Research Report

Child Safety, Justice and Recovery
RESEARCH GROUP

Making Sense of Recovery in Bairns' Hoose

Learning from expert interviews and literature

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1. Introduction and context

1.1 Aim and overview of this briefing

The development of what has been loosely termed 'recovery support' for children who experience abuse or maltreatment represents a significant investment and use of Scottish Government Bairns' Hoose Pathfinder funding. This responds to recognition that recovery support has to date probably represented the most significant gap in provision for children who experience abuse or maltreatment within Scotland (Galloway et al., 2017; Mitchell et al., 2023, Duncan et al., 2025).

This briefing aims to support Sycamore, Aberdeen City and Aberdeenshire Bairns' Hoose partnerships to further develop and refine their recovery offer, providing an overview of relevant evidence from expert interviews and a rapid review of literature on therapeutic support in Barnahus-type services[1]. It focuses particularly on evidence about:

- How recovery is understood and defined for children who experience abuse or maltreatment ('concepts')
- How children's recovery needs are identified and understood ('assessment')
- What types of support or interventions are effective and meaningful for promoting children's recovery ('interventions')
- The resourcing, feasibility and organisational considerations that support safe and effective recovery support ('implementation')

We recognise that the evidence informing this briefing has limitations and represents only part of the picture. In particular, we recommend that it is considered alongside evidence from children, young people and family members with experience of Bairns' Hoose or similar services; evidence about the nature of local contexts including existing services and resourcing; and wider evidence (outside of Barnahus or Barnahus-type services) on specific recovery needs of certain groups of children (such as those subject to intrafamilial physical abuse; children with disabilities; neurodiverse children; and refugee and asylum-seeking children).

1.2 Background context

Within the Scottish Bairns' Hoose standards, recovery support (also referred to as 'therapeutic recovery') is framed as one of four 'rooms' or offers provided within the multi-disciplinary Bairns' Hoose model. The standards note:

> **Barnahus is described as a 'house with four rooms.' The 'rooms' represent health services, child protection services, investigative and legal proceedings, and therapeutic recovery. (Health Improvement Scotland, 2023)**

1. When we refer to Barnahus or Barnahus-type services in the remainder of this document we include other analogous multidisciplinary and interagency services (often co-located) which span welfare and justice needs associated with child abuse and maltreatment. It includes services such as Child Advocacy Centers (CACs) and Canadian Child and Youth Advocacy Centres (CYACs) (Westphaln et al., 2021; Parker et al. 2025) alongside Barnahus and other 'Barnahus-type' services (Greijer & Wenke, 2023).

When considering the starting point for developing Bairns' Hoose recovery support we identify four contexts which explain why the 'recovery room' represents a distinct challenge within Bairns' Hoose and has a different starting point from the other three rooms. These are outlined below.

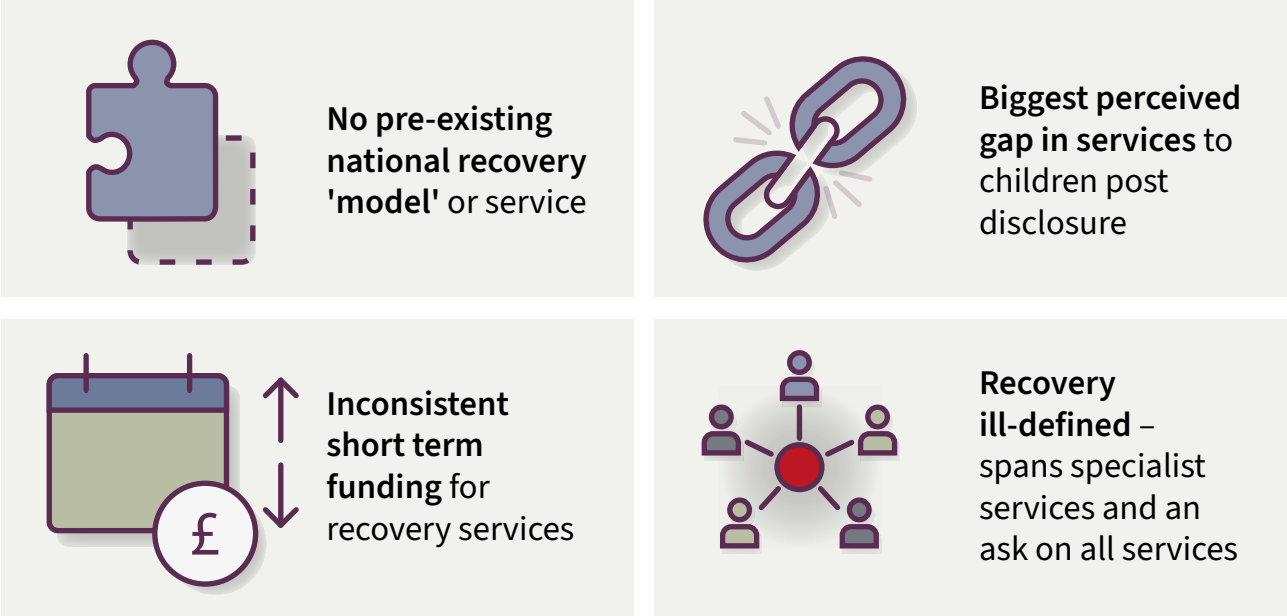

Fig 1: Summary of four key contexts presenting challenges for development of recovery offer in Bairns' Hoose

i) No pre-existing national recovery support 'model' or service

Unlike child protection (predominantly delivered by social work and the Children's Hearing System), investigative and legal proceedings, or justice (predominantly delivered through the police, the Scottish Courts and Tribunal Service, and the Crown Office and Procurator Fiscal Service) and health (predominantly delivered by the National Health Service) there is no equivalent national service or delivery partner for recovery. Therapeutic recovery support for child victims of abuse is also not framed by any single national policy framework or guidance – unlike many statutory aspects of health, child protection and justice. This means that, unlike the other three rooms of Bairns' Hoose – where pre-existing services and systems are integrated into a new collaborative partnership – recovery support is likely to require significantly more initial development work and investment.

ii) Recovery represents the biggest service gap prior to introduction of Bairns' Hoose

Prior to opening Bairns' Hoose, therapeutic recovery support and/or support for children's emotional wellbeing was widely recognised as the biggest gap in services for children after abuse or maltreatment had been identified. This message arises in evidence gathered across both local and national research addressing children who had experienced abuse and maltreatment (Galloway et al., 2017; Mitchell et al., 2023, Duncan et al., 2025).

iii) Pre-existing recovery funding models: inconsistent, short-term and subject to procurement

Unlike child protection, justice and health services, the majority (though not all) pre-existing recovery provision in Scotland targeting children who have experienced abuse and maltreatment is delivered by third sector organisations such as Rape Crisis, Children First or Women's Aid.

This means most such services are subject to a procurement model of funding – drawing variably on charitable grant-making and short-term local authority contracts. A consequence of this funding model is that services which fall under the remit of trauma recovery are delivered by a diverse range of services whose geographic reach, scope and criteria vary considerably. Service offers also reflect a broad range of approaches spanning those informed by clinical, psychosocial, feminist, social work and youth work approaches. Staff working in third sector services are likely to be subject to short-term contracts, job insecurity and potential pressure to design and change delivery models in response to funding opportunities rather than need.

Outside these services there are also a range of non-specialist services (i.e. those not specifically targeting victims of child abuse or maltreatment) which may support children's emotional wellbeing or mental health needs after an experience of abuse or maltreatment. These span third sector, education (such as school counselling provision and guidance teachers), social work, and Child and Adolescent Mental Health Services (CAMHS) for children with diagnosed mental health conditions).

iv) Recovery as both a specialist 'room' and overarching responsibility of all Bairns' Hoose stakeholders

A key observation about how children's recovery is understood within developing Bairns' Hoose is that it is both i) a recognised specialist or targeted intervention (or set of interventions) which constitute a distinct 'room' within Bairns' Hoose, and ii) a task which all staff within the Bairns' Hoose model contribute to through embedding trauma-informed principles in their work.

Implications for developing Bairns' Hoose practice

One consequence of this context is the absence of a shared language or perspective about what recovery means, who should deliver it, how it should be delivered, what outcomes it might hope to achieve and how it might be evidenced or measured. Evidence highlights that recovery holds variable meanings for different partners and that expectations about the role of recovery support differ.

Across the three Bairns' Hoose sites that supported this work (Aberdeen City, Aberdeenshire and Sycamore) different recovery models are being developed and piloted which variably involve a range of partners including third sector services, CAMHS, wider health provision and social work. It is reasonable to assume that these differences will affect outcomes for children and families. While there are clear strengths and opportunities in trialling different approaches, there is also value in developing some shared language and consensus around priorities for recovery support.

While this briefing cannot provide a singular vision or easy formula for an effective recovery model that will work for all children, we hope some of the learning presented will help inform how partnerships shape and steer their own developing recovery models in the future. With this in mind, each findings section ends with a set of learning points that we suggest might be useful to consider in local contexts.

1.3 Methodology

Overview

This briefing presents the synthesised evidence from two distinct strands of work:

1. a rapid evidence review focused on Barnahus-type services

2. a series of expert interviews focused more broadly on children's recovery needs.

Rapid Evidence Review

A rapid evidence review was conducted to identify existing literature which captured learning about approaches to 'recovery support' (characterised as therapeutic or focusing on mental health, emotional wellbeing or wider psycho-social needs) in Barnahus or Barnahus-type services (including Child Advocacy Centres).

The Rapid Review Title was**: Understanding the ways in which recovery support is conceptualised and delivered in Barnahus or Barnahus-type models.**

For the purposes of this study, 'recovery support' was defined broadly, encompassing any interventions focused on addressing children's needs after abuse or maltreatment that were associated with mental health, emotional wellbeing or broader psychosocial issues. There was some overlap with physical health needs, and child protection work – but these were only considered when they were described as having therapeutic benefits that affected children's mental health or social wellbeing.

The final review drew on 53 pieces of evidence from both academic peer-reviewed journal articles (n=35) and grey literature such as service evaluations, book chapters or commissioned research reports (n=18). Evidence spanned Barnahus or Child Advocacy Centre services from 12 countries (Australia, Bulgaria, Canada, England, Guyana, Ireland, Israel, Norway, Scotland, Sweden, Turkey and the US). The key questions the review sought to answer are outlined below.

Review Questions

- How are recovery services (mental health and therapeutic support) delivered for children within Barnahus – including variants specific to different types of abuse or different populations of children and young people?
- What are the key components of recovery interventions in these models (including but not limited to staffing, screening, duration, activities, environment, delivery model), and how do they relate to wider aspects of the Barnahus offer including advocacy, child protection, justice or physical health?
- What intended outcomes for children are articulated in recovery interventions within Barnahus?
- What assumptions or theories of change (tacit or expressed) underpin recovery interventions in Barnahus?

Searches were conducted on electronic databases, relevant websites and through citation review. Following development and refinement of inclusion/exclusion criteria, searches were followed by a two-stage screening process, with all items initially screened by two members of the team.

Data extraction and synthesis of findings were supported by an extraction and thematic analysis framework based on an expanded version of the research questions.

The evidence reviewed provides insights into a range of approaches to supporting children's bio-psychosocial wellbeing and 'recovery' in the aftermath of abuse and maltreatment.

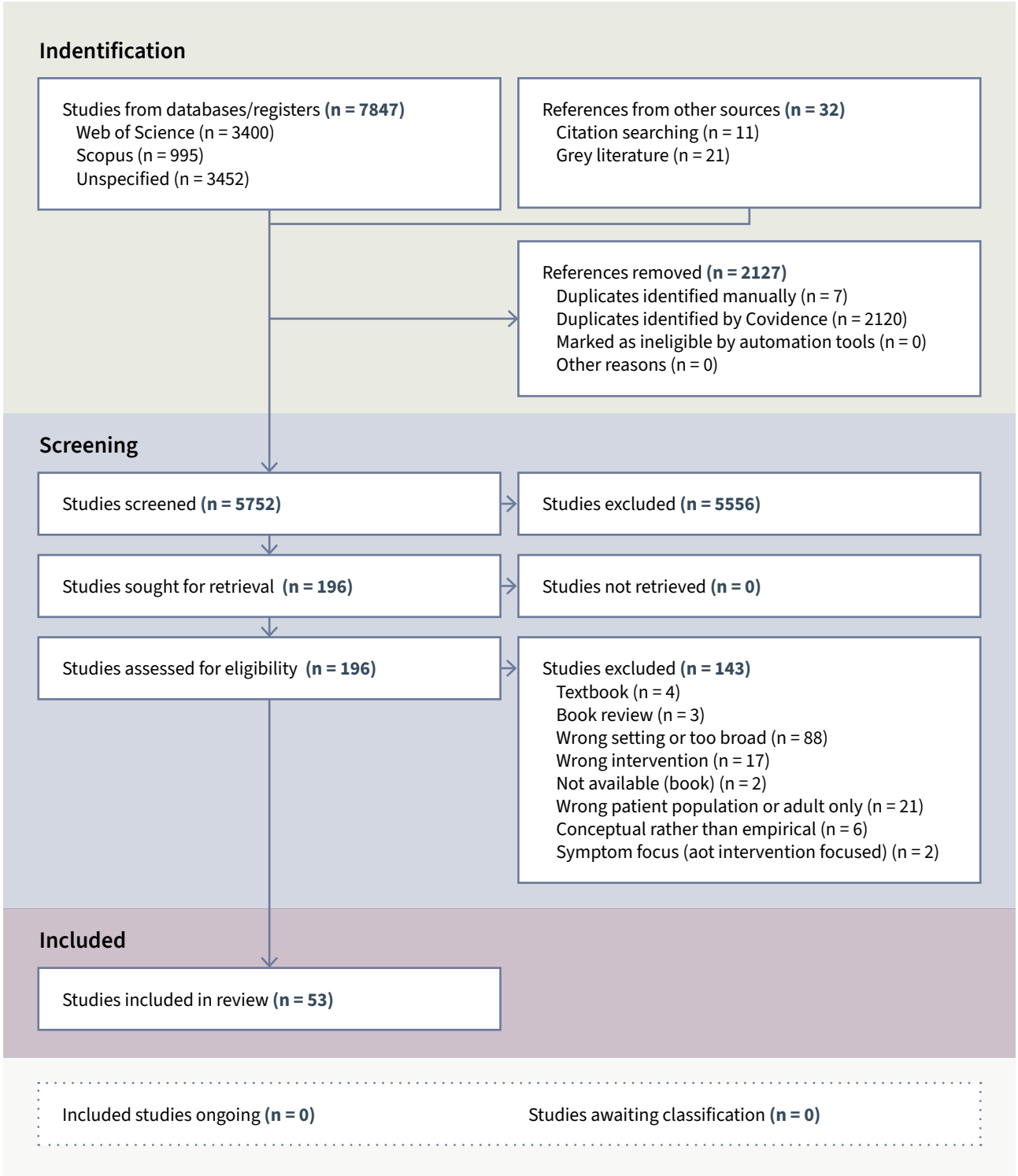

Fig 2: Prisma Diagram

Expert Interviews

The second aspect of this study involved a series of 18 expert interviews (with 19 individuals)[2] aiming to better understand the range of possible approaches to assessing and responding to trauma recovery needs in children who have experienced abuse or maltreatment.

Sampling was purposive: specific individuals were identified to reflect a broad range of perspectives and approaches to children's trauma recovery after abuse or maltreatment. Sampling drew on the research team's collective expertise on both child abuse and maltreatment and Barnahus models in Scotland, the UK, Ireland and internationally, alongside recommendations from those initially approached. Sampling aimed to purposefully capture representation from:

- **Different disciplines –** including clinical perspectives such as psychiatry; psychology and psychotherapy; paediatric health; social work; youth work; and community work perspectives.
- **Statutory and third sector services** – including both child rights and gender-based violence services.
- **Practitioners working at different service levels –** including frontline practitioners and operational or strategic leaders**.**
- **Perspectives from different areas and jurisdictions** including the three Bairns' Hoose partnerships funding this work alongside national and international experts.
- **Adults with lived experience of services that had similar aims to Barnahus-type recovery support**

Ethical approval was granted by the School of Social and Political Sciences ethics panel at the University of Edinburgh.

Interview Questions

All interviews followed the same format structured around four key questions:

- How is recovery for children who experience abuse or maltreatment understood and defined? (concepts)
- How should services assess and understand children's recovery needs? (assessment)
- How should services respond to and support children's recovery? (intervention)
- What factors impact implementation and help (or hinder) recovery support to happen? (resourcing and implementation)

All interviews were recorded and transcribed using Microsoft Teams and then thematically analysed by four members of the team. An initial sample of interviews was double coded before finalising a shared coding framework. Identification of key themes and final synthesis of findings were agreed collectively across the whole team. AI was used to cross check thematic summaries, helping to identify any gaps or over/underemphasis of findings, but the team's original manual analysis formed the basis of the final synthesis of findings. A full protocol is available upon request.

2. One interview was conducted with two staff from the same organisation who chose to be interviewed together.

Limitations

The key limitation of this study is the absence of children, young people, parents and carers' perspectives on recovery. This reflects the study's time span and resource constraints. A key next step to develop this work would be to gather perspectives from children, young people, parents and carers and/or existing research that has already captured children and young people's views on these issues, and compare them with the finding of the current study.

Further limitations include the scope of the literature review, which excludes wider work on trauma recovery services for children who have experienced abuse and maltreatment (outside Barnahus-type services). This literature is likely to include highly relevant insights. Conversely the broad scope of the study, spanning recovery in the context of all forms of child abuse and maltreatment, prevents learning that may be specific to particular forms of harm or cohorts of children.

Another key limitation from the literature is the dominance of evidence from North America, which may reflect differences in approach between the North American Child (and Youth) Advocacy Centre models and the European Barnahus models[3].

3. Literature review included 20 sources from North America, 12 from the UK and Ireland, 10 from the rest of Europe and 11 from the rest of the world including Australia, Turkey, Israel and Guyana.

2. Concepts: what do we mean by recovery?

> It's about living alongside the trauma, not imagining that you'll come to some magical end point, but actually living alongside that trauma and living the best life that you can. (IV8)

A challenge when talking about recovery within Bairns' Hoose – whether in relation to the recovery 'room', recovery interventions or hopes for children's recovery – is that the term appears to be deeply ambiguous. Practitioners use and understand it in different ways. While there are strengths in recognising recovery as subjective and individual, there may also be value in developing a shared understanding to support collaboration within a multi-disciplinary setting such as Bairns' Hoose.

2.1 Findings from literature

Findings from literature only minimally and indirectly address the concept of children's recovery after abuse or maltreatment and no attempt to define the term was identified. Observations about how the concept appears in the literature are noted below:

Language

Very few studies used the language of recovery to describe either the aims of interventions or children's needs. The exceptions were studies undertaken in Scotland, which appears to be an outlier in this regard. Instead, many Barnahus-type services refer to a (perhaps) narrower focus on children's mental health needs and/or delivery of mental health interventions or 'treatment'. Interestingly where terms such as 'treatment', 'clinical interventions', 'therapy' and 'therapeutic support' are used, they often lack definition and they often appear to be used to in different ways.

Other studies described examples of Barnahus-type services addressing a wider range of children's recovery needs – often termed 'social support' (Haar, 2020; Scoglio et al., 2021; Westphaln et al., 2021) or described as addressing 'psychosocial needs' (Voss et al. 2018; Dovi et al., 2022, Harewood, 2025; Madray and Tinnie, 2025). These extended beyond interventions for diagnosable mental health conditions and reflected approaches spanning therapeutic, social work and advocacy. There was also evidence that advocacy and therapy roles were sometimes combined, conflated or talked about interchangeably (Herbert and Paton, 2024, Mitchell et al., 2024).

Scope

The scope of services described which address children's recovery needs in Barnahus-type services varies considerably. Some appear to be restricted to provision of (or referral to) a limited or even

single evidence-based mental health intervention[4], while others describe a range of therapeutic approaches including those addressing broader psychosocial and advocacy needs and delivered by professionals using different approaches.

2.2 Findings from expert interviews

Expanding the idea of 'recovery'

For most interviewees, the word 'recovery' was contested. Key areas of critique were the potential of the word 'recovery' to conjure up the false possibility of a definite endpoint, a return to a prior state, or a cure. However, no single better word emerged to capture the trajectories or outcomes representing children's improved wellbeing after abuse or maltreatment. These trajectories or outcomes were variably described. Examples of descriptions include:

- children not feeling defined by an experience of abuse or maltreatment,
- feeling increasingly safe (physically, relationally and emotionally) and
- having lives which were not dominated by thinking about trauma.

Several descriptions suggested recovery was aligned to children experiencing (or re-experiencing) a sense of safety and normality and managing to get on with everyday aspects of life such as education, socialising with friends and pursuing interests and hobbies: what one professional described as children reaching a 'safe ordinariness'.

> **There is something very fundamental with the word ordinary. It's a very powerful word, and many young people who've experienced vulnerabilities will want to have built around them an ordinary, predictable everydayness … Being able to step out and step back into a world which is safe for them, where they feel they belong and within which they can be successful. (IV18)**
>
> **I think it means being able to feel their normal again, whatever that means for them. (IV10)**

Outcomes associated with recovery could be broadly grouped into those associated with:

- **safety** for example: taking back control; being able to trust others; finding 'island[s] of safety'[5])
- **success** for example: having hope for the future; recognising their strengths and progress; trusting their ability to make positive decisions, and
- **belonging** for example: enjoying experiences; connecting with others and being able to feel and present themselves authentically.

4. In this context, evidence-based mental health interventions refers to manualised approaches usually targeting specific symptoms or diagnosed conditions such as post-traumatic stress disorder, anxiety disorders or depressive disorders. The term 'evidence-based' usually refers to the fact they have proven effective in studies that draw primarily on randomised controlled trial methodologies.
5. Interview 10

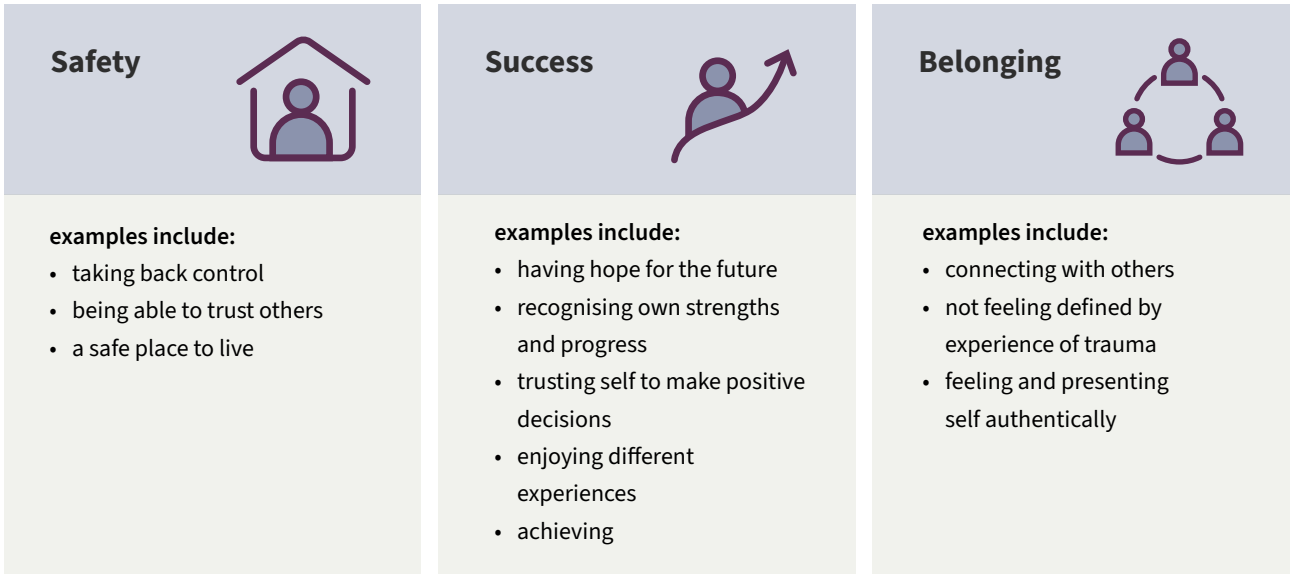

Fig 3: Potential outcomes framework for defining recovery based on expert interviews

Multiple interviewees challenged the notion of 'getting over' trauma. There was a strong consensus that recovery is often about 'living alongside' trauma, and that there may not necessarily be an end point.

> **Recovery makes me feel like you're trying to help me to get over it. I'm not going to get over it. And then so we talk about getting through it or getting alongside it. (IV9 - Professional describing what young people say)**
>
> **So recovery for me is a lifetime situation. It doesn't sit in six to 12 sessions of any specific form of therapy, and I see therapy as a tool for children and young people that they may need to revisit and come back to. (IV11)**
>
> **This is why it's not having those expectations that it will be all like it used to [be] before. It's about healing from trauma. It's often not linear – it's like a lifelong process with periods of stability or challenge and growth rather than a single recovered point. (IV7)**

Finally, there was a strong and consistent view that recovery for the child is deeply relational - intimately tied to the wellbeing (and potentially recovery) of those who care for them - parents, wider family members and other carers.

Recovery does not necessarily require therapy

Many acknowledged that discussions about children's recovery after abuse or maltreatment are often tied to assumptions about the need for mental health treatments or therapy. Yet a recurring message from interviews was that such interventions may only be needed in a minority of cases. One third sector child sexual abuse service manager, who provided a range of different support options for children, described how when offered a choice of different support options (sometimes referred to as different 'treatment modalities') only around 40% chose therapy. Warnings were also voiced about the possible dangers of suggesting to children or their parents and carers that they will need therapy to heal or recover, sometimes unnecessarily pathologising their difficulties and distress. It was noted that this narrow conceptualisation of recovery can limit children,

families and carers' understanding about how their needs might be best met and the choices available to them.

> **Children and young people are really familiar with the terms 'cope' and 'recover' and that tends to encompass a sort of really clinical world view where potentially therapy is the only thing that can enable healing from child sexual abuse. Young people are always told they need therapy. (IV11)**

A related point was raised about the danger of viewing children as broken and needing therapy to be fixed – suggesting instead the need to communicate an ethos that children may already have, within and around them, the resources they need to heal, including their passions, strengths, and things they take pleasure from, often alongside the support of those who care for them.

> **I guess the ethos of our organisation was very different, which is that you know you already have within you what you need to heal. So, let's start from your interests. Let's start from your passions, like, what do you want? You know, what do you do in a day? What makes you smile? (IV11)**

Child-centred understandings of recovery

There can be many voices defining and directing expectations about the meaning of a child's recovery. For example, they may include parents who hope for a simple 'cure' or return to a life that predates a child's disclosure, or professionals who assess that a clinical intervention is required to help a child 'heal'. In the midst of adult voices, it was noted that children's own perspectives must remain central – possibly through simply asking children: '*how do you want life to be different?*' and working to understand their own motivations and hopes for the future.

> **Sometimes the parents want one thing, the school want another, the social worker wants another, the clinician wants to help them with that – and actually we don't always stop and think, well, hang on, how do you [the child] want life to be different? (IV9)**

Recovery as different for each child

There was a strong consensus that children's recovery needs are highly individual and cannot be predicted simply from considering an experience of abuse. One interviewee proposed the value of the 'three E' framework (Event, Experience, Effects) as a model which conceptualised children's recovery needs through the interplay of what happened to the child (event), how they experienced the abuse (experience) and what the impact has been on their own and the wider world (effects). Using this framework can help ensure the individual's experiences remain central.

> **There's differences in terms of if it's a one-off versus a repeated type of trauma. But we need to think about it through the three Es as a way of thinking about the impact of trauma: the Event (the type of trauma, the frequency, the who), the Experience (how it was felt by the young person), and the Effects (the impact on day-to-day life). (IV1)**

Collective support for recovery

A final theme was that support for recovery is shared across the multi-disciplinary team, with the child and family playing an active role in decision-making. This ensures that recovery does not sit solely with the child, nor solely with the 'therapeutic recovery' room of a Bairns' Hoose.

> **It feels really important that children don't feel it is them that have to be responsible for getting better and recovering. (IV8)**

All professionals were noted to play a role in the child's and family's recovery journey, including, but not limited to, social workers, voluntary sector services, and CAMHS.

> **What I like about Bairns' Hoose is the approach that allows us to draw on different services – almost knocking down the walls that exist between them – making sure the child and their family have support from all of them. (IV2)**

2.3 Concepts: implications for local Bairns' Hoose partnerships

Professionals in Bairns' Hoose need to be aware that children, parents and other professionals hold diverse understandings and assumptions about what recovery means. For some people, the language of recovery may feel unhelpful or pathologising. This serves as a reminder to check with children and families what language works for them – and how they frame their hopes for the future. The use of the word recovery should not suggest an end point ('being recovered'), a predetermined set of outcomes or a linear journey that is unlikely to reflect children's experiences.

A number of key principles supported by both literature and expert interviews could serve as a helpful basis for some cross disciplinary consensus. These include:

- Approaches to support should move away from the concept of recovery as something 'done to' the child to something enabled through 'working with' the child – building on their own strengths and resources.
- Children's recovery after abuse or maltreatment extends beyond simply a reduction in mental health symptoms to helping children find ways to live safely and fully, beyond or alongside trauma. This reinforces why contributions from a range of disciplines is critical – spanning youth work, social work, advocates and health professionals including therapeutic clinicians.
- Ecological or systemic perspectives on recovery provide a helpful basis for designing services given the known impact of trauma on every aspect of a child's life. They help foster a broader understanding of support to include the family and wider contexts (such as school, peer groups, friendships and communities) rather than solely focusing on the individual child and their internal world.

3. Assessment: how can we understand children's needs?

> I think the question is how do we know what the right match is for each child who will come through Bairns' Hoose? And I guess that's a really important question because not everyone will need the same thing. (Interview 1)

Assessment of childen's needs is recognised as an essential component of Barnahus or Barnahus-type recovery provision. It informs decision making about allocating resources, the type of support provided and provides a means of recognising and reviewing children's progress. Neither the literature nor interviews offered a single recommended process or tool for assessing children's recovery needs after abuse or maltreatment within Barnahus-type services. The literature primarily described individual (mostly standardised) approaches to assessment across different settings including associated staff support or training needs. By contrast, expert interviews offered insights spanning highly structured to more integrated and sometimes informal approaches to assessment, and reflected on associated tensions.

3.1 Findings from literature

Variable scope and approaches to assessment

The literature highlights a range of screening and assessment processes – primarily (but not exclusively) focused on identifying children's mental health needs across Barnahus-type services. Assessment models which encompassed a wider focus (beyond diagnosable mental health symptoms[6]) could include consideration of physical and sexual health, social needs, family circumstances and 'functioning'.

Approaches to assessment ranged from conversational (or relationship based) models without any use of standardised tools (see for example Mitchell et al., 2024) to services applying multiple standardised screening and assessment tools, though sometimes integrated with conversational and observational methods (Lucas and Saunders, 2014; Thulin and Kjellgren, 2017; Whaling et al., 2020; Parker et al., 2021; Scoglio, 2021; Anderson, 2022; Dovi et al., 2022; Harewood, 2025; Mori et al., 2025). Several examples included those where assessment also incorporated goal-setting exercises, identifying children's (and their families') own recovery hopes (see Parker et al., 2021, Mitchell et al., 2024, Harewood, 2025).

The roles of assessment: early screening; initial assessment and review.

There appear to be three distinct roles for assessment within Barnahus-type services described across the literature. These are: early screening - determining support access; initial assessment – fully understanding a child's needs and shaping support; and ongoing review- identifying evidence of changes to a child's wellbeing over time. A majority of the literature focused on early

6. One study described this broad focus as 'bio-psychosocial needs' (Goransson et al., 2022)

screening - identifying whether a child qualifies for and/or would benefit from forms of support available within Barnahus-type services. Several studies noted the role of structured screening questionnaires in ensuring equitable decision making about allocation of support and supporting early identification of children's needs (Byrne et al., 2022; McGuier et al., 2023).Three studies focused on the process of introducing new screening tools and processes. These all demonstrated how staff support for and uptake of a structured screening process increased following training, implementation and recognition of its role in improved decision making and improving children's early access to appropriate interventions (Conners-Burrow, 2012; Byrne et al., 2022; Shepard et al., 2024).

Overall, screening was felt to prevent subjective assumptions about which children and young people did or didn't need support and ensure allocation of services (particularly mental health interventions) were based on an individual's need (McGuier et al., 2023). This linked to a recurring message in the literature that not all children and young people would need formal therapy following abuse. Examples were given of evidence that approximately 40% of children who experienced sexual abuse did not have psychiatric symptoms (Alşen Güney, 2018). However, the point was also made that even where children do not have mental health needs, they may benefit from other forms of early or preventative support (Schreier et al., 2022). The same study noted a danger of assessments for support in Barnahus-type services focusing too heavily on diagnosable mental health needs, meaning that funding and organisational priorities may then lean towards these needs above others (Ibid).

Fig 4: Three distinct roles of assessment described in Barnahus-type services

Identifying needs that fall outside Barnahus support

One study noted how assessment may identify needs that cannot be met within a local Barnahus-type service (Lacey et al., 2023). While this may help inform a child's referral to alternative services - sometimes referred to as 'linked services' - there was also recognition that this may limit children's access to support (Ibid). This may be because appropriate services aren't available in the community and/or have significant waiting lists, or because onward referral processes are shown to weaken a child's engagement in support (see section 4.1 p26).

Integrated assessment and intervention.

At least one intervention - Child and Family Trauma Stress Intervention (CF-TSI) - used in a number of north American CAC's and the Irish Barnahus – describes fully integrating assessment into an early intervention model of six session support to children and family members. In this example, assessment questions are described as woven into each session, ensuring that by the end of the six weeks support programme a more in-depth picture is developed about the child's ongoing needs (Hahn et al., 2019) and used to inform potential future support (Lacey et al., 2023).

Standardised assessment tools

Within the literature reviewed, there was strong support for the use of some structured or standardised tools – with a number of caveats. Where structured screening and assessment processes were described, they appeared to focus particularly on what were broadly considered 'trauma-related' mental health symptoms and needs, with a particular focus on identifying post-traumatic stress disorder (PTSD) and risks of suicidality, alongside low mood and anxiety. However, it should be noted that this may reflect the dominance of evidence from North America, where the recovery offer within Child Advocacy Centres appears to have a particularly strong focus on diagnosable mental health issues.

Some studies proposed evidence that standardised assessment tools were associated with improved outcomes for children (Byrne et al., 2022). Particular findings were noted in two studies which focused on screening for suicidality among children and young people who had experienced sexual abuse. These noted that formal screening supported early identification of this risk, and hence earlier access to suitable support (Byrne et al., 2022; Shepard et al., 2022).

However, limitations were also noted on the use of standardised tools. With some studies reporting that individual practitioners experienced some assessment tools as unwieldy or 'clunky' (Byrne et al., 2022). At least one study shortened and adapted standardised screening tools to make them more acceptable and appropriate to apply with children and families (Conners-Burrow et al., 2012). Another study noted how an initial multi-tool assessment process was streamlined and simplified following feedback that it could feel overwhelming for children and families (Read and Parker, 2025).

There also appeared to be mixed views on the importance of fidelity to a particular model or consistency of use. Many studies implied that the consistent application of tools was important – but this may have been linked to their use within research studies where comparability was particularly valued. Elsewhere there was reference to valuing local adaptations of existing screening tools –to shorten them, make them easier to undertake, and make professionals, children and families more likely to engage with them. There was also evidence about the value for professionals of having choices about which tools to use.

Assessment in multi-agency contexts

There was a strong message across the literature that many assessment processes within multi-agency Barnahus-type services - including the use of standardised mental health assessment tools could be applied by a range of professionals including those referred to as 'non-clinicians'. This included processes delivered by social workers, counsellors, advocates, psychologists and/or other mental health professionals. However, training and broader awareness raising among partners were identified as critical for the introduction of any tools or processes (Byrne et al., 2022).

A small number of studies highlighted the particular strength of Barnahus-type services enabling opportunities for assessment to draw more easily on evidence from multi-disciplinary perspectives including physical health examinations, forensic interviews and mental health assessments (Parker et al., 2021; Lacey et al., 2023; Harewood, 2025).

3.2 Findings from expert interviews

What is the role of assessment in the context of recovery

Reflecting evidence from the literature, interviewees identified assessment being used for three broad purposes.

- **Screening and triage** – capturing information to support initial decisions about who might need or qualify to access a service, identifying the urgency of a child's need and using this knowledge to inform prioritisation of support allocation.
- **Initial assessment** – supporting a fuller understanding of a child's experiences, circumstances and ongoing needs – to inform the exact nature of work that is undertaken with them. While the term 'initial' is used here, it was acknowledged that this process can take place over a substantial period of time (weeks or months) and may not neatly precede other early support.
- **Review progress or change** – to review a child's progress against identified goals and/or reflect and check in with them following a period of support.

There was also recognition that evidence from assessment processes (particularly those reviewing change over time) could support service development and monitoring by capturing evidence of change attributed to support. However, it was clear that this should not be the driving purpose of embedding assessment processes in services.

Experts also had different ideas about what assessment might focus on or seek to understand. There was acknowledgement that certain assessment processes may focus too much on specific mental health symptoms when what is ideally needed are questions which span both the child's internal and external world; their social, psychological and wider health support needs; involve both backward (historic) and future focused perspectives; and capture some form of a child's own hopes and goals.

Relatedly there was a strong message that professionals need to combine information about children's experiences of abuse or maltreatment with information about their wider context and subjective experience, whilst avoiding predicting recovery needs based only on the particular form of abuse the child had experienced[7].

Interviewees identified a range of different lenses through which assessment can be viewed. The list below lays out the different ways that professionals expressed the focus of the assessment. The list is not definitive, any assessment may include multiple elements and there may be overlap between the points.

- **A child's experience of harm** – the circumstances through which a child came into contact with a service – and potentially whether there are ongoing justice processes.
- **A child's (and parent/carer's) expressed needs** – including those specific to recovery – which may or may not be directly mental health related. They include wider essential and social needs such as housing, financial, educational or communication needs.
- **A child's goals or hopes for the future** – identifying a child's or family's own ideas of what they would like the recovery process to achieve.

7. This reflects the 'three E' framework (Event, Experience, Effects) cited in section 2.2, p10 – where understanding children's recovery needs may be understood through an interplay of what happened to the child (event), how they experienced the abuse (experience) and what the impact has been on their own and the wider world (effects).

- **How a child is managing to engage in daily life, also referred to as 'functioning'** – how well a child is able to do everyday things – for example getting up and dressed, attending school, engaging in social activities or hobbies.
- **Symptoms of mental health conditions** – including evidence of diagnosable conditions such as PTSD, depression, or anxiety disorders.
- **Safety and risk**– both in the child's internal and external worlds, for example, suicidality, self-harm or physical safety within their home.
- **A child's strengths and protective factors** – including both individual factors – such as evidence of resilience or self-efficacy and familial or contextual factors – such as strong relationships with supportive caring individuals or regular engagement with school or college.
- **How a child's needs may fit a specific intervention and/or need for onward referral** – sometimes, especially where only one intervention is available, assessment can be simply to see if the child would benefit from/or reaches the criteria for that intervention. Alternatively, where options are available it may involve supporting practitioners to guide children to make choices about possible interventions which they (children) may know little about.

While no one assessment process is ever likely to cover all of these, naming and identifying which are considered and recorded may provide further clarity about gaps in knowledge.

Who should be involved in assessment

There was a clear message that assessment ideally needed to involve the child and their parent or carers, with input from multi-agency professionals with relevant knowledge to share.

> **I think best practice would be involving the parent and the child in kind of regular reviews at different time points to get either together [or] separately ... being able to capture, I guess, also who else is noticing change. So even from other professionals as well in the network, from schools, getting different perspectives of is this working? (IV12)**

In addition, there was noted to be value in assessment being coordinated or led by one individual who is known to a child and can coordinate information sharing with multi-agency professionals, thereby reducing the number of times the child has to answer questions.

In the context of Bairns' Hoose, experts noted the potential and value of drawing on information collected for related purposes such as a Joint Investigative Interview.

> **I was thinking about how can we use what information we have already to help inform assessment. So for the SCIM, the Scottish Child Interview Model, there's a plan for the child's needs, which helps them prepare for the interview and think about the child and gather information about them already to help inform the interview. So I wondered if that might be a helpful starting point? (IV1)**

Who undertakes assessment

There was some limited reflection on whether specialist or clinical skills were required to undertake particular types of assessment. Overall, interviews suggested that professional's role or

discipline was less significant than their knowledge and experience of using different tools and approaches - with several references made to an ideal where professionals could choose from a range of standardised tools. However, it was clear that such tools were only one aspect of assessment and that where used, they could be applied by non-clinical professionals with the training to do so. The one exception to this was a clinician who noted a particular role for what they described as '*trauma enhanced specialists*' to assess certain trauma-related mental health needs.

How assessment is conducted

Despite different descriptions of ways assessments of children's recovery needs could be conducted, there were some broad points of consensus.

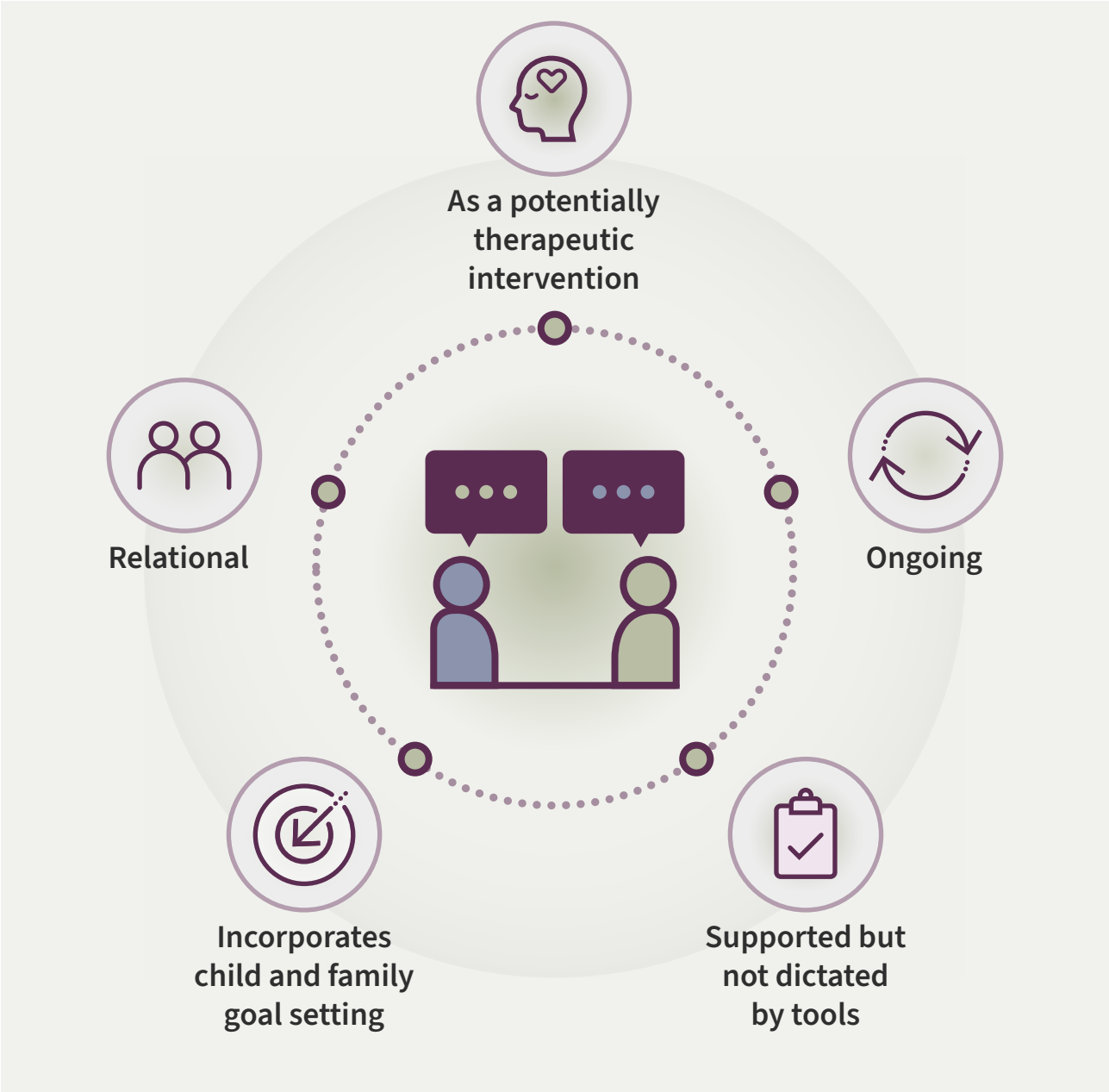

Fig 5: Points of consensus about effective assessment of recovery needs identified in expert interviews

Assessment as relational

There was a clear consensus that assessment was deeply relational – part of a process of engaging in deep listening and noticing – essentially getting to know a child more fully and understanding their needs through spending time with them and the development of a trusting relationship. It was noted that this could involve play, conversations, observations, activities, or the use of tools . The process of initial assessment was noted to 'set the tone' for later work with potential to validate, normalise, instil hope and build trust.

> **Listening carefully and working collaboratively with them to understand what are their priorities, what are their concerns and what are the goals over time (IV7)**
>
> **The basis though is … that we have that relationship established, first of all, and it feels actually safe, it feels trustworthy and that can take time … getting to know the young person before we jump into actually, 'okay, this is what we can work on together'. (IV5)**

As previously noted assessment was also recognised as a process which should combine information from a child and/or their family or carers with the practitioner's own knowledge.

> **So it's gathering and bringing together information that we can then synthesise through our own theoretical models and our own formulation to then inform how we can intervene and how we can best support. (IV12)**

Assessment is potentially therapeutic in its own right

Several interviewees observed that processes of assessment could themselves hold therapeutic benefits, supporting children and their families to feel heard, understood and validated; helping demystify trauma and its impacts; and/or providing a sense of hope by offering a first step and potential pathway of support. Equally there was recognition that it might not always be experienced in this way – emphasising the significance of relationality above any specific tool or approach.

> **I think the assessment process itself is also an intervention, though. I think there's a lot of kind of therapeutic impact of going through a process like the quality of the assessment and the relationship that can develop, the young person feeling heard, how questions are asked. I think that process in itself can be quite therapeutic, and equally, can also be more harmful in some ways, depending on how it's done. (IV12)**

Assessment as ongoing

While assessment was understood to involve dedicated processes, conversations and recording at different points in time, there was also recognition that it was an ongoing process – subject to updating in response to a child's changing needs and circumstances or willingness to share. There was a clear message that the planned timing of an assessment might not be right for a child, so 'leaving the door open' for future opportunities was also important.

> **You can only assess what they're bringing, what they bring to you. So we might think we're understanding something and only later discover – 'actually, I didn't really understand that'. (IV10)**

Assessment as goal setting

Understanding the child's perspective was considered particularly important in identifying and defining goals for recovery. Several interviewees mentioned identifying 'goal-based outcomes' as part of the assessment process that could be used to align the recovery approach to children and families own priorities and definition of needs. These tools were also described as offering a meaningful framework for children and families to assess progress.

> **Depending on the age of the child, work with the child or their family to think about what their goals could be around that indicator. Is it being in school for a certain amount of time? Is it managing only to have diarrhoea once a day? Is it being back to being included by your friends and going to the city, are we looking at that being achievable? (IV3)**
>
> **I think goal-based outcomes [is] something that we use a lot, and has been really helpful, because it also helps to capture, from a child and a parent's perspective, what it is that recovery means for them, what they're wanting to work on. (IV12)**

The use of tools to support but not dictate assessment

Across the interviews there was significant reference to and reflection on the use of standardised tools to support assessment. There was near consensus that such tools had a part to play but should only ever be one element of an assessment process and could not be relied on to 'do the work' of assessment separate from strong relational practice.

A number of arguments were proposed for the value of integrating standardised tools in assessment. These views were shared across clinicians and non-clinicians and identified within both third sector and health services. Some suggested that standardised tools were not only compatible with relational practice but could also be part of enhancing a child's sense of support.

Not just which tool to use but how to use it

The strongest message is the need to pay attention to how standardised tools are used. This meant drawing on them to enhance a wider relational process of assessment, rather than in place of it. Practitioners noted the importance of having permission to exercise discretion about their use and the timing of their use – and to be able to weave them in flexibly to an assessment process.

> **If you've got a traumatised young person and you throw them three questionnaires in the waiting room and you say, 'okay, fill those out, I'll be back in 10 minutes' they say, 'thanks very much', and you never see them again... But if you're having a chat with a young person, and you're saying, 'oh, you know, how's it going since that thing happened? Do you think about it much when you don't really want to? Oh, you do? Oh, funny you say that because I've got a questionnaire here. Look, it's only eight questions' and you show them the eight questions. I wondered, how do you feel about filling this in? ... We can do it together. We can do it in whatever way you want. (IV9)**

Standardised tools might identify concerns that could otherwise be missed

Similar to messages from the literature, interviewees suggested that standardised tools supported practitioners to identify particular challenges facing children that might otherwise be missed, thus preventing opportunities for early intervention. However, there were strong caveats that these had to be used flexibly and selectively and could never suffice for assessment alone.

> **Rapport building and relationship building is crucial, absolutely crucial – and difficult following traumatic events very often – so that's absolutely fundamental to the approach. But why would you … not weave in a simple, for example, PTSD questionnaire? An eight-item PTSD questionnaire? Why would you not weave that into that rapport building? … I would be wanting to look for PTSD, because we've got some stuff that works pretty well for that. I would be wanting to look for low mood. I would be wanting to look for anxiety. I would always caveat that with that's not the whole story. You know, I'm not only interested in PTSD, anxiety and depression. (IV9)**

The danger of tools determining the focus of support

Conversely to the point made above, two interviewees noted a potential danger if the tools used determined what type of concerns were focused on - particularly linked to an overemphasis on mental health symptoms in the absence of wider social support.

> **In my view, current assessment is far too focused on the symptoms of PTSD at the expense of other things … 'I have a treatment for PTSD and therefore it is PTSD that I will focus on'. That is a problem, but it's accompanied by a range of other mental health problems that usually make an individual vulnerable to PTSD that maybe pre-exist the trauma. (IV15)**

Standardised tools can offer structure and reassurance for children and families

A number of interviewees commented on the use of standardised tools to create a degree of structure and predictability within assessment processes which they noted some children could find containing or reassuring. There was also recognition that the use of tools and their results could help to structure conversations that could '*validate that distress is normal and natural*' - echoing earlier points about the potential therapeutic value of good assessment processes.

> **Actually, for children and adults who are traumatised when they come in … I've experienced [that to] be much more directive is really, really helpful because it takes the anxiety and the uncertainty away, this is what we're going to do, doesn't mean there's no space for them to say what they want. (IV10)**
>
> **Just because you've scored above 17 on the CRIES[8] doesn't mean I need to fix you. It means that's a blooming high score. 'That must be really tough for you?' and 'what's going to help bring that score down?' (IV9)**

8. CRIES refers to the Child Revised Impact of Events Scale which is described as 'a brief child-friendly measure designed to screen children at risk for Post-Traumatic Stress Disorder (PTSD), developed by the Children and War Foundation (Perrin et al. 2005). The tool is designed for use with children aged 8 years and above who are able to read independently' - see https://www.corc.uk.net/outcome-measures-guidance/directory-of-outcome-measures/child-revised-impact-of-events-scale-cries/ for more details.

Relatedly, the quantifiable element of tools was noted to help children recognise and understand their progress when integrated into practice as part of reflection and review.

> **And I think it's really helpful with data for young people to not just fill out the forms, but to actually see their progress. So in the end, we managed to get quite a few therapists integrating the data into the young person's journey and to see it as part of their review points. So I think to integrate the outcomes into practice is mission critical, but it takes a lot of work. (IV11)**
>
> **It's a journey of accompanying the young person for them to be able to identify what's going on – that is a crucial bit, I think, of assessment is if we can help somebody have that 'aha' moment themselves. (IV10)**

Shortcoming and limits to the use of standardised tools.

Some interviewees had noted the need for caution in the use of standardised tools, both in relation to the limits of what they could tell a professional and their potential to feel overly formalised, or offer a limited view of a child or young person.

> **You can use standardised tools for these things, but they tend to be rather clunky. And as a child psychotherapist, I find that sometimes they lack the level of detail about what a genuine experience really feels like, because the tools don't provide the means to really communicate and express that. (IV6)**
>
> **From what I've heard from young people, and this is something I've often felt, things like rating moods out of 10 and this can kind of feel very objective rather than subjective. And I understand that often this is to look at things over time and things like that, but it just, it seems a little insincere. (IV14)**

3.3 Assessment: implications for local Bairns' Hoose partnerships

Professionals in Bairns' Hoose settings need to be aware that effective assessment is relational, integrated, ongoing and must centre the child's perspective and agency in this process. While there are different understandings of, and roles for assessment, a number of key learning points, supported by literature and expert interviews, may serve as a helpful basis for developing local assessment processes.

- Clear processes need to be in place within the Bairns' Hoose for screening, assessing and measuring progress towards meeting children's needs. These processes should be relational, holistic, and not restricted to a single point in time.
- 'Assessment' may mean different things to different professionals within a multi-disciplinary team. When deciding how to use and undertake assessment in Bairns' Hoose, it is important to provide clarity about the purpose and scope of these processes (i.e. what is and isn't being assessed and by whom).

- Relational assessment involves deep listening and noticing, and takes place over time. Staff responsible for assessment need skills, time and capacity to build a relationship with a child as a means of coming to know a child's needs and world.
- Integrating goal-based outcome setting into assessment processes provides a valuable means of centering children and families' own priorities and expertise in decision making.
- There appears to be consensus about the value of some standardised assessment tools within Bairns' Hoose, but professionals need skills, permission and confidence to use them flexibly, and the knowledge to understand why and when different tools may be useful. Such tools can never supersede the value of strong relational practice.
- Assessment processes (including use of standardised tools) may be completed by both clinicians and non-clinicians. Services need to decide which people or person, from which agency, will lead on an assessment of a child's recovery needs and if this will be the same for every child. Flexible, child-centered application of these processes while require a degree of practitioner knowledge about different tools and their relevance, supported through training.
- When introducing new or shared assessment processes within Bairns' Hoose there will be a need for multi-disciplinary training to build confidence and common understandings and practice.
- Assessment cannot be a one-off process. Processes for follow-up assessment should be in place to respond to changing or newly emerging needs and to ensure opportunity for reviews. Relatedly, consider how assessment, review and outcomes can be intentionally and helpfully linked. For example, consider whether Bairns' Hoose assessment practice provides a baseline and a means for identifying and reviewing individual children's progress towards specific goals.
- Assessment processes should embed principles of ecological thinking and multi-disciplinary working. This means recognising that for some children, significant assessment work may already have been undertaken and hence drawing on information that has already been gathered (for example, Getting it Right for Every Child - GIRFEC[9]). It also means seeking input from wider professionals and contexts significant to the child and family (with their consent) such as school, health or other services, while also ensuring children's and families' perspectives remain central. When drawing on information about a child from different sources, professionals also need to consider the implications for consent, privacy and data protection and how these will be managed.

9. GIRFEC is described as both an approach and framework used by services across Scotland to improve and uphold the wellbeing of children and their families. It includes eight wellbeing indicators (referred to as SHANARRI) . These are: **Safe, Healthy, Achieving, Nurtured, Active, Respected, Responsible, Included** and used to help understand a child or young person's wellbeing at a given time. See https://www.gov.scot/policies/girfec/ for more information.

4. Intervention: how can we support children's recovery?

> **The risk when we're working with children with abuse and traumas, by the nature of trauma, it can fragment different parts. And I think there's something about each of us holding different roles and the importance of that, but how we also integrate and work together to bring all of the parts of the child together again. (Interview 12)**

This section focuses on recovery interventions used to support children and their families after abuse and maltreatment. The literature provides insight into the range of different interventions used in Barnahus-type services. While individual pieces of evidence explore issues of efficacy for specific interventions with specifc groups of children, this is not the focus of this report – given the limits of comparability across studies. Expert interviews provide additional insight into key principles and elements of support that span different models and interventions.

4.1 Findings from literature

Evidence from different Barnahus-type services shows highly variable approaches to recovery support, with no consensus on any single 'preferred' model. This also reflects the limited evidence about the efficacy of different forms of support.

> **"Despite widespread Barnahus across Europe, there is limited evidence of the effectiveness of therapy and variations in therapeutic approaches." (Harewood, 2025:5)**

Engagement in support

Several studies noted the challenge of engaging children in recovery support, with evidence that sizeable minorities (up to 40%) of children who are offered therapeutic support do not engage or sustain engagement with it (McPherson et al., 2012; Whaling et al., 2020; Schreier et al., 2022; Mori et al., 2025).

> **A high proportion of children that have access to evidence-based treatments drop out or intermittently attend treatment sessions (Eirich et al., 2020)**

This highlights how even before considering *what* forms of support to offer children it is important to think about *how* it is offered and how engagement will be sustained.

A number of articles draw attention to the fact that children with higher levels of 'protective factors' (such as parent or carer support) are more likely to engage with support and, therefore, are those most likely to benefit from professional support (Ibid). This is described in one article as a process of '*cumulative advantage' and* suggests the value of Barnahus-type services undertaking work to bolster children's wider protective factors alongside more targeted mental health support.

Protective factors are noted to include: support from parents and carer, educational involvement, peer support and existing social and coping skills. Meanwhile older children and those with learning disabilities were noted to be less likely to engage in therapeutic support (McPherson et al., 2012; Schreier et al., 2022).

Relatedly a number of factors associated with service design or parental circumstances are noted to support or inhibit children's engagement with forms of recovery support. Factors mentioned that support children's engagement include: a named single point of contact in services; models which require active parent or carer involvement in support; and integrated recovery support services provided on-site rather than referral to outside services (McPherson et al., 2012; Schreier et al., 2022). Conversely, barriers to engagement appeared to include therapeutic services that required an onward referral, practical challenges for parents to engage with support (e.g. scheduling of appointments), and/or their perception that their child didn't need or wouldn't benefit from support.

What? Different broad types of intervention

There are a number of distinct interventions referenced in the literature targeting children and families' psycho-social recovery needs. For the purposes of this report we have grouped them into three broad 'types' differentiated by the focus of needs that they target. These are outlined below. Note that in some services two or more of these 'types' of interventions were present.

i) Approaches targeting mental health symptoms

The most commonly mentioned interventions were a broad range of mostly manualised therapeutic approaches (or 'modalities'), delivered within (or linked to) Barnahus-type services. Access to these models was sometimes based on diagnosis. Across studies included in this review, play therapy (n=1510) and trauma-focused cognitive behavioural therapy (TF-CBT) (n=14) were the interventions most regularly mentioned as part of a recovery service offer. Other therapeutic interventions evident being used in more than one Barnahus-type service included psychotherapy (n= 8), art therapy (n=6), child and family traumatic stress intervention (n=4), Eye Movement Desensitisation and Reprocessing (EMDR) (n=3) and systemic family therapy (n=2). These approaches were often referred to 'evidence based approaches' and appear to be heavily informed by psychology, psychotherapy and psychiatric traditions.

ii) Approaches targeting broader psycho-social needs

Other examples described interventions that focused on needs beyond individual mental health symptoms and focused on the interplay between emotional wellbeing, familial and social circumstances. These were less likely to follow a specific named or manualised therapeutic approach but formed a significant element of many Barnahus-type recovery service offers. These tended to draw on ecological and/or systemic perspectives with support models informed by a mixture of social work, counselling, youth work and gender-based violence practice skills (Whaling et al., 2020; Mitchell et al., 2024; 2025).

10. n=15 refers to the number of distinct pieces of evidence that mention this approach reflecting a unique service. This means that where more than one piece of evidence is referring to the same Barnahus-type service this has only been counted once.

iii) Approaches focused on reducing potential systems harm - advocacy and 'interstitial' work'

Advocacy work was a highly prevalent aspect of service offers mentioned across the literature. Sometimes advocacy appeared to be integrated and conceptualised as part of the therapeutic offer –including references to advocates leading screening or initial assessment processes. At other times it was described as separate – focused on supporting children and families to engage with other therapeutic services and/or to understand and navigate systems. One Norwegian study described the importance of '*interstitial*' support work, referring to tasks professionals did "*to identify and compensate for the gaps in the system that the child must have to deal with after the police report to improve care and improve connection*" (Andersen, 2019 cited in Andersen, 2022:1039). This closely mirrors descriptions of a core component of the Advocacy Rights and Recovery workers' role in some Scottish Bairns' Hoose, which includes '*buffering children from systems harm*' (Mitchell et al., 2024) (also see Herbert and Bromfield, 2020). There was also evidence of a distinct form of advocacy support focused specifically on supporting children and families to navigate criminal justice processes, ensure their rights were upheld and intensive support was available through court processes (Ibid; Parker et al., 2021).

Integrating and adapting different forms of support

A number of studies described Barnahus-type services providing support through what were described as adapted interventions, integrated modalities or multi-modal approaches. Essentially this appeared to mean either adaptations of manualised approaches to tailor them to individual children and/or therapeutic support offers that drew on a range of different models of intervention. Examples given included adaptations to undertake TF-CBT in more age-appropriate and creative ways, using story books, visualisations and crafts; or extending support beyond the standard time frame of an intervention; and/or incorporating additional therapies such as EMDR alongside other modalities and/or social work and advocacy approaches. Evidence from two studies highlighted evidence of the efficacy of adapted approaches (Herbert and Paton, 2024; Dovi et al., 2022; Lucas and Saunders, 2014).

Where? On-site versus onward referral or 'linkage' models

Therapeutic support was described as being provided on-site at Barnahus-type services and/or through referrals to wider community resources (sometimes described as 'linked services'). These two models were often combined with community support following an on-site assessment and screening. In other cases, community support was drawn upon for longer-term support after children and their families accessed a short-term support intervention on site (Lacey et al., 2023). There was recognition that the linked service model relied heavily upon the existence of good trauma treatment in communities – and also that onward referral was associated with attrition.

Who? Support delivered by professionals from diverse disciplinary backgrounds

The literature shows varied configurations of staff teams. These include different professions delivering different aspects of a 'recovery' or therapeutic service, for example, therapeutically trained social workers delivering mental health provision and/or advocacy or clinical staff providing support and oversight to other professionals and/or direct therapies. The evidence reviewed suggested that often access to training, accreditation and ongoing supervisory support were more important than a specific disciplinary background.

When? Timing and duration of support provision

Different approaches to timing and duration of recovery support were described.

- **Value of early intervention:** Several studies noted the particular value of children and parents/carers' access to early help and its association with minimising distress and preventing worsening mental health (Thulin and Kjellgren, 2017; Hahn et al., 2019; Lacey et al., 2023; Shepard et al., 2024). This would suggest the value of models that enable access to support as soon as possible after disclosure or a forensic interview.
- **Desire for short- and long-term options:** A scoping study to inform the development of a national Barnahus therapeutic model noted professional consensus about the desirability of offering both short- and long-term provision. However, the implementation phase of this project also noted how resourcing limitations affected how this offer was delivered (Lacey et al., 2023).
- **Length of support framed by legal processes:** Another study noted that ideally access to support should extend at least for the duration of any court processes (Harewood, 2025) while another study highlighted potential limits on the impact of support until a child was beyond court processes (Mitchell et al., 2024).
- **Structured approaches:** Therapeutic approaches based on a manualised approach ranged from offers of six to about 24 sessions, depending on the approach, though many highlighted opportunities to tailor or extend the number of sessions offered in response to need (Herbert and Paton, 2024).
- **Opportunities for therapeutic 'booster' sessions:** One study/model suggested the value of opportunities for children and families to access 'booster sessions' following completion of support or treatment, enabling them to return for an additional five sessions and some ongoing assessment to check if needs had changed (Dovi et al., 2022).

Evidence for potential critical elements of support

Across the range of approaches identified within different Barnahus or Child Advocacy Centre models, a number of overlapping elements or components of support were described that were cited as desirable or necessary to be able to offer children and their families after an experience of abuse or maltreatment. Interestingly these components represented commonalities spanning very different types of support but yet these similarities were sometimes masked by the use of very different language to describe them.

It appeared that not all of these components were considered necessary for all children – but their availability to provide as an offer may be critical in services committed to addressing children's recovery needs. Elements include:

Safety and stabilisation work

Multiple pieces of evidence stated that work to help a child feel safe, calm and contained was fundamental to recovery support. Descriptions reflected that this work could span physical safety (e.g. supporting a child's access to safe housing – or becoming safely embodied) (O'Keefe and McElvaney, 2022; Mitchell et al., 2024); relational safety (e.g. building a trusting relationship

between a child and professional through which more support could be offered) (Ibid) or emotional safety (e.g. supporting a child to more easily identify and regulate their feelings of anxiety or fear) (Hahn et al., 2019). It was also noted that the efficacy of this work often depended on children's and families' wider circumstances. Contexts that continued to distress and destabilise children – such as anticipation of testifying in court or continued proximity to the perpetrator - were shown to undermine the impact of therapeutic inputs (Elmi et al., 2018; Tener et al., 2020). In these circumstances support which targeted these ssues was likely to prove more of a priority than any specific clinical approach.

Parent/carer support

Support provided for parents and carers includes both support to enable them to better tolerate and respond to their children's distress and/or support for their own needs and prior experiences of trauma. This support was delivered in different ways, including individually, in groups, in joint sessions (parent and child together), or in separate parallel sessions from children. Various combinations of these formats were described (Thulin and Kjellgren, 2017; Haar, 2020; Parker et al., 2021, Dovi et al., 2022; Lacey et al., 2023; Mitchell et al., 2024). Active parental involvement was also noted to increase the likelihood of children's engagement with support, reducing the chance of drop out (McPherson et al., 2012; Eirich et al., 2020).

Understanding and managing difficult thoughts and feelings

This was described as a central aspect of many interventions – variably described as *affect identification, emotional or affect regulation; modulation training* or *mentalisation work* – but also apparent in non-clinical social work approaches where it was described in lay-person terms. Primarily the focus of this work was helping a child or parent recognise different feelings or emotions; including through their physical impact; find ways to name and make sense of those feelings; and use this as basis to be able to better manage (or regulate) them (Lucas and Saunders, 2014; Thulin and Kjellgren, 2017).

Psycho-education

This term appeared to cover a broad range of activities, some of which appear to overlap with interventions that seek to understand and manage difficult thoughts and feelings. Activities involved sharing knowledge to help children and their families better understand, make sense of and respond to what had happened to them, including through understanding the contexts and dynamics of abuse and concepts like consent. It could include support to help children understand impacts of trauma, challenge unhelpful narratives such as victim-blaming or self-blame, and counter stigma (Lucas and Saunders, 2014; Thulin and Kjellgren, 2017; Dovi et al., 2022; Harewood, 2025; Read and Parker, 2025).

Trauma-specific work

The element that appears to rely most heavily on specialist professionals with appropriate clinical training, accreditation and supervision was trauma-specific work, which encompasses a range of interventions that broadly fell under the category of *trauma exposure work, processing work* and/or *developing a trauma narrative*. It includes work to support children and parents or carers to tolerate memories of traumatic experiences and help them process these memories to

prevent them causing continued distress or symptoms such as flashbacks or dissociation (Lucas and Saunders, 2014; Wherry et al. 2015; Thulin and Kjellgren, 2017).

Practical support

This included work to help address children and their families' basic needs and engagement with wider opportunities. It could include support to access other resources through onward referral or attending meetings together with children and family members or liaising with other agencies. It might also involve help for children and families to pursue goals and engage with a range of community-based activities and support. While this work was rarely described or understood as being therapeutic, the activities described which strengthen children's safety and stabilisation and sense of reconnecting with wider life clearly aligns to a phase based model of trauma recovery which is commonly considered to comprise of three 'phases'. The activities included in 'practical support' fall under both phase 1 (safety and stabilisation) and phase 3 (integration and growth)(see figure 8).

Advocacy (see also section 4.1.2 above)

Advocacy is a broad term used variably across the literature. It appears to primarily reflect the work of a single named point of contact who supports children and families to navigate through services and systems including through representing their views to other professionals. A subset of specialist court advocacy work was described to help children navigate legal processes and ensure their rights are upheld within these processes.

Collective participation and peer support opportunities

Examples of Barnahus-type models in England and Scotland and a multi-agency child sexual exploitation service in the US highlighted the value of group work including youth advisory or participation groups that informed the ongoing development of services and policy. Often these groups or activities were positioned as opportunities for children and young people to 'move on' from their role as service user and adopt new, more active roles in relation to services, develop skills, and access peer support (Whaling et al., 2020).

Figure 6: Eight critical elements of Barnahus recovery support identified in literature

4.2 Findings from expert interviews

Analysis of expert interviews highlighted a number of key practice principles that spanned diverse interventions and disciplinary perspectives. Strong messages were also given about the value of advocacy work alongside or integrated with explicitly therapeutic practices- supporting children and families to navigate complex systems – often acting as conduit to share information with children and families from services and vice-versa .

> I think it's a multi-agency approach where you have workers who are navigators – the people that help families navigate, help children navigate, the journey of repair. (IV8)

The need to focus on principles rather than a single named approach

Although a wide range of different therapeutic approaches were named (often referred to as 'modalities') the overarching points of consensus were not about any single approach but principles and components which spanned a range of these modalities. Analysis of the interviews identified six distinct – but overlapping - principles, characterised as critical for effective recovery support for children who had experienced abuse or maltreatment. These were principles or approaches mentioned by a strong majority – or in some cases all – experts interviewed, regardless of discipline. These are explored in detail and summarised in the figure below:

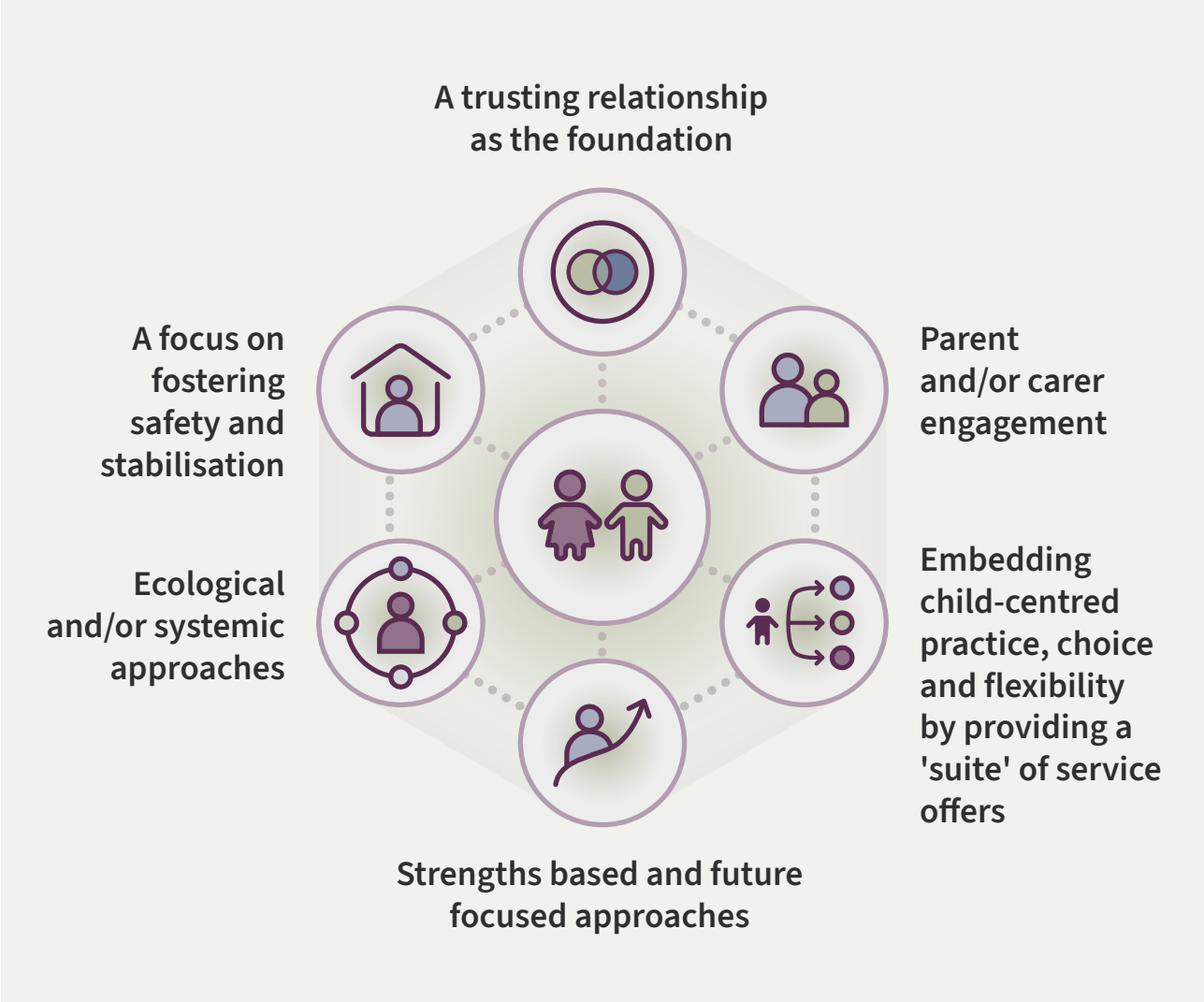

Fig 7: Six principles or components for effective recovery support identified by expert interviews

Principle 1: A trusting relationship as the foundation

The development of a trusting relationship between a child and a professional was cited by all as the fundamental basis for providing any form of effective support to children, whether it be through clinical, psychosocial, practical or advocacy interventions. Relational practice is recognised as therapeutic in its own right, through offering relational and emotional safety and modelling positive attachment and reciprocity.

> **Human beings learn from other human beings. You have to trust the person that you're learning from. Unless you trust that person, you learn nothing from them – and you have to address the mistrust. What we call epistemic mistrust that traumatised children and adults often have... So, unless you focus on re-establishing social trust, you find it quite difficult to impact on things other than this. (IV15)**

Trusting relationships were also explained as the basis through which a child's needs come to be more fully understood and a means through which the child might access a range of different forms of support. Interviewees repeatedly emphasised that the nature of an intervention (*what*

was offered) was less important than its grounding in strong relational practice and trauma-informed principles (*how* it was offered).

> **That sort of really honest kind of trusting relationship forming is the only way... one-to-one time offered in a private sort of setting is usually the kind of backbone, I think. Talking, listening is the sort of most important theme that might take the shape of baking a cake or playing with some toys or going for a walk. But I think that allowing a young person to speak and helping them speak. (IV4)**
>
> **It has to be somebody they can trust, right? So trust, reliability, doing things in a timely way, being affectionate, but boundaried, being able to be on their side and by their side... good companionship in a way which lifts the young person up. (IV18)**
>
> **I think the core components across all a lot of the research says it's about the therapeutic relationship, first and foremost. I think it's developing a relationship with a professional that you can trust, and that offers a sense of safety if you're able to speak to and get support from (IV12)**

Principle 2: A focus on fostering safety and stabilisation

Fostering safety and stabilisation is the starting point for interventions; it may provide a precursor for more in-depth trauma processing work, or may prove sufficient in itself. Safety in this context refers to physical, relational and emotional forms of safety and so may include (for example) efforts to support placement or housing stability, improved family functioning and/or the ability of a child to better regulate or manage their feelings. Interviews also referred to the value of framing recovery support within the phased-based model (Herman, 1992), reflected within Scotland's own Trauma Transformation Programme (NES, 2017). This model presents a simple phased based trajectory for trauma recovery starting with the development of safety and stabilisation, to processing and integration of trauma, to reconnection with everyday life. Interviewees were clear, however, that movement between these phases may not be linear, that not every child needs all three stages, and that Bairns' Hoose may only be able to formally deliver stage one, with referral pathways for stages two and/or three.

Interviews also highlighted that the potential for change may be limited for children whose circumstances remain chronically unsafe or whose experience of safety is further undermined after beginning recovery support – for example through having to testify in a court process.

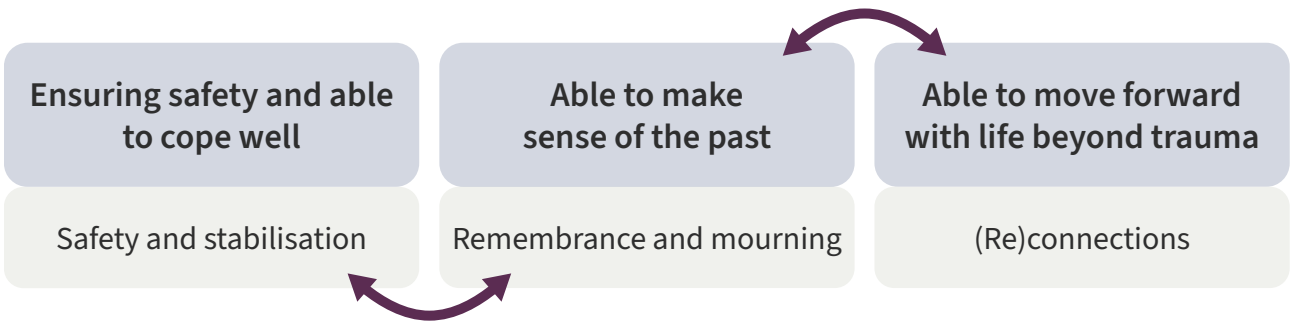

Figure 8: Herman (1992) 's phased based approach to recovery, adapted from NES (2017)

> **Before any direct interventions are offered to children and different workers thrown at them, [it] is [about] the stability of their safety network where they're living, and it's shoring up the people who are caring for them to help them to understand what their behaviour is communicating. (IV17)**

Principle 3: Parent and or carer engagement

There was absolute consensus that support to parents and carers was '*mission critical*'[11], recognising that for most children, families are the most significant context through and in which they access recovery.

> **Children are never in a vacuum; they always come with loved ones or safe ones... It's about the whole system because it's impacting everyone and then actually supporting people who are the safe people who are loving, caring people can bring more benefit to the child or young person. (IV7)**

Support to parents and carers was noted to play a number of overlapping roles. These include:

i.) building carer capacity through psycho-education; helping them better understand and respond to their child's needs. This also means that parents are supported to recognise themselves as a central resource in providing recovery support to their child and family.

ii.) supporting carers to tolerate their child's distress which can in turn minimise or prevent family rupture

> **Often with children who've been traumatised, it can be extremely painful and distressing for the people caring for them. And I think the impact on their carers can be really underestimated. So you see really traumatised children experiencing multiple placement breakdowns, then moving from pillar to post and it just adds to the trauma. (IV17)**

iii.) identifying and responding to parents' or carers' own needs including responding to any unresolved trauma.

> **Also allowing parents and young people a bit of space just to sort of unravel – so it's the pacing of those parts that are really important. They need that space to just go, 'oh, this is horrible' – and just actually take a moment to let it all out before we start putting it back together. (IV5)**

iv.) reducing the burden on children, who feel responsible for the impact of their disclosure on those who care for them. This reflects the observation that children often worry more about their parents than themselves.

> **Only 40% (of children) wanted therapy, but they would come through the door often asking us, 'Well, I'm here, but actually what I really want is support for my parents or carers. They're really struggling with this right now...' So we built one-to-one parent work, and then parent groups, and that led parents to set up their own services for other parents and carers. (IV11)**

11. Interview 11

v.) Building parent or carers own trust in, and knowledge about, available services as a means of supporting children to trust and access services.

Principle 4: Ecological and/or systemic approaches

Ecological or systemic approaches reflect the need to intervene beyond the child's internal world and interact with their family and social context. Interviewees recognised that trauma has the potential to affect all aspects of children's lives – and thus requires responses that reflect that. There was strong support for the need for responses that span both psychological and social interventions including family work (hence 'psychosocial') and also health. This meant drawing on a range of skills and disciplines including social workers, education professionals, clinical mental health practitioners and paediatricians.

> **If a trauma service is... not linked to education provision, we are not linked to social justice provision... not linked to the voluntary sector more broadly ... If a trauma service... can't link the child to a soccer team, they're useless as far as I'm concerned, because that child will benefit by being with other kids who also play great soccer and will feel they belong and will survive. (IV15)**

Such approaches were noted to have a critical role in supporting the sustainability of support beyond service engagement - transitioning children from reliance on professionals to reliance on support from family, friends, and community. However, there was also recognition that a child who returns to an unchanged traumatic context will not sustain any therapeutic gains.

> **Trauma might happen in isolation, but healing is happening in community. (IV7)**
>
> **It's really important for them to feel that they can move away from the mechanical scaffolding that's provided by welfare services to the organic scaffolding that's available in community, friends and family. The type of scaffolding must change over time from the mechanical to the organic. (IV18)**

Principle 5: Embedding child centred practice, choice and flexibility through providing a 'suite' of service offers

It was widely recognised that child-centred practice depends upon flexible and responsive services that offer a choice of approaches to respond to a range of needs and circumstances.

> **Flexibility and person-centred approaches to therapy and counselling are mission critical for children and young people, and then around the outside, we definitely need systemic family practice. (IV11)**

A majority of interviewees referred to the idea of a 'suite' or 'toolkit' of therapeutic interventions with flexibility to draw on a number of traditions to match need. There was no clear consensus about what a minimum suite of offers should be, but there was acknowledgement of the value of: individual and group-based approaches; approaches that required verbal communication and reflective skills and those that didn't (such as art, nature-based or play therapy); approaches to respond to social and psychological needs; support to parents or carers; alongside inclusion of offers such as engagement in activism or participation groups.

Beyond this there was acknowledgement that standardised or manualised approaches could play an important role for some children. Several approaches were acknowledged, with TF-CBT recognised to have a particularly strong evidence base for responding to PTSD, anxiety, and low mood. However, most interviewees emphasised that i) such approaches should not be offered in isolation and/or ii) they might need to be applied and tailored in individual ways. It was also noted that formal or highly structured practices may not always be comfortable or appropriate for individuals whose boundaries had been violated.

> **We have our own little toolbox of skills that, you know, CBT might be in there, but other components of what we've picked up through experience or through learning that can work. (IV5)**

It was also acknowledged that managing high levels of choice and flexibility in provision can present significant challenges for those resourcing and managing services, requiring individual practitioners and those supporting them to hold relevant knowledge and skills.

> **It's a skill to marry the person, parent, child, young person in front of you and the evidence of what might work. (IV5)**

Principle 6: Strengths based and future focused approaches

Several interviewees highlighted the need to avoid rescue or ' salvationist' approaches – emphasising that children and young people don't need to be 'saved' but do need someone to accompany them while they make choices, move forward and are enabled to 'unlock' their own expertise and potential. This aligned with an emphasis on models which recognise and work with children and young people's strengths, goals and passions.

> **We tend to view children as participants in our services, but actually we are in their life for a fraction of a second. It's the other way round, where we are participants in their healing journey. (IV11)**

Such approaches were viewed as part of countering the loss of control that characterise victims' experiences of trauma and abuse, and also as means of helping children re-engage or connect with the wider world, reclaiming the sense of normality or 'safe ordinariness' described in chapter 2 of this report. Furthermore, as well as building skills, opportunities for activism, participation and youth leadership were also noted to have potential to be therapeutic in their own right. Opportunities for fostering peer support and connection to others with shared experiences were identified as a significant enabler of change – countering isolation and providing solidarity and support that could outlast traditional interventions.

> **They're waiting for their potential to be realised, to be contributors, to feel alive through giving back to people. (IV18)**

Timing, duration and pace of interventions

A number of clear messages emerged relating to timing, duration and pace of interventions.

Value of models with flexible duration and pace. As noted earlier, recovery is recognised as non-linear, and often a life-long journey. Flexibility to adjust timing and intensity of support was seen as aligned to the principle of child-centred practice. Some people voiced an ideal of open-ended support that could shift gears or intensity in response to the ebb and flow of children's needs. Furthermore it was acknowledged that an initial offer of recovery services might not coincide with a child or young person feeling ready or able to take up support. One interviewee reflected that children '*need to be allowed to forget*'[12] and that their choice to avoid thinking about difficult things is a valid response that can be protective and should be respected. However, there was also recognition that high levels of flexibility and open-ended service offers can present challenges for managing resources.

Short-term vs long-term support. It was noted that for some children. short-term support may be all that is required - while recognising that for many others short-term support held more limited value: '*[it] doesn't touch the sides for some children*'[13]. Access to longer-term support was seen as important for many children who had experienced abuse and maltreatment and models (such as England and Wales' Children's Independent Sexual Violence Advisors (CHISVAs)) which extended alongside the duration of any court case were highly valued. Opportunities for longer-term support were noted to be particularly important for learning disabled children, with whom work often progresses at a much slower pace. There was also noted value in mechanisms that enable children and families to step down the intensity of support but maintain longer-term engagement. Overall, the consensus appeared to be that the length of support should be determined by children's need rather than constrained by a model.

Endings. Knowing when to end an intervention was noted to be a source of anxiety for practitioners, who may worry about both creating dependency or leaving children unsupported. However, endings were also noted to provide opportunities to share valuable messages with children about how far they'd come and to hand back responsibility for support to parent/carers – so long as they could be properly managed and were gradual.

Where possible, leaving the door open for children and young people to return was seen as highly desirable, with the message 'you can come back' framed as a powerful tool in helping to contain children or families' anxieties. Ensuring that endings did not involve a hard stop was also part of demonstrating that relationships were authentic, enabling workers to check in with children on significant days or difficult anniversaries.

Adapting approaches to meet the needs of different children

Despite the clear significance of individually tailored approaches, and avoiding assumptions about children's needs, some patterns for adapting interventions linked to aspects of children's biography or identities did emerge from the interviews and are summarised below.

Age: Adapting processes for developmentally younger children was noted to rely on creative, play-based and child-led approaches which are less dependent on verbal approaches. It is important to adapt language and social communication to developmental stage rather than chronological

12. Interview 8
13. Interview 8

age. Younger children are also often more reliant on support through work with their parents or carers – often in joint sessions. For older children (adolescents), provision of sessions separate from their parents or carers was equally important - enabling them to inform whether and how they'd like their parents or carers to be invovled.

Learning disabilities and neurodivergence: For children with learning disabilities, there was strong support for the use of therapies which did not rely on talking alongside the value of non-clinical spaces. This work was also recognised to be slower, involving more preparatory work such as the use of Makaton video introductions, and resource development. For some neurodiverse children, certain therapeutic approaches were considered unsuitable, such as narrative therapy or those relying on metaphor.

Gender: Some noted the need to recognise potential additional barriers for boys engaging in recovery work and the value of boys connecting with other male survivors of abuse. However, it was also recognised that male and female survivors often have more in common than not.

Ethnicity or culture: Suggestions for working with children of different ethnicities, cultures and communities included the importance of translating resources, working with interpreters, taking time to learn about a child's family and culture, and drawing on games, music and toys they could relate to. Culturally sensitive approaches which take account of culturally associated shame, stigma and guilt were also noted, alongside acknowledgment that western ideas or narratives of trauma may not always fit other cultural contexts.

4.3 Interventions: implications for local Bairns' Hoose partnerships

Professionals in Bairns' Hoose need to be aware that there is no single therapeutic approach that holds the key to effectively supporting children's recovery after violence or abuse. Instead, the ideal of child-centred practice means creating conditions to offer a flexible model of provision, which reflect evidence of effective practice principles and offer a suite of interventions allocated on the basis of the child's needs and preferences. Key 'effective practice' principles span different interventions and are outlined below:

- Establishing and sustaining trusting relationships with children and families is foundational to enabling engagement and providing effective recovery support. It can, in itself, be therapeutic. Staff must therefore be given time and capacity to prioritise relationship-building as a core component of delivering any intervention.
- Effective recovery support must include support for parents and carers, and ideally siblings. Support to parents and carers may involve strengthening their capacity to support their child while also addressing their own support needs.
- Interventions should ideally be able to offer a degree of flexibility in relation to the length of a child's engagement, including the timing of initial engagement and potential for re-engagement at later stages, and different intensities of support.
- Stabilisation and safety are vital components of any support and established through both the child's internal and external worlds. Therefore, including resources to address

contextual issues facing children and their families, such as social isolation, housing, education, physical and sexual health concerns, will be essential to enabling their capacity to recover. Addressing children's needs for social (re) connection is also important, for example through re-establishing links to education, interests, community and peers.

- Specialist victim advocacy work to support children and families navigate justice processes appears integral for supporting and promoting recovery where court processes are part of a child's experience.
- How endings are anticipated and planned for should be considered from the beginning of any Bairns' Hoose intervention. Ideally, this should include opportunities for children and families to reconnect with support at a later date if required and particularly in the context of future court engagement.
- In recognition that a lot of a child's recovery will take place, or be facilitated by, factors outside Bairns' Hoose, there is value in comprehensively mapping and developing links with wider networks of statutory and voluntary sector services. This will include clarifying how referrals or information-sharing between Bairns' Hoose services and wider services will be operationalised.

5. Implementation: what factors help make recovery support happen

> **What I like about Bairns' Hoose is the approach that allows us to draw on those different services – almost knocking down the walls that exist between them all – and making sure that the child and their family have support from all of them. (Interview 4)**

This section identifies implementation considerations for recovery interventions in Barnahus. The literature identifies both strengths of multi-agency working to support service implementation and the challenge of realising the most desirable model of support in contexts of limited resources. Expert interviews draw out wider issues including the importance of paying attention to context, support for the workforce, and the need to identify shared recovery outcomes for Bairns' Hoose.

5.1 Findings from literature

The rapid evidence review identified three key themes in relation to implementation of recovery support in Bairns' Hoose: funding and managing resources, multi-agency working, and workforce development and support.

Funding and managing resources

Evidence reviewed suggested that many funding structures for recovery support within Barnahus-type services were often inadequate and/or misaligned with trauma-informed, prevention-focused care. This message appeared across different models and jurisdictions (Schreier et al., 2022).

Despite a strong consensus that access to integrated therapeutic and mental health support was an essential or highly desirable aspect of Barnahus-type services, the literature shows that this is not always available, with some services relying on 'linked service' models requiring onward referral after a Barnahus-based screening or assessment. A Swedish study suggested that health, including therapeutic support, was often given less priority and investment than justice or child protection services (Goransson et al., 2022), reflecting findings that internationally there has been less interest in children's wellbeing outcomes compared to justice outcomes within Barnahus-type services (Westphaln et al., 2021).

Several articles noted the challenge of services deciding on the scope of recovery support within Barnahus or Barnahus-type services in a context of limited funding (Herbert and Bromfield, 2020; Lacey et al., 2023). Decisions were noted to be too often led by resourcing limitations rather than what was seen as the optimum offer for children and families. This reflected the difficult balance between delivering a 'gold standard' of care to an individual child without undermining accessibility of the services to wider groups of children and families. As a professional cited in Herbert and Bromfield (2020) notes:

> **We're not going to have this wonderful service for families if we carry on providing [this level of] support for every single person. (652)**

Findings from a report on the development of the Barnahus therapeutic offer in Ireland (Lacey et al., 2023) highlighted the real challenge in balancing implementation of an ideal recovery model with available funding. This resulted in providing a mixture of support from in-house and onward referral services and prioritising early intervention.

> **The consensus among those involved in developing the framework is that due to limited resources and the need to maximise timely access to Barnahus services, a short-term therapeutic intervention, drawing on models such as Trauma-Focused Cognitive Behavioural Therapy would be optimal as a first response. (2023: 26)**

As previously noted there was a strong message across the literature that the ideal recovery offer had a strong degree of flexibility enabling individually tailored, integrated or multi-modal recovery support. However, managing the resources to support this was noted to be challenging. Challenges with integrated models included maintaining clinician training and competence across multiple therapeutic approaches and ensuring sufficient supervision and support (Herbert and Paton, 2024). Other studies noted challenges associated with determining reasonable caseloads and time frames for assessment and support (Krushas et al., 2023). One study from Norway noted that the highly valued dynamic social work practice (which responded to gaps and shortcomings in children's experiences of justice and welfare systems) was only possible because staff had the permission to adapt their practice to individual children (Andersen, 2022). Similarly, there was noted to be tension between highly regulated practice or strict application of evidence-based practices and the needs of diverse children.

A related challenge was cited to be managing resources to ensure services could adapt to the needs of children with different or additional needs, including those with learning disabilities or neurodevelopmental disorders, those who are multilingual, and children living in rural areas (Dovi et al., 2022; Harewood, 2025). Consequentially there were noted to be real risks that the needs of certain groups of children were less well met.

Multi-agency working

Both the value and challenges of multi-agency work were strongly represented in the literature. Strategies noted to support multi-agency working included joint training and co-location which was noted to enable better cross-disciplinary trust, understanding, information-sharing and improved decision-making (Dovi et al., 2022; Mitchell et al., 2023; Harewood, 2025; Mitchell et al., 2026).

Some particular challenges were noted with multi-agency working across internal and external partners: those working in different buildings; and/or statutory and third sector partners. These divisions were noted to reflect different systems, definitions or standards; professionals working with distinct mandates and funding restrictions; and different disciplinary philosophies (Krushas et al., 2023).

Workforce development and support

Several articles highlighted challenges facing staff providing therapeutic or advocacy support for children and families in Barnahus-type services. These underlined the critical need for robust staff support structures. Particular risks cited included secondary trauma of those providing counselling type services, burnout and subsequent challenges with staff retention and absence (Dovi, 2022; Krushas et al., 2023; Madray and Tinnie, 2025). Mitigating responses included robust training (Lotty et al., 2026), and balancing caseloads and maintaining adequate staffing levels with qualified and supported staff (Madray and Tinnie, 2025).

5.2 Findings from expert interviews

Value of longer-term funding

Safe, trusting and reliable relationships were widely understood as the foundation of recovery support. However such models were noted to require long-term, consistent funding that ensures secure staff teams are in place to deliver them.

> **I don't understand how the funding can run for a recovery service on a yearly basis, because how can you establish a service and be confident – and let people know that you will be around – when you cannot say that? (IV7)**

Additionally, commissioners who focus only on funding therapeutic services for a child, without including resources to support parents or carers, advocacy and group work was noted to lead to significant gaps in provision.

> **If parent work was just always seen as a necessary part of funding for children's services, that would make a big difference. (IV10)**

Multi-agency working as a fundamental strength requiring investment

There was a strong consensus that no single agency can hold responsibility for supporting a child's recovery journey and that multi-agency working was the greatest structural strength of Barnahus or Bairns' Hoose services. Effective recovery support was recognised by all interviewees to require collaboration across statutory and voluntary sector partners, funders and local community services - working as an alliance with a shared understanding of trauma. However, there was also acknowledgement that effective multi-agency working takes investment and that time must be built in to allow this to happen.

> **It's really important for that [multi-agency] community to be harmonised – they need to sing like a choir on the child's behalf. If at any point in the system you generate adversity rather than respond to the difficulties the child is experiencing, that's probably not going to benefit the child in the longer term. What you need is to make alliances. (IV18)**
>
> **The best CAMHS services I've worked in – there is time built in for me as a clinician to do the liaison with other services, to do the consultation. By having that length of time to hang out with them and listen to their challenges and realities, we didn't have this 'oh you CAMHS, why don't you take them on'. (IV9)**

At both practice and management levels, interviewees noted that highly relational practices, such as spending time together outside formal meetings or training, sharing food, and allowing authentic connections to be made, help to bridge disciplinary and role divides.

> **I think doughnuts are important. What I mean by that is the opportunity for different people with different roles to come together and eat together. Bringing people together around the most basic human need of food and drink just changes the dynamic – and then you can do a bit of training, but then you have lunch together. (IV11)**

Workforce development and support

The need for children to have access to recovery professionals with specialist training in working with trauma and abuse was a consistent message. However, there were also concerns that centring all the 'recovery expertise' in one team may deskill a wider workforce, who will have vital roles to play and capacity to contribute to children's recovery. Several interviewees noted a need to balance developing specialist support within Bairns' Hoose while empowering all statutory agencies and wider community services to develop skills to respond.

A related point was made by a small number of interviewees that child sexual abuse was a particular area where some practitioners (clinical and non-clinical) reported feeling they "*don't have the skills to work with what the child has told them*".

> **There is a widespread terror of working with CSA within statutory agencies in particular. In social care or in education, they're really frightened to ask the question. And when disclosures are raised, they don't know what to do with that, and often they think a specialist is needed. We see this a lot in CAMHS as well — the moment that a disclosure of sexual abuse is made, they will often close the case and refer on to a specialist, believing that they don't have the skills to work with what the child has told them. (IV11)**
>
> **An individual has expressed some interest or might have had a number of cases where that [CSA] has been a feature, and quite quickly becomes identified as the person who deals with those sorts of things... In doing so, I think we all potentially slightly de-skill ourselves, and it's a sort of 'over there' problem, someone else is dealing with this. (IV6)**

A similar point was made about avoiding rigid assumptions about which professionals were able and equipped to undertake different aspects of support. It was noted that robust training and support often mattered far more than role title or discipline. Examples included the fact that a model like TF-CBT did not need to be delivered by a psychologist as some assumed, and that clinically trained staff may also perform more of the social support.

Support to staff

Supporting children and families after abuse and trauma may have a profound personal impact on practitioners, with burnout and attrition cited as real risks. Mitigating these risks and improving staff wellbeing and retention was widely recognised to require robust clinical supervision structures, cultures of reflective practice and wider forms of wellbeing support. Varied caseloads, regular supervision and informal relational time were all identified as further strategies to respond to these challenges.

> Supervision is so important. As a therapist, I get clinical supervision – with a qualified psychotherapist, funded by Barnahus, once every four weeks – and supervision with my manager once every four to six weeks. I couldn't do without it. It's vital, really. (IV13)

> In terms of workforce: adequate training, clinical supervision, and recognition of the psychological impact of working with traumatised children. Providing support for staff will improve retention and reduce sickness absence – because if staff are poorly supported, either people leave or they burn out. (IV17)

Context matters

A degree of local autonomy and adaptation were recognised as essential within a national implementation programme. There was a relatively strong consensus that expectations of fidelity to a single 'recovery' model, imposed from outside a local area are likely to fall short in many places. Instead it was argued that implementation should aim to amplify what works well locally while working towards embedding shared evidence based practice principles.

> If you want something which is consistent, it doesn't have to be the same template in every location. Locations may vary in terms of their flavour, culture and methods of delivery – so it needs to be a model which is adaptable to the local context so it lands well and respects the context within which it's landed. This isn't the kind of shiny bright light … coming in with a saviour complex designed to make things better. (IV18)

Applying strengths-based approaches to professional practice were also noted to be important – valuing and acknowledging existing skills and contributions before seeking to build upon them.

> What people would generally appreciate within localities is being respected. Coming in with a model which says 'what do you do well already, and how does this model amplify what you do well?' – that would be the approach I would take. (IV18)

Identifying a shared outcome framework for Bairns' Hoose

Interviewees noted that where comparable recovery services were measuring different things, held different aims, or were not measuring outcomes at all, this posed challenges for national implementation and cross site learning.

There was also recognition that many existing frameworks for capturing outcomes are unhelpfully narrow, with the main criticism being that they that they focused too heavily on mental health symptom reduction or a few measures of 'functioning' that may not reflect the child and parent or carer's needs or hopes. While there was no clear solution to this problem, several interviewees highlighted the value of some form of child-led goal-based outcome framework (where children help to identify their own ambitions for support) and some provision of comparable cross site measures, which take account of wider social and ecological outcomes associated with family, education, peers and community.

> There needs to be a planned long-term evaluation model, and when costing the delivery they're not just doing a cost-benefit analysis that looks purely at symptom reduction but looking at longer-term other outcomes for children that have meaningful long-lasting implications — stability, employment, education, safety and relationships. (IV17)

5.3 Implementation: implications for local Bairns' Hoose partnerships

Implementation of newly integrated recovery support within local Bairns' Hoose partnerships represents a complex task – itself part of wider multi-disciplinary systems change. While considerations of implementation represents only a small part of this study, there are a number of key emerging messages for the local strategic leaders driving this change.

- To drive forward real meaningful change for children, recovery services should be developed in response to children's needs rather than starting with existing resources and capacity.
- Recognising implications of short-term funding cycles for services and children, it is imperative that local partnerships and the Scottish Government explore longer-term funding models for recovery. This is particularly pertinent for third sector partners both working within Bairns' Hoose and those who Bairns' Hoose may wish to refer on to.
- Bairns' Hoose models need to adapt to and align to local contexts. The development of Bairns' Hoose provides an opportunity to amplify and integrate existing good practice models rather than replace them.
- Evidencing progress and outcomes for recovery is complex and needs to avoid an over-reliance on symptom-reduction measures. Though these may be easier to measure, they do not adequately reflect children and their parents' and carers' own priorities. Instead, outcomes need to consider children's and families' subjective experiences of safety and wellbeing.
- It is vital that the workforce is well supported through training, supervision and reflective practice structures to help ensure the wellbeing of staff, optimize staff retention, and maintain capacity to work well. The complexity and emotional intensity of some recovery work can result in burnout, staff attrition and a reluctance to take on or continue treating complex trauma cases. Ensuring staff have a varied caseload in terms of intensity and complexity is also important in enabling them to manage their own wellbeing.
- Investing in an environment in which multi-disciplinary working can thrive is essential. This requires opportunities for staff to spend time together, formally and informally and building time in professional schedules for contact, liaison, reflection, information-sharing and peer support. Mechanisms such as joint training, dedicated team spaces, shared decision-making fora, co-location and sharing breaks and food together are all an important and effective means of fostering this.
- Investment in trauma informed built service environments matters. This means creating and sustaining welcome, homely, accessible environments which are well maintained and promote effective practice across a range of interventions.
- Naming and mapping the gamut of therapeutic, advocacy and support offers within the partnership and identifying significant gaps is a vital part of Bairns' Hoose recovery support. While it may not be possible to fill gaps immediately, recognising where they exist will be a valuable step in prioritising and addressing them, either through identification of community-based resources, development of enhanced referral pathways, and/or identifying allocation of new Bairns' Hoose resources.

6. Conclusion

To date there has been no shared national understanding of what recovery means for children in the context of Scotland's developing Bairns' Hoose model. While it is important to acknowledge the subjective and individual nature of recovery for children after abuse there is also clear value in developing some consensus about the definition, role and scope of recovery support in Bairns' Hoose. This feels particularly critical in a multi-disciplinary context where shared language and understanding supports effective cross disciplinary collaboration.

For Bairns' Hoose pathfinder and affiliates, working together to develop a local understanding or vision is also important. While the scope of recovery services in each partnership area might be different, each partnership does need to make a clear decision about what is included or not. This will require considerations of where Bairns Hoose recovery support starts and ends, and crucially how it will connect and integrate with wider service landscapes and children's familial and community context.

Effective recovery support for children after abuse is ecological (or psycho-social) in nature – requiring support that addresses intersecting needs in children's internal worlds (their emotional and mental wellbeing) and their external or relational worlds (including family, peer groups, school, communities, systems of support and wider contexts).

The research highlights that while there is no singular, agreed upon 'recipe' for recovery support in Bairns' Hoose, there are points of strong consensus, spanning evidence from different disciplines and jurisdictions. These could provide a helpful framework for service development and are listed below:

- **Strong trusting relationships.** The development of strong trusting relationships between children, their parents or carers and practitioners is widely recognised as the most fundamental element of any support – creating the conditions through which change is enabled.
- **Support to parents and carers.** Effective recovery support for children must include opportunities to support those who care for them directly – parents and other carers – and where appropriate support to other family members.
- **Embedding choice and flexibility.** Providing genuinely child-centred support requires embedding opportunities for choice and flexibility in service offers. This recognises the variability in children's needs and when/how they feel able to engage.
- **Minimum suite of offers spanning social, emotional and advocacy support.** A minimum suite of recovery support offers to children is likely to include: assessment; psycho-education (helping to make sense of trauma and its impacts for children and carers); direct carer support (helping them support children); work to make sense of and manage difficult thoughts and feelings; practical support – supporting safety and stabilisation; specialist court support, including advocacy, for children in criminal justice processes; and access to specialist trauma interventions for children who would benefit from targeted trauma processing work.
- **Flexible duration and planned endings.** Ideal support models contain flexibility of duration – offering short and longer-term offers, with opportunities for re-engagement where needed. Availability of support during (and in the aftermath of) criminal justice engagement appears

to be critical. Endings should be carefully planned and if possible recognised as positive transitions, marking children's progress and strengths.

- **Support models are nothing without sustained engagement in them.** No matter how effective a single intervention is it has no value for children or families who don't engage in it. Paying attention to how to enable and sustain children and their families' engagement in support is therefore an important task in itself.

Addressing and implementing effective recovery support to children requires national investment and it is clear that recovery support to date has suffered from the absence of secure long-term funding. Arguably this reflects a lack of recognition or value placed on this type of support and children's associated needs. Bairns' Hoose provides an opportunity to address this gap. Recovery service development and the trained, supported workforce who deliver support require secure long-term and sustainable resource commitments. Sustainable commitment to recovery in Bairns' Hoose will enable children who have experienced abuse and maltreatment to flourish, experiencing safe, loving and fulfilling lives beyond and alongside the trauma they have experienced.

7. References

Alşen Güney, S., Bağ, Ö., & Cevher Binici, N. (2018). An Overview of a Hospital-Based Child Advocacy Center's Experience from Turkey. *Journal of Child Sexual Abuse*, 27(5), 476–489. https://doi.org/10.1080/10538712.2018.1483461

Andersen, L. (2022) Phronetically Guided Use of Knowledge: Interstitial Work at Barnahus and How It Can Inform the Knowledge Debate in Social Work, *The British Journal of Social Work*, Volume 52, Issue 2, March 2022, 1038–1054, https://doi.org/10.1093/bjsw/bcab081

Byrne, K. A., McGuier, E. A., Campbell, K. A., Shepard, L. D., Kolko, D. J., Thorn, B., & Keeshin, B. (2022). Implementation of A Care Process Model for Pediatric Traumatic Stress in Child Advocacy Centers: A Mixed Methods Study. *Journal of Child Sexual Abuse*, 31(7), 761–781. https://doi.org/10.1080/10538712.2022.2133759.

Conners-Burrow, N., Tempel, A., Sigel, B., Church, J., Kramer, T., Worley, K. (2012) The development of a systematic approach to mental health screening in Child Advocacy Centers, *Children and Youth Services Review*, 34 (9) https://doi.org/10.1016/j.childyouth.2012.04.020.

Dovi A., Macaulay J., Repine A.; APRN; De Jong A., Williams R.E., Deutsch S.A. (2022) Multidisciplinary Team Approach to Addressing Child Sexual Abuse at Nemours Children's Health, Delaware. *Delaware Journal of Public Health*, 8(2):22-27. https://doi.org/10.32481/djph.2022.05.004.

Duncan, C., Wretman, C., Mitchell, M. and Warrington, C. (2025) *Preparing for Bairns' Hoose in Aberdeenshire and Aberdeen City: Professionals Survey on Current Systems and Readiness for Change*. Edinburgh: University of Edinburgh

Eirich, R., Racine, N., Garfinkel, D. Dimitropoulos, G., and Madigan, S. (2020) Risk and Protective Factors for Treatment Dropout in a Child Maltreatment Population. *Adversity and Resilience Science* 1, 165–177. https://doi.org/10.1007/s42844-020-00011-9.

Elmi, M. H., Daignault, I. V., & Hébert, M. (2018). Child sexual abuse victims as witnesses: The influence of testifying on their recovery. *Child abuse & neglect*, 86, 22–32. https://doi.org/10.1016/j.chiabu.2018.09.001.

Galloway, S., Love, R. and Wales, A. (2017) *The Right to Recover: therapeutic services for children and young people following sexual abuse: an overview of provision in the West of Scotland*. London: NSPCC

Göransson L., Ekermann S., Dovik C., Klingberg G., Ridell K., and Laurell L. (2022) Children's advocacy centre fails to respond to dental, mental and physical ill-health in abused children. *Acta Paediatrica*; 111:1186–1193. https://doi.org/10.1111/apa.16328.

Haar R. (2020) Evaluation of Child Advocacy Centres Supported by UNICEF Bulgaria: Assessment of the model, its implementation, relevance, efficiency, effectiveness, sustainability. UNICEF (Available at: Evaluation of Child Advocacy Centres Supported by UNICEF Bulgaria | UNICEF Bulgaria).

Hahn, H., Putnam, K., Epstein, C., Marans, S., & Putnam, F. (2019). Child and family traumatic stress intervention (CFTSI) reduces parental posttraumatic stress symptoms: A multi-site meta-analysis (MSMA). *Child abuse & neglect*, 92, 106–115. https://doi.org/10.1016/j.chiabu.2019.03.010.

Harewood, E. (2025) Barnahus Ireland Therapeutic Mapping. Council of Europe (Available at: https://rm.coe.int/mapping-study-of-therapeutic-services/1680b5d2c0).

Health Improvement Scotland/ Care Inspectorate (2023) *Bairns' Hoose Standards*. Edinburgh: Health Improvement Scotland/ Care Inspectorate.

Herbert, J., & Bromfield, L. (2020). Worker Perceptions of the Multi-Agency Investigation & Support Team (MIST): A Process Evaluation of a Cross-Agency Response to Severe Child Abuse. *Journal of Child Sexual Abuse*, 29(6), 638–658. https://doi.org/10.1080/10538712.2019.1709241.

Herbert J., and Paton A. (2024) Effects of Therapy at a Community Based Trauma Therapy Service Treating Child Abuse and Neglect: A Pre-Post Study Using Administrative Data. *Journal of Child and Adolescent Trauma*. 17(3):735-749. https://doi.org/10.1007/s40653-024-00625-6.

Herman, J. (1992) *Trauma and Recovery.* New York: Basic Books.

Krushas, A. E., Kulig, T. C., Wright, E. M., Spohn, R. E., & Castrianno, L. M. (2023). Identifying Successes and Barriers in a Child Advocacy Center: An Examination of Five Service Areas. *Child & Youth Services*, 44(3), 275–299. https://doi.org/10.1080/0145935X.2022.2107505.

Lacey, E., Mc Elvaney, R., Walsh, A., Holden, A., McCabe, B., & Geoghegan, A. (2023). *Training Needs Analysis: Working towards Barnahus in Ireland*.

Lotty M., McCabe, B., McElvaney, R., and Lacey, E (2026) Building capacity for Barnahus Ireland: Development of trauma-informed care, child advocacy and participation training for professionals, *Child Protection and Practice*, https://doi.org/10.1016/j.chipro.2026.100308.

Lucas, C., & Saunders, B. E. (2014). TF-CBT With a School Age Girl with a History of Severe and Prolonged Sexual Abuse: The Case of Mary T. In B. Allen & M. Kronenberg (Eds.), *Treating Traumatized Children: A Casebook of Evidence-Based Therapies* (pp. 64–81). Guilford Publications, Inc. http://www.jstor.org/stable/10.1521/jj.41115636.7.

McGuier, E. A., Campbell, K. A., Byrne, K. A., Shepard, L. D., & Keeshin, B. R. (2023). Traumatic stress symptoms and PTSD risk in children served by Children's Advocacy Centers. *Frontiers in psychiatry*, 14, 1202085. https://doi.org/10.3389/fpsyt.2023.1202085.

McPherson, P., Scribano, P., & Stevens, J. (2012). Barriers to successful treatment completion in child sexual abuse survivors. *Journal of interpersonal violence*, 27(1), 23–39. https://doi.org/10.1177/0886260511416466.

Madray, O., Tinnie, H. (2025). Child Sexual Abuse, ChildLinK, Civil Society and Communities of Practice in Collaboration with the Guyanese State. In: Mc Fee, D.N., Rogers, T.A. (eds) *Public Policy Making, Gender, and Human Security in the Caribbean*. Palgrave Macmillan, Cham. https://doi.org/10.1007/978-3-031-81592-8_3

Mitchell M., Warrington, C., Devaney, J., Lavoie, J. and Yates, P. (2023) *North Strathclyde Bairns' Hoose Evaluation: Phase one report*. Edinburgh: University of Edinburgh

Mitchell, M., Warrington, C., and Duncan, C. (2025) *Key learning for change: Aberdeenshire Bairns' Hoose programme theory*. Edinburgh. University of Edinburgh

Mitchell, M., Warrington, C., and Duncan, C. (2025) *Key learning for change: Aberdeen City Bairns' Hoose programme theory Edinburgh*. Edinburgh.University of Edinburgh

Mitchell, M., McMellon, C. and Warrington, C., (2025) *Joining the dots: Sycamore Bairns' Hoose evaluation. Edinburgh*. University of Edinburgh

Mitchell M., Warrington, C., Devaney, J., Lavoie, J. and Yates, P. (2024) ***North Strathclyde Bairns Hoose Evaluation: Phase two report***. Edinburgh: University of Edinburgh

Mori, C., Devereux, C., Racine, N., Hartwick, C., Madigan, S. (2025) Descriptive characteristics and exploratory treatment outcomes of a population referred for problematic sexual behavior at a Child and Youth Advocacy Centre, ***Child Abuse & Neglect*** 167. https://doi.org/10.1016/j.chiabu.2025.107594.

NHS Education for Scotland (NES) (2017) ***Transforming Psychological Trauma: A knowledge and skills framework for the Scottish workforce***. Edinburgh: NHS Education for Scotland (Available at https://traumatransformation.scot/app/uploads/2023/09/nationaltraumatrainingframework-final.pdf).

O' Keeffe, N. & McElvaney, R. (2022) Forensic medical examinations: The body as gateway to healing after child sexual abuse. ***Child Abuse Review,*** 31(4), e2750. Available from: https://doi.org/10.1002/car.2750.

Parker, R., Read, T., Scragg A., & Paul Dawson, P. (2021) ***The Lighthouse: Final evaluation report***. MOPAC Evidence & Insight

Read, T., Parker, R. (2025). Implementation Continued: Evaluating the Lighthouse, the largest CSA/E Service in the UK. In: Dawson, P. (eds) Applied Policing Policy Research. Springer, Cham. https://doi.org/10.1007/978-3-031-87240-2_14.

Schreier, A., Coffey, H., May, G., Hansen, D (2022) Financing mental health services at Child Advocacy Centers for victims of child sexual abuse and their families, ***Aggression and Violent Behavior***, 65, https://doi.org/10.1016/j.avb.2021.101638.

Scoglio A., Kraus S., Saczynski J., Jooma S., Molnar B. (2021) Systematic Review of Risk and Protective Factors for Revictimization After Child Sexual Abuse. ***Trauma Violence Abuse*** (1):41-53. doi: 10.1177/1524838018823274 .

Shepard, L. D., Campbell, K. A., Byrne, K. A., Thorn, B., & Keeshin, B. R. (2024). Screening for and Responding to Suicidality Among Youth Presenting to a Children's Advocacy Center (CAC). Child maltreatment, 29(2), 272–282. https://doi.org/10.1177/10775595231163592.

Thulin, J., Kjellgren, C. (2017). Treatment in Barnahus: Implementing Combined Treatment for Children and Parents in Physical Abuse Cases. In: Johansson, S., Stefansen, K., Bakketeig, E., Kaldal, A. (eds) ***Collaborating Against Child Abuse***. Palgrave Macmillan, Cham. https://doi.org/10.1007/978-3-319-58388-4_4.

Tener, D., Newman, A., Yates, P., and Tarshish, N. (2020) Child Advocacy Center intervention with sibling sexual abuse cases: Cross-cultural comparison of professionals' perspectives and experiences, ***Child Abuse & Neglect***, 105, https://doi.org/10.1016/j.chiabu.2019.104259.

Voss, L., Rushforth, H., and Powell, C. (2018) Multiagency Response to Childhood Sexual Abuse: A Case Study that Explores the Role of a Specialist Centre. ***Child Abuse Rev.***, 27: 209–222. https://doi.org/10.1002/car.2489.

Westphaln, K. K., Regoeczi, W., Masotya, M., Vazquez-Westphaln, B., Lounsbury, K., McDavid, L., Lee, H., Johnson, J., Ronis, S., Herbert, J., Cross, T., & Walsh, W. (2021). Outcomes and outputs

affiliated with Children's Advocacy Centers in the United States: a scoping review. *Child Abuse and Neglect*. https://doi.org/10.1016/j.chiabu.2020.104828.

Whaling, K., der Sarkissian, A., Sharkey, J., Akoni, L.C. (2020) Featured counter-trafficking program: Resiliency Interventions for Sexual Exploitation (RISE), *Child Abuse & Neglect*, 100, https://doi.org/10.1016/j.chiabu.2019.104139.

Wherry, J. N., Huey, C. C., & Medford, E. A. (2015). A national survey of child advocacy center directors regarding knowledge of assessment, treatment referral, and training needs in physical and sexual abuse. *Journal of child sexual abuse*, 24(3), 280–299. https://doi.org/10.1080/10538712.2015.1009606.

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