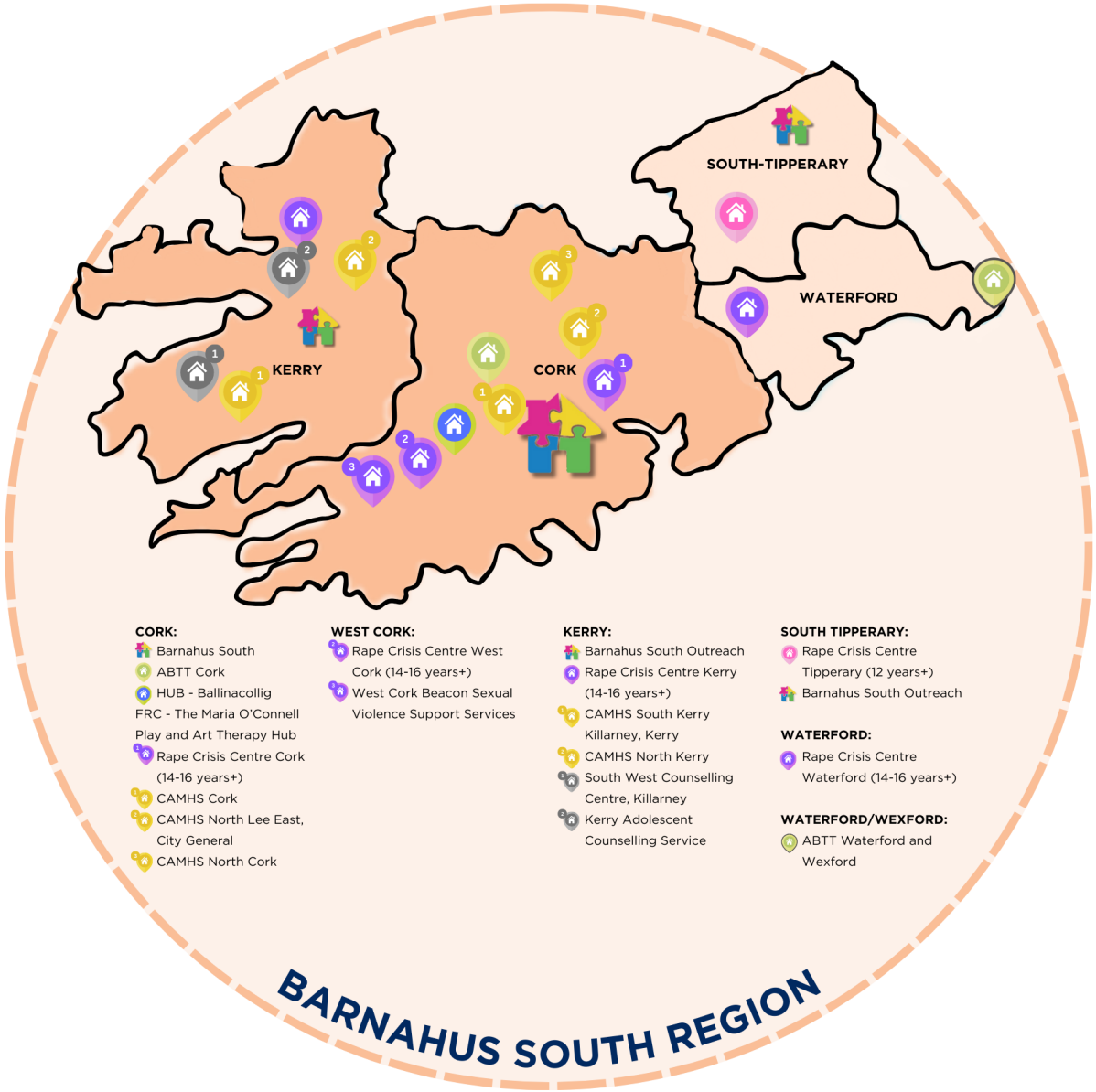


Figure 8: Map of Therapy and support services for CSA in Barnahus West region

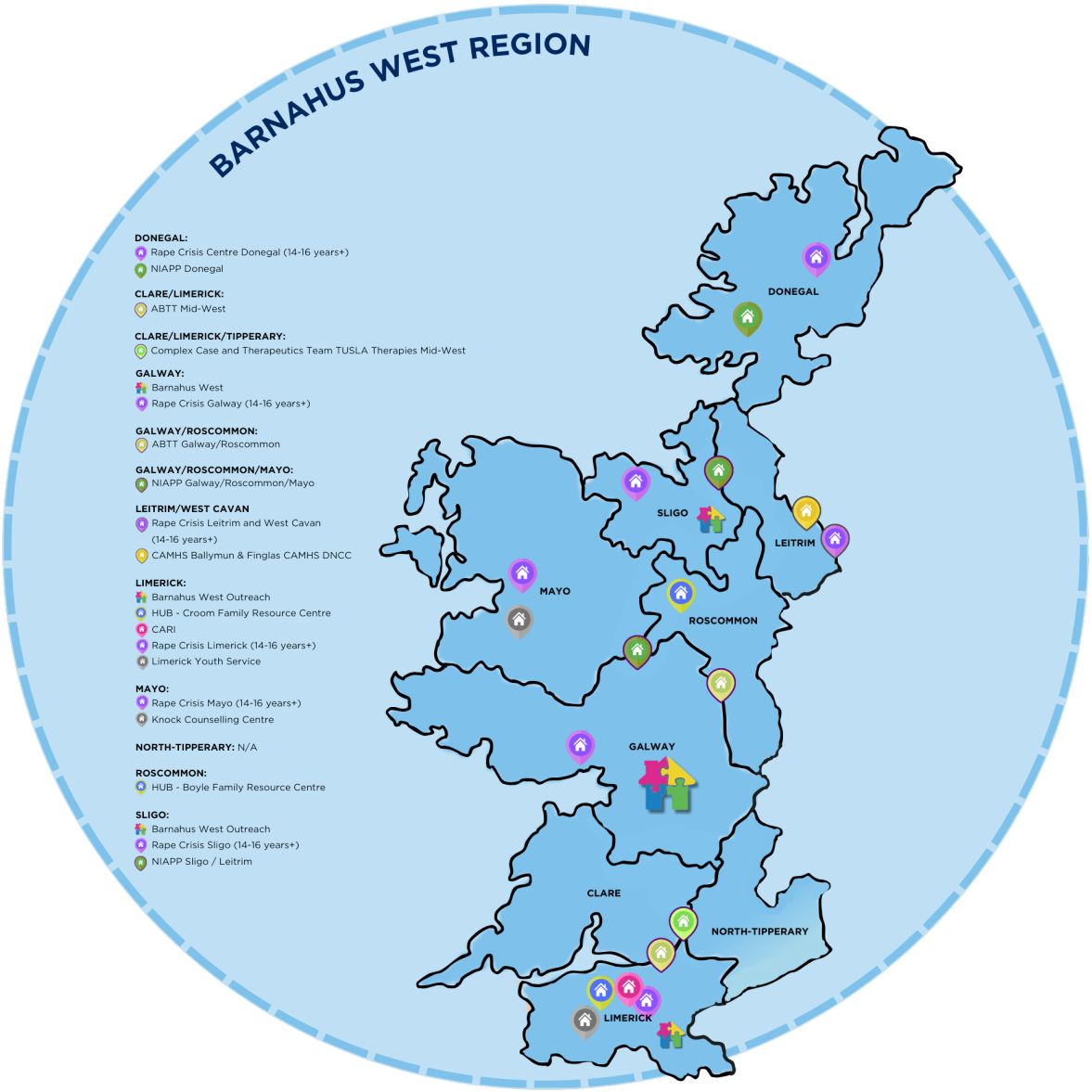


Figure 9: Map of Therapy and support services for CSA in Barnahus East region

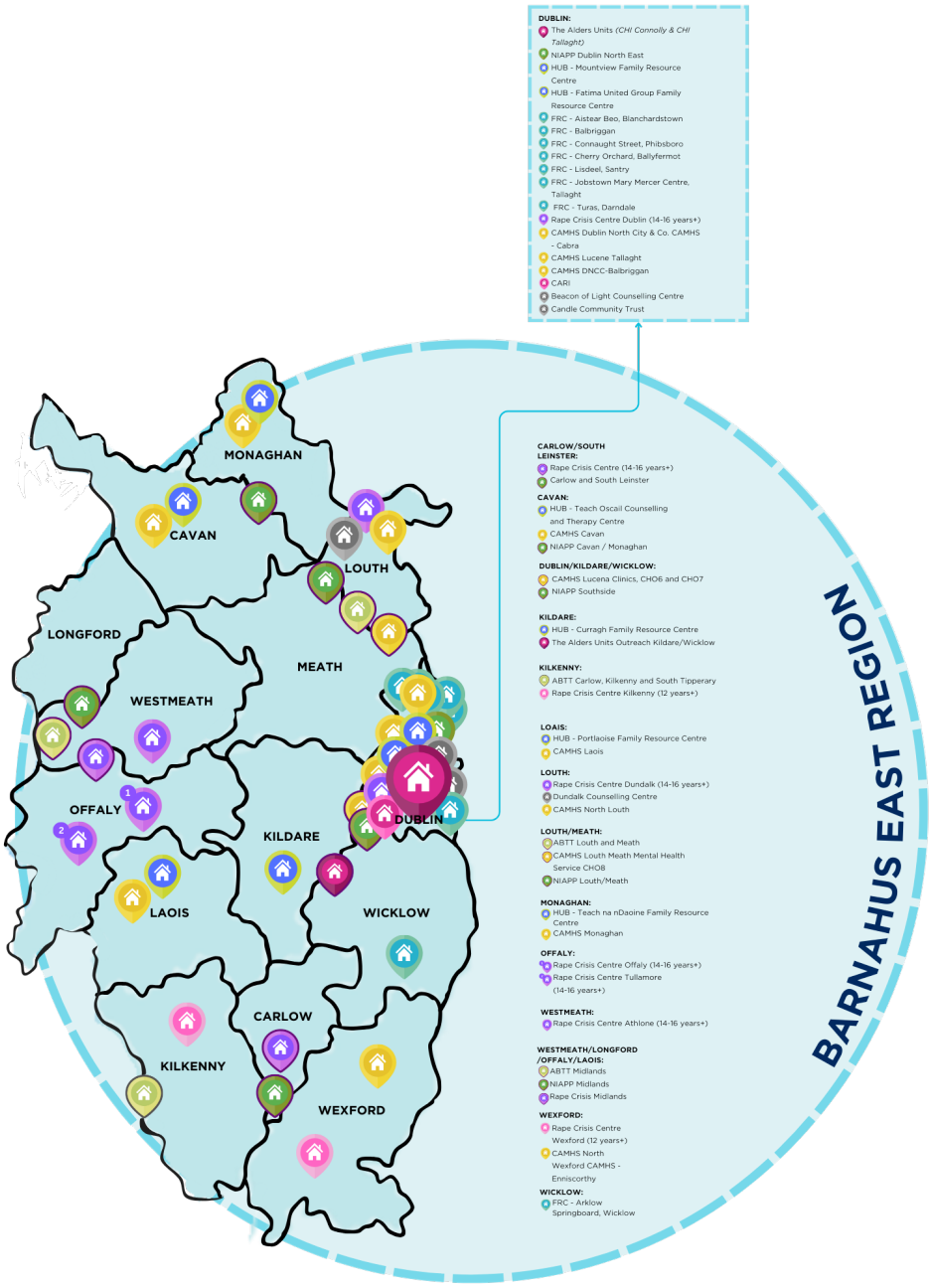


Table 5: Service summary

Service type	Service name	Service offer	Locations
1. Barnahus	Barnahus West	Integrated health, medical, child protection, therapeutic, and policing services for children and young people who may have experienced child sexual abuse.	Galway
1. Barnahus	Barnahus South	Integrated health, medical, child protection, therapeutic, and policing services for children and young people who may have experienced child sexual abuse.	Cork
1. Barnahus - outreach	Barnahus West Outreach	Integrated health, medical, child protection, therapeutic, and policing services for children and young people who may have experienced child sexual abuse.	Limerick and Sligo
1. Barnahus - outreach	Barnahus South Outreach	Integrated health, medical, child protection, therapeutic, and policing services for children and young people who may have experienced child sexual abuse.	Kerry and Tipperary
1. The Alders Units (CHI)	The Alders Units (CHI) in Connolly (Blanchardstown), Tallaght	Range of psychotherapy, art, play and systemic family therapy. Group for YP and parents. Support through the criminal justice process and support for children under 12 years with harmful sexual behaviour	Dublin
1. The Alders Units (CHI)	The Alders Units (CHI) outreach	Range of psychotherapy, art, play and systemic family therapy. Group for YP and parents. Support through the criminal justice process and support for children under 12 years with harmful sexual behaviour	Satellite sites in Wicklow, Naas and Dublin D18 Plans for sites in Cavan and Louth
2. Specialist CSA Support service	Rape Crisis Wexford - 12 years+	Support and counselling for adults and adolescents 12 years+ impacted by sexual violence.	Wexford, Kilkenny and Tipperary
2. Specialist CSA Support service	West Cork Beacon sexual violence support services		West Cork
2. Specialist CSA Support service	CARI	Child-centred therapy for children & adolescents who have been affected by sexual abuse. Also support for children who present with sexually harmful behaviour (up to age 12)	Limerick and Dublin
2.5 Specialist CSA Support service	Rape Crisis Centres – Donegal	Support and counselling and advocacy for people 14 years + impacted by sexual violence.	Donegal
2.5 Specialist CSA Support service	Rape Crisis Centre Kerry	Support and counselling for people impacted by sexual violence.	Kerry

2.5 Specialist CSA Support service	Rape Crisis Centre Waterford	Support and counselling for adults and adolescents 14 years + impacted by sexual violence.	Waterford
2.5 Specialist CSA Support service	Rape Crisis Athlone	Free counselling for recent and historic abuse	Athlone
2.5 Specialist CSA Support service	Rape Crisis Midlands		
2.5 Specialist CSA Support service	Rape Crisis West Cork	Support and counselling for adults and adolescents 14 years + impacted by sexual violence.	West Cork
2.5 Specialist CSA Support service	Rape Crisis Carlow and South Leinster	Support and counselling for adults and adolescents 14 years + impacted by sexual violence.	Carlow/ South Leinster
2.5 Specialist CSA Support service	Rape Crisis Cork	Support and counselling for adults and adolescents 14 years + impacted by sexual violence.	Cork
2.5 Specialist CSA Support service	Rape Crisis Dublin	Support and counselling for adults and adolescents 14 years + impacted by sexual violence.	Dublin
2.5 Specialist CSA Support service	Rape Crisis Dundalk	Support and counselling for adults and adolescents 14 years + impacted by sexual violence.	Dundalk
2.5 Specialist CSA Support service	Rape Crisis Galway	Support and counselling for adults and adolescents 14 years + impacted by sexual violence.	Galway
2.5 Specialist CSA Support service	Rape Crisis Limerick	Support and counselling for adults and adolescents 14 years + impacted by sexual violence.	Limerick
2.5 Specialist CSA Support service	Rape Crisis Mayo	Support and counselling for adults and adolescents 14 years + impacted by sexual violence.	Mayo
2.5 Specialist CSA Support service	Rape Crisis Sligo	Support and counselling for adults and adolescents 14 years + impacted by sexual violence.	Sligo
2.5 Specialist CSA Support service	Rape Crisis Leitrim and West Cavan	Support and counselling for adults and adolescents 14 years + impacted by sexual violence.	Leitrim/ West Cavan
2.5 Specialist CSA Support service	Rape Crisis Tullamore	Support and counselling for adults and adolescents 14 years + impacted by sexual violence.	Tullamore
2.5 Specialist CSA Support service	Rape Crisis co. Offaly	Support and counselling for adults and adolescents 14 years + impacted by sexual violence.	Offaly
3. Counselling services for children (CTI member)	South West Counselling Centre, Killarney	Psychology, psychotherapy and play therapy for children and families	Kerry
3. Counselling services for children (CTI member)	Dundalk Counselling Centre	Psychology, psychotherapy and play therapy for children and families	Louth

3. Counselling services for children (CTI member)	Beacon of Light Counselling Centre	Mental health support and positive interventions for children, adolescents and adults	Dublin
3. Counselling services for children (CTI member)	Kerry Adolescent Counselling Service	One to one counselling and psychotherapy for adolescents	Kerry
3. Counselling services for children (CTI member)	Knock Counselling Centre	Psychotherapeutic services to adults and adolescents living in Mayo, Roscommon, North Sligo and South Galway	Mayo
3. Counselling services for children (CTI member)	Limerick Youth Service	Mental health support for adolescents and young people across Limerick City & County	Limerick
3. Counselling services for children (CTI member)	Candle Community Trust		Dublin
4. Therapy Hub (hosted in FRC)	Boyle Family Resource Centre	Counselling and psychotherapy for children & adolescents, and family therapy	Roscommon
4. Therapy Hub (hosted in FRC)	Curragh Family Resource Centre	Free counselling and family support	Kildare
4. Therapy Hub (hosted in FRC)	Teach Oscail Counselling and Therapy Centre	A low-costs art and play therapy for children	Cavan
4. Therapy Hub (hosted in FRC)	Teach na nDaoine Family Resource Centre	A low-costs art and play therapy for children	Monaghan
4. Therapy Hub (hosted in FRC)	Mountview Family Resource Centre	Counselling & psychotherapy for young people and play therapy for children	Dublin
4. Therapy Hub (hosted in FRC)	Fatima United Group Family Resource Centre		Dublin
4. Therapy Hub (hosted in FRC)	Croom Family Resource Centre	Low-cost counselling, psychotherapy and play therapy	Limerick
4. Therapy Hub (hosted in FRC)	Portlaoise Family Resource Centre	A low-cost counselling service for young people and play therapy for younger children	Laois
4. Therapy Hub (hosted in FRC)	Ballinacollig FRC - The Maria O'Connell Play and Art Therapy Hub	Low cost talk therapy, play therapy and art therapy for children and young people	Cork
5. Therapeutic Family Centre (Daughters of Charity)	Aistear Beo Connaught St. Family Centre	A range of evidenced-based therapeutic interventions for children and adolescents up to the age of 18, as well as their families.	Dublin

5. Therapeutic Family Centre (Daughters of Charity)	Arklow Family Centre	A range of evidenced-based therapeutic interventions for children and adolescents up to the age of 18, as well as their families.	Wicklow
5. Therapeutic Family Centre (Daughters of Charity)	Balbriggan Family Centre	A range of evidenced-based therapeutic interventions for children and adolescents up to the age of 18, as well as their families.	Dublin
5. Therapeutic Family Centre (Daughters of Charity)	Connaught Street, Phibsboro, Dublin	A range of evidenced-based therapeutic interventions for children and adolescents up to the age of 18, as well as their families.	Dublin
5. Therapeutic Family Centre (Daughters of Charity)	Cherry Orchard Family Centre	A range of evidenced-based therapeutic interventions for children and adolescents up to the age of 18, as well as their families.	Dublin
5. Therapeutic Family Centre (Daughters of Charity)	Lisdeel Family Centre	A range of evidenced-based therapeutic interventions for children and adolescents up to the age of 18, as well as their families.	Dublin
5. Therapeutic Family Centre (Daughters of Charity)	Jobstown Mary Mercer Centre	A range of evidenced-based therapeutic interventions for children and adolescents up to the age of 18, as well as their families.	Dublin
5. Therapeutic Family Centre (Daughters of Charity)	Turas Family Centre	A range of evidenced-based therapeutic interventions for children and adolescents up to the age of 18, as well as their families.	Dublin
6. CAMHS	CAMHS Louth Meath Mental Health Service CHO8	Child and adolescent mental health service	Louth/Meath
6. CAMHS	CAMHS Ballymun & Finglas CAMHS DNCC	Child and adolescent mental health service	Leitrim/ West Cavan
6. CAMHS	CAMHS Dublin North City	Child and adolescent mental health service	Dublin
6. CAMHS	CAMHS North Louth CAMHS,	Child and adolescent mental health service	Louth
6. CAMHS	CAMHS Cork	Child and adolescent mental health service	Cork
6. CAMHS	CAMHS North Lee East, City General	Child and adolescent mental health service	Cork
6. CAMHS	CAMHS Cavan	Child and adolescent mental health service	Cavan
6. CAMHS	CAMHS North Wexford CAMHS - Enniscorthy	Child and adolescent mental health service	Wexford
6. CAMHS	CAMHS North Cork	Child and adolescent mental health service	Cork

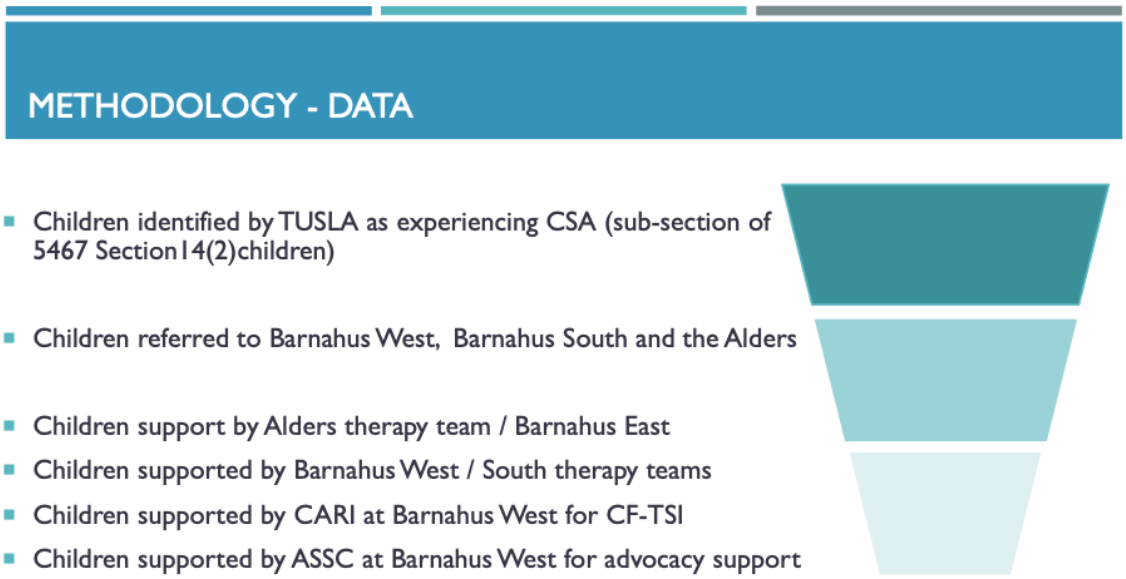
6. CAMHS	CAMHS Monaghan	Child and adolescent mental health service	Monaghan
6. CAMHS	Lucena Clinics, CHO6 and CHO7	Child and adolescent mental health service	Dublin/ Kildare/ Wicklow
6. CAMHS	CAMHS Lucene Tallaght	Child and adolescent mental health service	Dublin
6. CAMHS	CAMHS DNCC-Balbriggan	Child and adolescent mental health service	Dublin
6. CAMHS	CAMHS Cork.	Child and adolescent mental health service	Cork
6. CAMHS	CAMHS South Kerry Killarney, Kerry	Child and adolescent mental health service	Kerry
6. CAMHS	CAMHS North Kerry	Child and adolescent mental health service	Kerry
6. CAMHS	CAMHS North Cork	Child and adolescent mental health service	Cork
6. CAMHS	CAMHS Laois	Child and adolescent mental health service	Laois
7. Area based therapy team	ABTT Midlands	Therapy and support for children in care	Westmeath/ Longford/ Offaly
7. Area based therapy team	ABTT Mid-West	Therapy and support for children in care	Clare/Limerick
7. Area based therapy team	ABTT Galway/Roscommon	Therapy and support for children in care	Galway/ Roscommon
7. Area based therapy team	ABTT Carlow, Kilkenny, South Tipp	Therapy and support for children in care	Kilkenny
7. Area based therapy team	ABTT Louth and Meath	Therapy and support for children in care	Louth/Meath
7. Area based therapy team	ABTT Cork	Therapy and support for children in care	Cork
7. Area based therapy team	ABTT Waterford and Wexford	Therapy and support for children in care	Waterford/ Wexford
8. Complex care and therapy team (CCATT)	Complex Case & Therapy Team TUSLA Therapies Mid West	Development of therapeutic plans for 17 children and their carers who are survivors of organised child sex abuse Mid-West	Clare/Limerick/ Tipperary
9. NIAPP	NIAPP Dublin North East	Community-based treatment program for young people who have shown sexually harmful behaviour	Dublin
9. NIAPP	NIAPP Southside (South Dublin, Kildare, Wicklow),	Community-based treatment program for young people who have shown sexually harmful behaviour	Dublin
9. NIAPP	NIAPP Louth/Meath	Community-based treatment program for young people who have shown sexually harmful behaviour	Louth/Meath

9. NIAPP	NIAPP Cavan/Monaghan	Community-based treatment program for young people who have shown sexually harmful behaviour	Cavan/ Monaghan
9. NIAPP	NIAPP Sligo/Leitrim	Community-based treatment program for young people who have shown sexually harmful behaviour	Sligo/Leitrim
9. NIAPP	NIAPP Galway/Roscommon/Mayo	Community-based treatment program for young people who have shown sexually harmful behaviour	Galway/ Roscommon/ Mayo
9. NIAPP	NIAPP Midlands	Community-based treatment program for young people who have shown sexually harmful behaviour	Midlands
9. NIAPP	IAPP Donegal	Community-based treatment program for young people who have shown sexually harmful behaviour	Donegal

10 Demand and capacity mapping

The mapping sought to understand the predicted number of children experiencing child sexual abuse and coming to the attention of statutory services, those who access support at Barnahus and those who may need to access early help or long-term therapeutic support after child sexual abuse in local services. See Figure 10 below.

Figure 10: Planned data methodology



There was limited data available as the majority of statutory and voluntary sector services do not record data about child sexual abuse in their case management systems and in most cases do not directly ask children if they have experienced child sexual abuse. For example, child and adolescent mental health teams record mental health diagnosis according to ICD10 categories but do not code referrals for trauma, abuse or other potential causal experiences. Data from specialist CSA support services like CARI, The Alders Units (CHI), Rape Crisis Centres and Barnahus can be assumed to be children where there has been a suspicion or disclosure of sexual abuse.

Data from Barnahus in 2024 is not reflective of their future capacity to provide therapy, as there has been a significant investment from Tusla into the team during 2024. Both Barnahus West and Barnahus South have recruited therapeutic teams of senior social work practitioners and psychologists who will be providing early help using the CTFSI model and long-term support with TF-CBT in future. Therefore, the capacity mapping below includes 2024 data and a predicted capacity for 2025 onwards.

10.1 Demand and capacity in 2024

Child sexual abuse (CSA) is a pervasive issue, with an estimated 15% of girls and 5% of boys experiencing abuse before the age of 16. Yet, most of these cases remain unreported or unsupported, highlighting a significant service gap. In Ireland, while CSA referrals to Tusla in 2024 were 3483, this mapping exercise found that only a 24% (844) of affected children

accessed the Barnahus/The Alders Units (CHI) and only 15% (514) accessed therapeutic support.

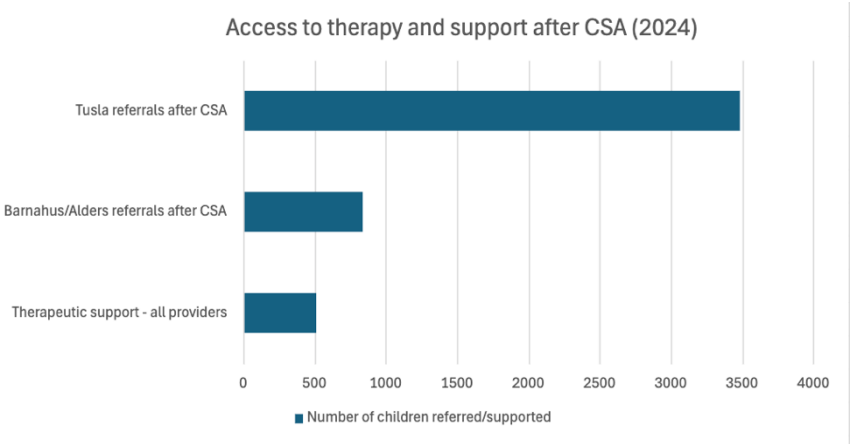
Table 6 and Figure 11 below highlight a significant gap in referrals from Tusla to Barnahus for children identifying as having experienced child sexual abuse. This was not explored in the mapping but further work is recommended to understand this difference. In addition, a further drop off was seen at the point of accessing therapeutic support, both at Barnahus or at a local support service. This section will explore the gap between demand and capacity.

This data shows that in 2024, there were 330 children attending the Barnahus/The Alders Units (CHI) that did not access therapeutic support at Barnahus or a local specialist CSA support service. This discrepancy may be due to lack of available data, as most statutory and voluntary sector services do not record data about child sexual abuse in their case management systems. However, it may reflect what we heard in interviews and focus groups that there are a lack of support services for children and families in Ireland seeking therapeutic support after child sexual abuse.

Table 6: Access to Barnahus/The Alders Units (CHI) and support services in 2024

Children identified as having experience child sexual abuse	3483
Children and young people attended Barnahus/The Alders Units (CHI)	844
Children accessing therapeutic support	514
Children not accessing therapeutic support	330

Figure 11: Access to therapy support services in 2024



The following specialist CSA support is available for children after sexual abuse:

- Barnahus West and South provide specialist CSA support for children 7-17 years and the parent/caregivers of younger children under 7.
- The Alders Units (CHI) provide specialist CSA support for children of any age up to 18 years.
- CARI support children under 18 years old
- The three Rape Crisis Centre following the adolescent framework support children over 12 years

- The remaining Rape Crisis Centres support children 14-18 years
- Nine local FRC therapeutic hubs, nine DoC therapeutic centres and six area based therapy teams occasionally provided play therapy or adolescent psychotherapy to children and young people of any age, but reported usually referring onto a local independent practitioner.
- Independent practitioners offering play therapy or adolescent psychotherapy

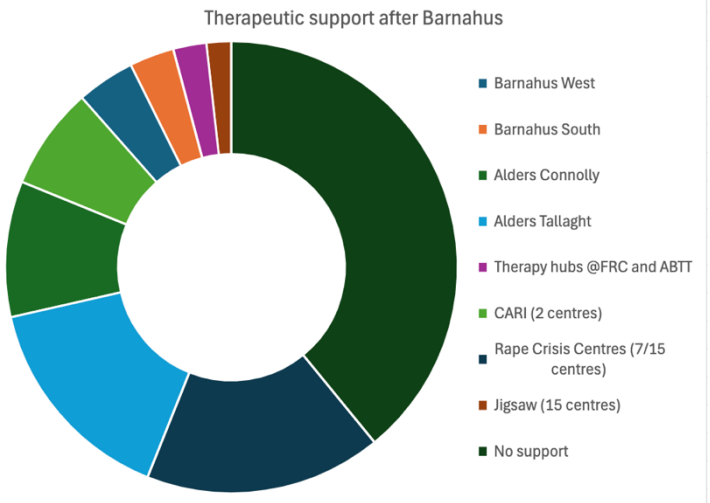
Table 7 and Figure 12 below detail the range of therapeutic support provided at specialist CSA support services in 2024. Due to waiting lists for statutory and voluntary sector providers, many children and families are seeking therapeutic support from independent practitioners but there is no mechanism to capture this data.

Table 7: Therapeutic support provided at specialist CSA support services in 2024

Therapeutic service	Children seen in 2024
Barnahus West*	35
Barnahus South**	27
The Alders Unit Connolly	82
The Alders Unit Tallaght	130
Therapy hubs @FRC and ABTT***	20
CARI (2 centres)	62
Rape Crisis Centres (7/15 centres) ****	143
Total	514

*based on 35 per year - 1 per year Barnahus team and 34 per year from two CARI team members
**extrapolated based on 20 children support in 10 months
***estimated based on one per team per year
****based on responses from those RCC support younger children: Kilkenny, Tipperary and Wexford (adolescent framework) and Sligo, Limerick, Laois and Offaly

Figure 12: Share of therapeutic support provided by specialist CSA support services



Note: No support refers to the proportion of children that attended Barnahus/The Alders Units (CHI) and did not go onto receive therapeutic support. It was possible to determine if that was due to therapy not being needed at that time or a lack of capacity.

10.2 Future predicted capacity

The Barnahus are currently developing caseload models, but have a long-term aim that:

- senior social workers or social care leaders will each have a caseload of eight children and parents accessing therapeutic support, plus two children for therapeutic screening and involvement with up to ten at MDIA meeting stage for the senior social workers;
- social care staff that are trained interviewers will have a lower caseload of four open cases to allow capacity for joint interviewing;
- psychologists will have four open cases to allow time for consultation and advice.

Final therapeutic staffing at Barnahus South is expected to be six senior social workers/social care leaders and 1.4 psychologists; and therapeutic staffing at Barnahus West as six senior social workers/social care leaders, one psychologist and one family therapist. For the caseload calculations, the assumption will be that three of the senior social workers/social care leaders at each site will have the reduced capacity of four open cases, to allow time for joint interviewing.

Using Lighthouse evaluation[6] to provide an estimated ratio of case types[7], for each senior social worker we can assume five open cases will be TF-CBT for up to six months (10 children per year) and three open cases will be CFTSI for up to 3 months (12 children per year), which equates to 22 children supported per year per practitioner; and four open cases for each psychologist or interviewing social worker which equates to eight open cases each year[8].

The two CARI team members at Barnahus West offering CFTSI each have a caseload of 10 children, reduced from the original 14 due to the capacity needed to engage with the ongoing Barnahus MDIA screening and case management process. Each CARI practitioners could offer 10 children CFTSI every quarter, which equates to 40 children per year per practitioner – or 80 per year.

During the mapping process, the Barnahus West team reported between 40% and 60% of children they are referred meet the criteria for Barnahus therapeutic support, but it was clear that previously the Barnahus team could not meet the needs of all children, especially for those children that need medium to long-term intervention. To make assumptions about likely uptake of CFTSI and TF-CBT, the demand and capacity modelling below uses the comparative findings from the Lighthouse Annual Report 2021 which identified 67% children needed support - 24% accessed short-term support and 43% accessed medium to long-term support. It was noted that some Barnahus may offer more flexibility in different types of

[6] Based on Lighthouse evaluation – 24% short term support and 43% long-term support – ratio 3:5

[7] Barnahus in Ireland has only been providing limited access to therapy while staff are trained and recruited, and therefore an established Barnahus evaluation is proposed to provide the estimated ratio of short-term to medium/longer term support

[8] Barnahus West – three senior social workers (22 cases *3); three senior social worker/interviewers (8 cases*3); one psychologist (8 cases) and one family therapist (22 cases). Barnahus South - three senior social workers (22 cases *3); three senior social worker/interviewers (8 cases*3) and 1.4 psychologists (12 cases)

modalities as local expertise allows, but this is not predicted to change the ratio of short-term and longer team support.

Demand data in Table 8 below suggests at least 565 children may need to access therapeutic support in 2025, but ideally all 844 should be offered the choice to access therapeutic support. Table 9 estimates the potential capacity for therapeutic support on the assumption that all Barnahus posts are filled and all staff are sufficiently embedded in their roles to work at the predicted caseload capacity.

Table 8: Predicted Barnahus demand in 2024

Children identified as having experience child sexual abuse	3483
Children and young people attended Barnahus/The Alders Units (CHI)	844
Assumption that 67% may need therapeutic support	**565**

Table 9: Predicted specialist CSA capacity from 2025

Therapeutic service	**Predicted capacity**	**Children seen in 2024**
Barnahus West	200	
Barnahus South	102	
The Alders Unit Connolly		82
The Alders Unit Tallaght		130
Therapy hubs @FRC and ABTT*		20
CARI (2 centres)		62
Rape Crisis Centres (7/15 centres)**		143
Total		**739**

*estimated based on one per team per year

**based on responses from those RCC support younger children: Kilkenny, Tipperary and Wexford (adolescent framework) and Sligo, Limerick, Laois and Offaly

This demand and capacity mapping suggests that once Barnahus West and South teams are fully recruited, there may be sufficient capacity to support all the children attending Barnahus or The Alders Units (CHI) (who require therapeutic support) with CFTSI, TF-CBT or other modalities as required. However, knowing that child sexual abuse is under-reported with only 1 in 8 children reporting in childhood, and noting that only 24% of children that identify as having experienced child sexual are referred to the Barnahus; it is likely that the estimated demand of 565 children per year needing therapy is a significant underestimate of demand.

Additionally, the capacity estimates are based on the Barnahus West and South teams being fully recruited. However, it should be noted that we heard in this mapping that ongoing national recruitment difficulties into specialist roles like therapeutic social workers, family therapists and child and adolescent psychotherapists may hinder Barnahus reaching full capacity in 2025. At the time of publication, Barnahus West team was fully recruited.

Finally, the services at Barnahus West and South are currently only available in the Barnahus itself or four trial outreach sites, and therefore in reality the capacity for delivering therapy is not accessible to the children within one hour of their home.

11 Findings and conclusion

This review set out to map the existing therapeutic services in the Barnahus and beyond, to identify the gaps in provision for children and young people after sexual abuse in Ireland. A review of existing services identified through key stakeholders in the pathway identified a range of therapeutic services, with variable capacity, specialist CSA competencies and understanding of the impact of trauma. There are gaps related to geographical location, age restrictions, capacity and competency in the workforce. This section will summarise these findings service by service and then identify the gaps, barriers to access and what an ideal support offer would look like.

Barnahus West and South have historically focused on assessing therapeutic need, offering early help/psychoeducation and providing consultation to professionals; with less than 18% of referred children accessing therapeutic support. They have not had the capacity in the team to offer long-term therapeutic support for children, parents and siblings or to offer groups or participation opportunities. Since 2023, CFTSI has been available for children from the CARI pilot in Barnahus West and a small number have accessed TFCBT. In 2024, the Barnahus West team piloted the You are Enough group model; and from 2025 TF-CBT will be available at both Barnahus sites, in line with the Barnahus Therapeutic Framework, following a significant investment from TUSLA in a new team of social workers who are undergoing therapeutic training. We noted that this team are still establishing their ways of working, being trained and building up to a full therapeutic caseload; and are also responsible for delivering specialist interviewing. It is anticipated that during 2025, there will be a significant new capacity available in Barnahus to offer therapeutic support with capacity to support up 120 children each year plus a further 80 from the in-house CARI team in Barnahus West, and 102 children in Barnahus South.

Previously access to Barnahus support was hindered by geographical access to Barnahus Galway and Cork, but outreach is being trialled in four areas. The outreach will still leave significant areas with limited access and travel times of more than one hour, including the west of Galway, Mayo, Clare, Donegal and Waterford. Stakeholders interviewed identified there are currently no opportunities for young people to return to the service to volunteer and no formal feedback mechanisms.

The Alders Units (CHI) is a well-established an effective therapeutic service that has been serving the population of Dublin and surrounding areas for over 30 years. Children and parent/caregivers are assessed in person, with several sessions of psychoeducation available

in the first instance. There are a range of therapeutic interventions available including: various types of psychoanalytic therapy, art, play and systemic family therapy; and evidence of research and participation. 43% of referrals accessed 1:1 support and family support, ranging from short term (six up to 12 sessions), medium term (up to 25 sessions) and long-term support of a year or more; and 8% accessed groups. The Alders Units (CHI) were well known amongst stakeholders interviewed, although many still knew the services by their old names of St Claire's and St Louise's. Many spoke of accessing professional consultation and advice from The Alders Units (CHI) and several local therapy services has more formal supervision arrangements in place.

Much like the Barnahus West and South, geographical accessibility can be an issue with The Alders Units (CHI) service available in-person in Connolly and Tallaght; as well as at outreach sites in Wicklow, Naas and the Dublin D18 area. Travel across Dublin city can still take up to one hour for some families on public transport. At the time of the Therapy Mapping review, although children living in Louth, Meath, Cavan and Monaghan were supported by the Connolly team, some reported that the long travel distances made this difficult at times to come into Dublin for in-person support. In future, the Alders Units (CHI) plan to offer interventions from local facilities in Cavan and Louth to enhance the access options available to children and families. When the Barnahus East opens and The Alders Units (CHI) provide the therapeutic support, access difficulties will be exacerbated as the catchment area will grow to fourteen counties and extend far beyond The Alders Units (CHI) current catchment.

Both Barnahus and The Alders Units (CHI) are, or will be, providing specialist CSA support services in line with the Barnahus Therapeutic Framework, and together have the potential to support over 500 children and families each year. However, the travel time and limited outreach areas, mean that these high-quality services are inaccessible for a significant number of children and families.

The mapping identified a number of early help and wellbeing services supporting children, such as Jigsaw, Family resource centres, Therapy hubs and Therapeutic family centres and Area based therapy teams. The **Family resource centres** and **Jigsaw**, are well known locally and provide community based early help, counselling, family support and advocacy. However, when a child has experienced sexual abuse many of these services assess children and refer onto a specialist services, such as Barnahus, Rape Crisis Centres or local independent therapists. Stakeholders interviewed said they do not have specialist training or experience needed to support after the impact of trauma and abuse. Specialist CSA services may assess that for some children a local offer of play, art and family therapy, to support a strong resilient family network, is sufficient after sexual abuse; but this would need ongoing consultation/supervision from the specialist CSA service.

Tusla is piloting nine **Therapy Hubs** who can offer in-house play therapy and adolescent psychotherapy; although so far each has only supported one or two children after CSA each year out of the 300 children supported at the hub. The therapy hubs cover Roscommon, Dublin, Limerick, Cavan, Laois, Monaghan and Kildare. Only one Therapy Hub that responded had expertise in TF-CBT and most offer medium term support with an average of 13 sessions; except for the hub in Kildare. Stakeholders in the focus group noted that they cannot always support the child themselves and refer onto local independent practitioners with expertise in play therapy or adolescent psychotherapy. Additionally, **Daughters of Charity** run several therapeutic family centres in Dublin children and families after child abuse, including child sexual abuse. They use nondirective play therapy, art therapy, sand trays, adolescent psychotherapy; access regular supervision; and felt confident working pre-trial when there is an ongoing criminal investigation.

Some specialist Tusla teams were identified in the mapping including **Area based therapy teams**, for children new into care and the **Complex case and therapy team**, set up originally to support 17 siblings affected by children sexual abuse in the Mid-West. These multi-disciplinary teams offer psychoeducation, parent/caregiver support and systemic family support; making recommendations for long-term therapeutic support as needed. As with the Therapy hubs they noted supporting only one or two children each year who were known to have experienced child sexual abuse. Whilst they may have local knowledge of long-term support services, stakeholders in the focus group told us they are limited to supporting children in care, any referrals received from Barnahus will be referred onto local independent practitioners for Tusla funded therapy. A small number of these local independent practitioners or local counselling services may be member of Community Therapy Ireland; which offers assurance to Tusla and other statutory agencies that members have high standards of clinical governance and corporate governance. All 25 members undergo clinical and organisational governance to join and which is refreshed annually.

Stakeholders across TUSLA services (ABTT, CCTT, FRCs and therapy hubs) all spoke of procuring **independent/private practitioners** to provide therapy where statutory and voluntary sector services like Barnahus, The Alders Units (CHI) or CARI lack capacity or capability. We heard they are also commissioned where there is no local service and families may prefer to be seen closer to home. The Therapy hubs and one regional therapy manager spoke about holding local lists of contacts for independent practitioners that can assist Barnahus teams in identifying a local play or art therapist. Until Tusla has establishes a national governed list of independent providers; some regions have established local governance process to identify those independent practitioners with the clinical expertise, professional registration, procedures, qualification and insurance to deliver play/art therapy and adolescent psychotherapy.

We heard from Tusla staff that confidence varies significantly across independent practitioners. While some play therapists may feel confident supporting trauma, not many have CSA-specific trauma training. Particular concerns were raised about the lack of a structured clinical supervision system and the practitioner isolation. Tusla colleagues were aware that local independent practitioners are not embedded in multi-disciplinary teams, so their work with the child is disconnected from wider safeguarding/MDIA processes.

Specialist CSA support services, outside of Barnahus and The Alders Units (CHI), that were identified were CARI and Rape Crisis Centres (RCC), with two and twenty sites respectively across Ireland. Other key support services in the pathway included the national Accompaniment and Support Service for Children (ASSC) providing advocacy and National Inter Agency Prevention Programme (NIAPP) providing support for children and young people who have exhibited harmful sexual behaviour to others, as well as support for their parents or caregivers.

CARI is a highly regarded service offering a play, music, art, talk and family therapy, as well as adolescent psychotherapy to children and families. They are very well known, with several stakeholders interviewed calling for a national roll out of their support, in addition to their existing Limerick and Dublin services. Capacity and geographical location has limited the number of children they can support each year to 67 in 2024, and their waiting list remains high with 76 currently waiting even after significant work to support children and families through psychoeducation and check-ins. CARI's model provides a range of child-led, best practice support as highlighted in the evidence base, however in terms of the Barnahus Therapeutic Framework in Ireland they only offer CFTSI and not TF-CBT.

Three of the **Rape Crisis Centres** offer the Adolescent Framework to support children from aged 10-12 years and their parents/caregivers. Using McElveney's research and RCC expertise, the model includes person-centred counselling in the context of the family, 1:1 counselling psychotherapy, parent/caregiver support, play therapy and creative tools. This long-term support of six to eight months was accessed by 96 children and families across three of the RCC sites in Kilkenny, Tipperary and Wexford in 2024. There is interest in rolling this model out to other RCCs and Cuan are undertaking a national mapping and co-design phase in 2025. The remaining RCCs support young people 14 years and over.

Finally, **CAMHS** provide evidence-based interventions to treat moderate to severe mental health disorders. Many children who experience sexual abuse are not diagnosed with a mental illness immediately after the trauma of sexual abuse and, as a result, do not meet the criteria for CAMHS. CAMHS practitioners interviewed felt that their expertise was in the area of treating disorders, such as depression, suicide, anxiety, PTSD; and not everyone in the team had the skills to address the impact of trauma from child sexual abuse. Barriers to accessing CAMHS were identified including lack of practitioner training in trauma, concerns about

working pretrial, and the absence of a diagnosed mental health condition. Practitioners in the focus group said they often referred children and young people to specialist CSA support services.

Gaps identified:

- The estimated demand of 565 children per year needing therapy is likely to be a significant underestimate of demand due to under-reporting.
- Barnahus West and South therapy services are currently only available in locations in Galway, Cork, Kerry, Tipperary, Limerick and Sligo meaning the travel times to access support may be more than one hour away and inaccessible to children living in other boroughs in the West and South.
- The Alders Units (CHI) therapeutic services are only available in locations in Dublin, Wicklow, Kildare and Naas, meaning in-person support may be more than one hour away and inaccessible to children living in other counties in Louth, Meath, Cavan and Monaghan.
- Children under 12 years old are can only access specialist support at Barnahus, The Alders Units (CHI) and CARI.
- The therapeutic teams at Barnahus West and South teams are not fully recruited and other practitioners are new in post, limiting the current capacity in the team to provide long-term therapy.
- There is a lack of training in trauma-informed therapeutic support after child sexual abuse and working pretrial in Tusla therapy hub teams, CAMHS and independent practitioners.
- Independent practitioners are often working in isolation, outside of multi-disciplinary teams and without specialist consultation/support - and as a result are not able to provide play/art therapy or adolescent psychotherapy for children attending Barnahus.
- There is currently a reduced capacity in CAMHS which has resulted in long waiting lists and referral criteria are limited only to moderate to severe mental health conditions.
- There are no bespoke services for young people who have experienced CSA and are neurodiverse or identify as LGBT, although all existing services reported being inclusive.
- National recruitment difficulties mean that many therapy and specialist CSA support services have vacancies in their teams, reducing their capacity and leading to a greater reliance on independent practitioners – and in some cases temporarily closing.
- The Barnahus Therapeutic Framework focuses primarily on CFTSI and TF-CBT; with other best practice therapeutic approaches only available as staffing expertise allows – such as creative therapies, group work, psychotherapy and systemic family therapy.

Barriers to accessing CSA support services:

- Lack of awareness of current therapeutic services available in Ireland.
- Geographical travel times to specialist support services and existing outreach sites over one hour – Barnahus, The Alders Units (CHI), CARI.
- A child who reported the trauma of sexual abuse more than 45 days ago does not meet the Barnahus Referral Criteria to access CFTSI.

- A child harmed by another child who is under 10 years, does not currently meet Barnahus Referral Criteria because this type of abuse is not classed as child sexual abuse by Tusla[9]
- Cultural barriers of shame and stigma may discourage boys and those from the traveller community from accessing services – CAB particularly noted the name 'rape' in RCC or cultural understanding of RCC services are for may be off putting for boys.
- A child cannot access CAMHS unless they have a diagnosed mental health condition.
- Children from refugee and migrant communities may struggle to access long-term support due to lack of linking into community services, translation requirements and the need to relocate.

Ideal service model:

Interviews and focus groups with professional stakeholders and the CAB considered what the ideal therapeutic support would look like for children and families after child sexual abuse. These findings were used to shaped the final recommendations.

- The support offered should be flexible in length to meet needs of children and parent/caregivers (noting the average length is 13-18 sessions, even in open-ended services).
- Children should have a choice in the type of support they access – including one to one and groups.
- Therapy should be evidence based and in line with the Barnahus Therapeutic Framework.
- There should be a wide range of therapeutic support - play therapy, family therapy, child and family support, TF-CBT, EMDR.
- There should be more capacity in specialist CSA support services, to enable all children access support within an hour of their home.
- There should be assurance about the clinical governance (professional standards, qualifications, quality, safeguarding and data protection standards) and capabilities of the therapist/practitioner - this message was particularly in relation to independent practitioners and local counselling services and some suggested membership of professional bodies.
- Support should include parents, caregivers and guardians.
- Access to support should consider the length of the criminal investigation/court trial and be available for children and families to return to later in the court process or post-trial.
- Specialist CSA support services should consider co-location with local community centres, family resource centres, schools - and should ensure the setting is homely with snacks and drinks.

[9] The National Barnahus Referrals sub-group is currently requesting a change in the Barnahus Referral Criteria to include children who have experienced sexually harmful behaviour from another child under 10 years.

- Services could consider telephone or online support, as long as the child has a choice and noting that the CAB were clear that in-person feels better.
- There should be access to group work for young people and parents.

12 Recommendations

Commissioners and funders e.g. future investment

1. Every child that needs therapeutic support after CSA should be able to access a local, specialist CSA support service within an hour of their home and that is accessible by public transport.
2. Specialist CSA support from Barnahus, The Alders Units (CHI) and CARI should be funded to expand to include a regular presence at child-friendly satellite sites in all 30 Tusla regions in Ireland, considering co-location with therapy hubs, family resource centres, CAMHS or local support services.
3. The Department should consider national therapeutic outcome measures and oversight, as part of the National Barnahus Therapeutic Framework.
4. Rape Crisis Centres should consider adopting the adolescent framework to extend support to children 12 years old and above in their 22 regions.
5. The use of TUSLA funded independent practitioners, where necessary in rural areas, should include a robust governance process for all independent practitioner types (qualifications, trauma training, professional registration, trauma-informed therapeutic model, insurance, compliance with safeguarding and data procedures) and lead to the creation of a national directory which is accessible by professionals and the public.

Specialist child sexual abuse (CSA) support services*

6. Barnahus, The Alders Units (CHI) and CARI should expand their outreach to child-friendly satellite sites to enable more children to be able to access services – exploring opportunities to co-locate with Therapy hubs in Family Resource Centre, CAMHS or Rape Crisis Centres.
7. Specialist CSA services should offer support for children and parents on waiting lists - such as regular check-ins, self-help resources, webinars or psychoeducation groups.
8. Specialist CSA services should be funded to enable all to provide professional advice, ongoing consultation, training and quarterly learning spaces for local professionals that are already working therapeutically with a child and family, to skill up local practitioners and maintain continuity for the child.
9. Barnahus should offer a quarterly learning spaces (complex case forum) for independent practitioners and Therapy hub practitioners working in CSA, to reduce isolation and enable multi-disciplinary interagency working.
10. Once the therapeutic teams in Barnahus have become established, the National Barnahus Therapeutic Framework can be refreshed as planned and could consider expanding the therapeutic offer to the holistic support identified in the 'Continuum of Recovery©' - such systemic family support, creative therapies, groups for young

people, parent groups; inviting learning from experts at CARI and The Alders Units (CHI).

11. The Barnahus should consider expanding CAB to Barnahus service users and creating other opportunities for participation.
12. Barnahus teams should take care that their assessments are not duplicated by local ABTT/CCTT/Therapy Hubs, when seeking support to identify local play and adolescent psychotherapy and seek to establish a trusted referrals process.
13. Barnahus teams should seek to establish trusted referrals to CAMHS, when required, without the need for a child to retell their story to their GP to make a referral.

*** This section relates to Barnahus West, Barnahus South, The Alders Units (CHI), CARI, Rape Crisis Centres**

Providers of therapy and support services

14. Therapists in FRC Therapy hubs should be trained to ensure that they are confident and competent to support children and families after the trauma of child sexual abuse with play, art and family therapy. This should include trauma informed training specific to child sexual abuse and working with children who case is pretrial.
15. Therapists in FRC Therapy hubs should have access to specialist supervision with expertise in CSA and a quarterly learning space with Barnahus.
16. Independent practitioners seeking to deliver Tusla funded support to children and parents/caregivers after CSA should evidence that they have appropriate trauma training, awareness of the impact of CSA and access to specialist supervision.

*** This section relates to Therapy hubs, FRCs and independent practitioners**

Communication and awareness raising

17. Barnahus West and South should raise awareness of their new Barnahus Therapeutic Support offer.
18. All services supporting families should be made aware of the therapeutic support in their area by sharing the National Children's Therapy Services Map and accompanying spreadsheet.
19. The National Children's Therapy Services Map and accompanying spreadsheet should be made available as an interactive directory of services for young people and parents on the TUSLA Barnahus website, with links from local FRC websites.
20. Further research or mapping is recommended to understand why only 24% of children known to Tusla after disclosing child sexual abuse, are referred to the Barnahus or the Alders Units (CHI).

Appendix 1: Interviews and focus groups

Interviews in Phase 1:

Name	Role and organisation	Date
Laura Mc Kittrick, Manager	Jigsaw Donegal	12/08/24
DI Siobhan Mollahan	Gardaí, Donegal	12/08/24
DI MaryAnn Donaghue	Gardaí, Galway	13/08/24
John Donnellan, Area Manager	Tusla, Galway	13/08/24
Fiona Geraghty, Manager	Barnahus South	14/08/24
Joanne Tubritt, Manager	Brill FRC, Waterford	14/08/24
Joan Cronin, Independent Social Worker,	Independent Social Worker, Cork	15/08/24
Stuart Morrin, Specialist Interviewer,	Gardaí, Dublin	16/08/24
Colm Leonard, Investigator	Ombudsman For Children,	16/08/24
Ger Brophy	Chief Social Worker, Tusla	16/08/24
Olive Moloney, Psychologist	Barnahus South	20/08/24
Helen Shortt	HSE	20/08/24
Paul Longmore, Snr Project Manager, Policy Implementation Team	HSE	20/08/24
Sarah Hennessy, General Manager Child and Youth Mental Health	HSE	20/08/24
Keith O'Reilly, Director of The Alders Unit	The Alders – Connolly, CHI	20/08/24
Joan Sheerin, Social Worker	Tusla, Donegal	21/08/24
Aideen Walsh, Forensic Nurse Examiner	The Laurel's Clinic, CHI	22/08/24
Monica Hynds O'Flaherty, Assistant Director And four GALs from across the country	Barnardo's GAL Service	22/08/24
Aoife O' Malley, Manager Áine Griffin, Social Care Leader	Barnahus West	23/08/24
Marcella Leonard, Director	Leonard Consultancy	26/08/24
Adele Moorhouse, Principal Clinical Psychologist and Family Therapist	The Alders Connolly, CHI	04/09/24
Rosaleen Mc Elvaney, Principal Psychotherapist	The Alders Connolly, CHI	05/09/24
Breege Maxwell, Interim Director	The Alders Tallaght, CHI	09/09/24
Niall Rynne, Independent Social Worker	Independent Social Worker, Cork	10/09/24
Deborah Wilson, Principal Social Worker	Five Rivers Fostering, Donegal	17/09/24

Interviews in Phase 2:

Clarification interviews

Attendees	Organisation	Date

Adele Moorhouse, principal psychologist Rosaleen McElveney, principal psychologist Keith O'Reilly, Director of Alders at Connolly	The Alders Units, CHI	22/1/25
Julie O'Donnell, National Barnahus manager	Tusla	22/1/25
Olive Maloney, Psychologist	Barnahus South	22/1/25

Interviews

Name	**Role and organisation**	**Date**
Keith O'Reilly, Director of The Alders Unit, Connolly	The Alders Units, CHI	30/1/25
Aideen Walsh, Forensic Nurse Examiner	The Laurel's Clinic (CHI)	30/1/25
Brigid Maxwell, Director of The Alders Unit, Tallaght	The Alders Units, CHI	30/1/25
Fiona Geraghty, Barnahus Manager	Barnahus South	31/1/25
Linda Cooney, Psychologist	Barnahus South	31/1/25
Sonya Joyce, Psychologist	Barnahus West	31/2/25
Elaine O'Sullivan, Clinical manager	Jigsaw	6/2/25
Elaine Kerry	Jigsaw Cork	6/2/25
Cian	Jigsaw Limerick	6/2/25
Laura	Jigsaw Donegal	6/2/25
Brid	Rape Crisis Centre, Kilkenny	7/2/25
Claire	Rape Crisis Centre, Wexford	7/2/25
Natasha	Rape Crisis Centre, Tipperary	7/2/25
Brid Meighan, Clinical lead	Community Therapy Ireland	13/2/25
Geraldine O'Hara, Head of Operations	Daughters of Charity	20/2/25
Maria Cleary, CEO	Community Therapy Ireland	20/2/25
Brid Meighan, Clinical lead	Community Therapy Ireland	20/2/25
Denise Collins, Regional Therapy Manager	Tulsa - West and North West	24/2/25
Lesley Devlin, principle social worker	Complex case and therapy team (CCTT) - Mid West	26/2/25
Alan Bryne, programme manager	National FRC network	27/2/25
Liz Pena	Cuan	3/3/25
Louise Betson	Cuan	3/3/25

Focus groups:

Organisation	**Attendees**	Date
CAMHS	Dr Louise Sharkey, Consultant Psychiatrist, CHO6, Dublin South East Diane O'Donoghue, CAMHS OT, CHO8, Dublin North East Kelly Martin, Clinical Nurse Specialist, CHO1 Leonia Gravante, Consultant Psychiatrist, CHO1 Helen Greenan, Clinical Nurse Specialist. CHO1 Sylven Veerasoo, Clinical Coordinator, CHO4	12/2/25

	Una Dunne, Acting Principal Social Worker, CHO8 Ciara OKeeffe, Principal Psychologist, CHO7 Emma Nolan, Senior Social Worker / Child and Adolescent Art Psychotherapist, CHO6 Patricia Doherty, Senior Social Worker, CHO1 Sligo Leitrim	
Voluntary and charity service (VCS)	Siobhan O'Leary, RCC Mid-West Grace Jordan, CEO at ASSC Angela Broderick, RCC Mayo Yvonne Lucas, Jigsaw Rachel Falk, Clinical lead, Childhood Matters Emer O'Neill, CEO at CARI	13/2/25
Therapy Hubs and Family Resource Centres manager	Amy, Boyle FRC Catherine O'Donohoe, South East lead for FRCs Susan Rodden, manager, Wexford and Waterford FRC Louise, Therapist, Wexford and Waterford FRC Mary, Clinical nurse specialist, Wexford and Waterford FRC Louise Smith, Cavan FRC and Therapeutic Hub Maria Cleary, CEO at Community Therapy Ireland Liz McGuckin, Therapist, Dundalk Counselling Centre, County Louth Una Holstead, The Curragh Family Resource Centre, County Kildare Des Bailey, Kerry Adolescent Counselling Service, County Kerry	13/2/25
Child Advisory Board (CAB)	Five young people from the Cork area CAB	20/2/25
ABTT and NIAPP	Maria Larkin, Regional manager of ABTT Rhonda Turner, principal psychologist, national NIAPP Judy McCarthy, principal SW, national NIAPP	27/2/25

Appendix 2: National Therapy Services for Children in Ireland – Map

Appendix 3: National Therapy Services for Children in Ireland – interactive spreadsheet

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