Proposal to Tusla from Treehouse Practice in relation to preventing and rethinking placement disruption for children in care

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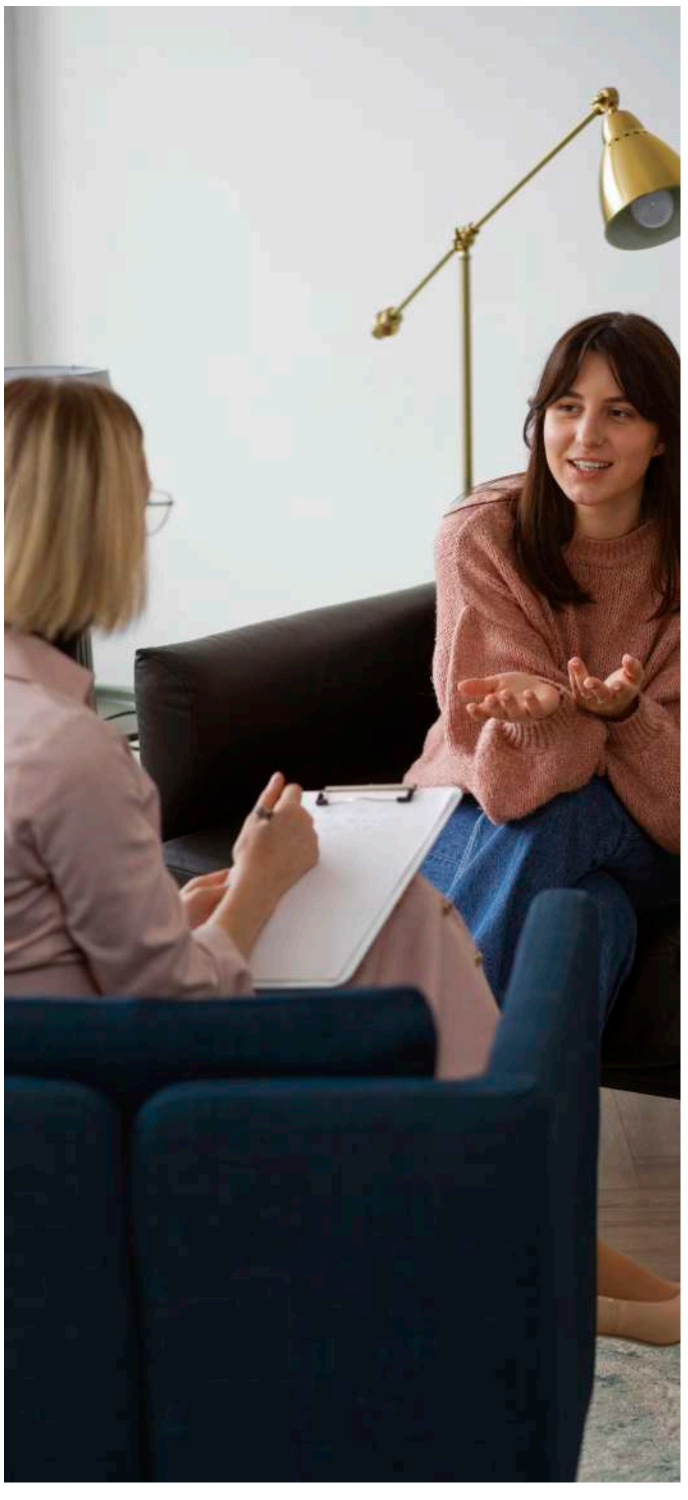
Introduction and Context

This proposal is for Treehouse Practice to provide therapeutic support to children and young people (and their families) referred by Tusla to prevent placement disruption, and to enable them to remain in their foster care placement. The aim is to collaboratively prevent placement disruption and to avoid the need to provide an alternative care placement and/or the need to provide a Special Emergency Arrangement (SEA).



The Context of Children in Care in Ireland

The number of children in care in Ireland has been estimated as varying between 5000 and 6000 at any given time (ESRI and CSO data). Foster care accounted for about 88% of placements for children in care in January 2024. Approximately half of children in care in Ireland have had a single placement. About 9% of children in care in January 2024 had experienced more than 5 placements (CSO, 2024). For children who had exited care between 2018 and 2024, 47% had a single placement, with 14% having experienced more than 5 placements (CSO, 2024). Ongoing challenges in Ireland with recruitment and retention of foster carers has led to increased reliance on private residential care and unregistered special emergency arrangements or SEAs. Tusla's spend on Special Emergency Arrangements (SEAs) has surged dramatically in recent years. According to recent figures presented to Ireland' Public Accounts Committee SEA spending has risen from less than €5 million four years ago to approximately €70-71 million in 2023-2024. In February 2024, there were 174 children in an unregistered placement or SEA, of which 111 were separated children seeking international protection (Child Law Project, 2024).

The Risks Associated with Placement Disruption

Placement stability is important for a sense of permanence for children as it creates opportunities to develop alternative models of relationships beyond those shaped by adversity (Rubin et al., 2007). Stable foster placements are associated with better psychosocial, mental health and educational outcomes (Rubin et al, 2007). Placement disruption on the other hand can be thought of as the premature ending of a permanent foster placement (Argent & Coleman, 2012). Placement disruption is associated with a host of negative outcomes for children including disruption to the child's identity and connection with community, amplifying feelings of mistrust in adults and exacerbation of mental health concerns (Maguire et al., 2024; Strijker et al., 2008). Young people's engagement with school whilst in care is influenced by changes in care placements. Multiple moves can have an impact on a young person's ability to adjust to new routines and rules, form new peer connections and engage in learning task (Darmody, 2025).

For the social work system, placement disruptions are inherently stressful, particularly at a time when there is a scarcity of placements. In the midst of planning and organisation change, placement disruption can inhibit openness and reflectiveness regarding system practice (Argent & Coleman, 2012). Space for reflectiveness and support and an opportunity to review decision-making can provide a counterbalance to more risk-focused actions. Foster carers, too, are significantly impacted by placement disruption (Valentine et al., 2019) and report a range of emotional responses, including joy, relief, shame, guilt, grief and sadness.

Identifying the right placement is the key to stability and permanence. Of course, finding the right placement is easier said than done in a situation involving shortage of suitable placements. Decisions made in crisis and moves to emergency placements invariably necessitate subsequent moves. Rather, attention is needed to understanding factors that contribute to disruption and prevention strategies, rather than intervention.

Factors That Contribute to Placement Disruption

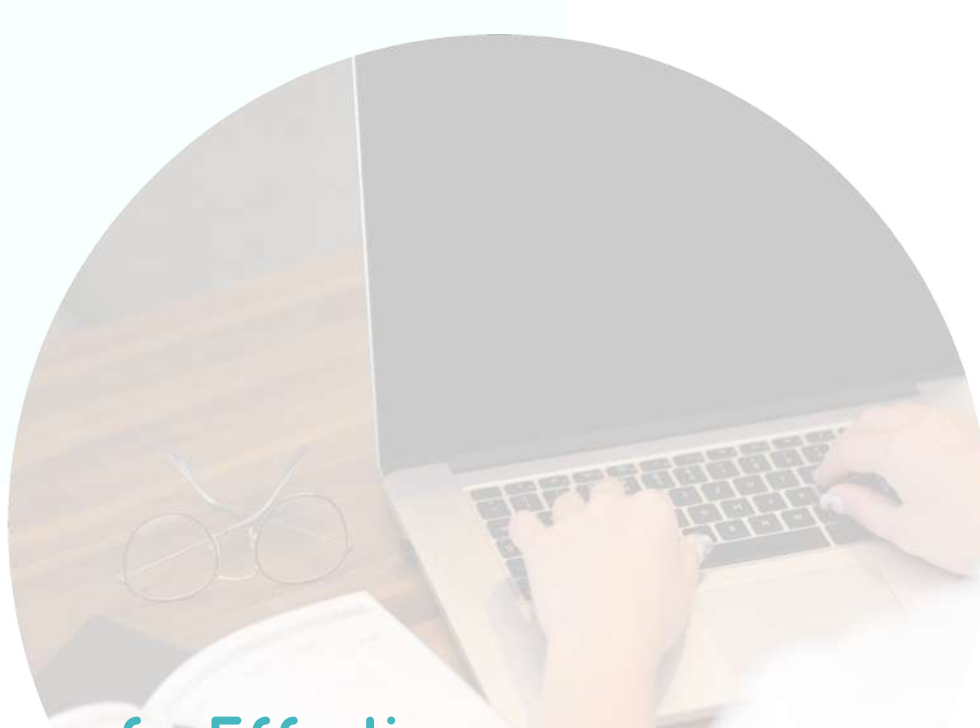
Placement breakdown is not a single event but a process involving the interplay of dynamic risk and protective factors over time (Harkin & Houston, 2016). These include the young person's history and life experiences, the role of foster carers, the impact of contact with birth families and the support offered by social workers.

Argent and Coleman (2012) identified common causes of disruption including incomplete or inaccurate information about children, lack of attachment assessments, adult-focused introductions, unclear family contact arrangements, poor preparation of children and carers and inadequate support once placements begin. Child factors include older age at placement, a history of previous disruptions and challenges with emotional regulation (Harkin & Houston, 2016). Adolescents who enter care for the first time after age 11 have the least placement stability (Rees et al., 2011) and adolescents have the highest proportion of multiple moves in comparison to other age cohorts (Valentine et al., 2019). Children with disabilities are significantly more at risk of placement disruption, with case examples of children being placed in hospitals and unsuitable arrangements due to lack of availability of suitable homes (Child Law Project, 2024).

Timely access to therapeutic support has been linked to placement stability (Stanley et al., 2005) but limited access to trauma sensitive and holistic assessment and therapy services remains a reality for many children in care. Tusla's yearly spend on counselling and therapeutic services equates to approximately 1.5 million per annum (Tusla Business Plan, 2025) in comparison to increasingly high rates of spending for SEAs. Foster carers' perception of social worker support is strongly associated with stability (Brown & Bednar, 2006), in particular the quality of the relationship with the social worker and accessibility to support. Further, challenges in inter-agency collaboration across disability, mental health and social work services have been repeatedly highlighted, leaving some children vulnerable to falling between the cracks in terms of service provision (Child Law Project, 2024; Daly, 2016).

Inconsistencies in court proceedings can lead to lack of permanency and what is known as "drift in care" (Brown et al., 2019; Christiansen et al, 2013). Many children remain on Voluntary Care or recurrent Interim Care Orders in Ireland for extended periods, delaying experiences of settling and permanency.

Whilst foster and residential care is professionalised and regulated, care remains fundamentally relational (Christiansen et al., 2013). Placement success often depends on the quality of the carer–child relationship (Stanley et al., 2005). Indeed, Brown and Bednar (2006) contented that "the interaction between foster parent and child characteristics is more predictive of placement outcome than the characteristics of either alone". From the perspective of young people in the care system 'genuine' care feels non-contractual, with a sense that goes 'above and beyond' and will endure 'no matter what' (Brown et al., 2019). Tobin (2016) explored the lived experiences of young people who have experienced multiple placement moves in care in Ireland. Central to the themes arising was the idea of navigating connections to two family systems whilst in care. Indeed, poorly planned contact with the child's birth family can disrupt placement stability (e.g. Hunt et al., 2010). Further, placement success can be influenced by the young person's relationships with other children in the foster home (Tobin, 2016). Often, however, the focus is on assessment of child factors, rather than consideration of broader familial and ecological contributions.



The Gap in Evidence for Effective Interventions

Meta-analyses show that placement breakdown occurs in about 26 percent of cases, with higher rates among adolescents (34 percent) compared to younger children (16 percent) (Eltink et al., 2025). More recent studies have highlighted higher rates of placement breakdown than in the past, suggesting that this might be a growing problem (Eltink et al., 2025).

There is little evidence that therapeutic foster care has reduced breakdown rates compared to traditional models (Eltink et al., 2025). However, most interventions have focused on parenting skills and child behaviour without adequately addressing trauma and attachment needs (Schoemaker et al., 2020). NICE (2021) concluded that existing studies provide no robust evidence of effective interventions, but recommended trauma-informed and attachment-focused training for carers along with planned respite. Some attachment-focused interventions for carers show promise in improving parent–child interaction and psychosocial adjustment, though evidence remains limited (Dalgaard et al., 2021).

A Call for Collaboration

The prevention of placement breakdown requires early detection, trauma-sensitive and relationally focused planning, sustained multi-disciplinary support, empowerment of carers and systemic cooperation. Stable placements are linked to better long-term outcomes across educational, social and health domains (Rubin et al., 2007). This issue cannot be solved by a single service or agency and requires collaboration and fresh thinking across child protection, mental health, education, therapeutic providers, foster care recruitment and the court systems.

The following are the key recommendations arising from review of existing literature and policy, as well as best practice clinical guidelines:

1. Firstly, it is recognized that solutions involve **inter-agency collaboration** and establishing trust, safety and working relationships amongst multiple agencies, all of whom are united in improving outcomes for children in care. Reform is both a shared responsibility and an urgent priority.

2. All children on entry to the care system require thorough and **holistic therapeutic assessment**. This involves consideration of the strengths and support needs of the child, birth family, foster family and system. This invariably involves considering the strengths, dynamics and support needs from multiple perspectives. This is the foundation of a preventative model, in which therapeutic needs are front and centre from entry to care and the system of support around the child feels held in mind.

3. Following therapeutic assessment, **bespoke therapeutic care planning** which involves unique solutions for unique children and families is required. Treatment is not a one-size-fits-all approach and will depend on the age and stage of trauma occurrence for the child (Perry & Dobson, 2013), the relational factors within the birth and foster family systems, and the reflectiveness and support of the system of care around the child.

4. Intervention needs to follow assessment rather than remain dependent on what might be locally available. Children and families benefit from **differential responses** that are driven by holistic and detailed knowledge of their experiences.

5. **Research efforts** should focus on the effectiveness of individualized therapeutic care planning, with knowledge of the factors that are known to contribute to placement disruption in mind.

6. At moments of crisis within foster families, **timely access to therapeutic supports** is required. These supports should adopt a whole-family, systemic approach, rather than honing in on the individual child. This is in light of knowledge that adult and sibling perspectives are associated with risk of placement disruption.

SECTION 2

Treehouse Practice Suitability

Treehouse Practice is a specialised, team-based service for young people aged 0-25 years who have experienced trauma and adversity in their lives, and the adults who support them. We also specialize in providing integrated services for neurodivergent children and young people who have also experienced childhood trauma. We believe that all children and young people need to feel loved, safe, seen and supported in their relationships and that this is the basis of recovery from trauma. We understand the impact of trauma on childhood development, and we support other adults in young people's lives to become more trauma aware too.

Treehouse Practice started in 2013 and from the outset strived to hold children's voices and stories at the heart of what we do. This community starts in Treehouse Practice but is so much bigger than us. It's about communities, it's about tailored, naturalistic supports for children and it's about guiding, shaping and nurturing these systems.

History of Referrals and Engagement with Tusla

Over the last 2 years Treehouse Practice has worked with 245 children who are within the care of Tusla. Many of these children remain within the service for a period of 1-2 years, starting with a process of in-depth assessment and then proceeding to bespoke intervention in line with their strengths and needs identified on assessment.

Treehouse Practice operates in collaboration with Tusla in all situations. A professional planning meeting is the first point of contact with the service, in which goals for the assessment and/or intervention are co-created by Tusla and Treehouse Practice. Following this meeting a proposal is shared with Tusla for consideration. Throughout the assessment and/or intervention process there are in-built opportunities for professional engagement and feedback. Whilst the process is one of collaboration, like all good relationships, there remains room for improvement. In particular, Treehouse Practice has reflected on challenges in terms of pressure to align with court mandated timeframes, inconsistent collaboration across multiple agencies (HSE and Tusla for example) and delays in allocation of funding. There is a shared commitment to clear communication channels, shared protocols, and regular joint reviews to mitigate these risks.

Target Group

The service is suitable for the 0-25 age ranges, with tailored supports depending on the age and stage of development of the young person. Treehouse Practice work with young people, birth parents, foster carers and social work departments.

Young people might present with the following challenges in their lives:

- Mental health concerns
- Lack of involvement in education
- Limited or no social connections
- Multiple placement moves
- Involvement in criminal behaviour
- Aggressive behaviour
- Areas of neurodivergence such as autism, intellectual disability or ADHD
- Communication challenges
- Learning English as a second language

Identified challenges within birth and foster families include the following:

- Lack of agency and voice
- Neurodivergence within the adult system
- Communication challenges
- Learning English as a second language
- Adult history of childhood trauma
- Lack of trust in services
- Social isolation and marginalization

Treehouse Practice recognize that childhood trauma and mental health needs co-occur. As such, Treehouse Practice accepts referrals for young people who present with mild to moderate mental health presentations. For moderate to severe presentations, the involvement of CAMHS and/or a psychiatrist is also required. Similarly, for young people who are experiencing addiction, the involvement of specialized addiction services is a requirement. Treehouse Practice will work alongside CAMHS, adult mental health services and addiction services but will not hold such cases in isolation.

Service Outcomes

Treehouse Practice works to an agreed set of outcomes, which are collaboratively agreed for each young person. In general, the following set of outcomes are deemed to demonstrate good practice within the service.

- Increased placement stability and reduced disruption (unless placement is not deemed to meet the young person's needs)
- Increased parental capacity and confidence to engage with young person
- Increased participation in community pursuits
- Return to education
- Improved co-regulation or self-regulation skills
- Increased moments of attunement between adult and child

Treehouse Practice uses both quantitative data, collected on the client database, and observational data (such as a video analysis during VIG intervention) to ensure adherence to agreed goals.

Service Components

Service delivery stages:

1. Referral query received from the social work department by email.
2. Referrals and allocations manager responds within 7-10 days and referral is either re-directed with advice or accepted.
3. Finance and operations manager sends a quotation for a professional planning meeting to Tusla.
4. Planning meeting takes place with 2 senior clinicians from Treehouse Practice and engagement from the social work department, schools, parents, foster carers, Guardian ad litem and other professionals involved with the young person. Young people can be involved in this stage if over the age of 16 and if determined appropriate by social worker who knows the young person.
5. Proposal for assessment and/or intervention is sent to the social work department by the finance and operations manager.
6. On receipt of a PO number from Tusla, allocation is made to the clinicians within the team with the best expertise to carry out the assessment. A keyworker is allocated who is identified as the main point of contact for the system and families.
7. The practice manager sends an information and consent pack to parents and carers for review. A child-friendly introduction later is shared at this point also.
8. If the young person attends for a therapeutic assessment this will take place over a 2-3 month period. Therapeutic interventions can run alongside this assessment at times (e.g. supporting foster carers from the outset of the process) and in this case, a separate clinician who is not involved in the assessment will be allocated to complete this work.
9. Following completion of the assessment report a feedback session will take place with Tusla, parents and carers. These meetings can be held collaboratively or can take place over 2-3 separate sessions, depending on the needs, wishes and preferences of the group.
10. Recommendations are made in respect of therapeutic goals and supports for the child, family and system. If Treehouse Practice identifies an ongoing role for the team in providing these interventions, a proposal will be sent at this stage for review by Tusla. If there is no ongoing role, the case will be closed and Tusla will be formally notified of this ending.
11. The Treehouse Practice team will continue to provide therapeutic supports to many young people, families and systems, with regular therapeutic review meetings.
12. Therapeutic 'pause points' may be recommended on occasion to consolidate gains. When the therapeutic work is completed, a therapeutic summary and discharge letter will be issued to Tusla.

Approach

Treehouse Practice works directly and indirectly with children, young people, foster carers, birth families and social work systems. This is delivered both in the clinical space, in homes and schools and in other locations (such as within residential teams). Some interventions are delivered online.

Our therapeutic approach to assessment, consultation and intervention involves integrating specialised models. Our team have pursued additional training in therapeutic models known to help support recovery from childhood trauma, including the following: Neurosequential Model of Therapeutics, Theraplay, DDP, play therapy, sensory integration, sensory attachment intervention, Video Interactive Guidance (VIG), EMDR and child psychotherapy.

→ Neurosequential Model of Therapeutics (NMT)

The Neurosequential Model of Therapeutics (NMT) is a neurodevelopmentally-informed framework created by Dr Bruce Perry and colleagues at the Child Trauma Academy. It guides clinicians in selecting and sequencing interventions based on how the brain develops.

→ Theraplay

Theraplay is a play-based therapy that focuses on building connections, improving emotional regulation and enhancing parent-child relationships through interactive, nurturing activities.

→ Dyadic Developmental Psychotherapy (DDP)

Dyadic Developmental Psychotherapy (DDP) is a relational therapy developed by Dan Hughes for children who have experienced childhood trauma and attachment ruptures. DPP builds trust and safety through attuned, emotionally responsive interactions between child and caregiver.

→ Play therapy

Play therapy is a therapeutic approach that encourages children to process trauma, emotions and behaviour in a developmentally appropriate way.

→ Sensory Integration Therapy

Sensory integration therapy is carried out by a suitably qualified occupational therapist using activities that challenge and organize sensory systems to improve regulation and function.

→ Sensory Attachment Intervention

Sensory attachment intervention combines sensory integration with attachment theory to support emotional regulation and attachment securing through sensory-based co-regulation.

→ Video Interactive Guidance (VIG)

Video Interactive Guidance (VIG) is a video-based intervention that enhances caregiver-child interactions.

→ Child Psychotherapy

Child psychotherapy is a therapeutic approach using talk, play and creative methods to explore a child's emotional world, unconscious processes and developmental needs through a trusting therapeutic relationship.

→ Adult Psychotherapy

Adult psychotherapy is a therapeutic approach that helps adults explore and resolve emotional, behavioural, relational and mental health challenges with the support of a psychologist/ psychotherapist.

→ Eye Movement Desensitisation and Reprocessing

EMDR (Eye Movement Desensitisation and Reprocessing) is a structured therapeutic method designed to help children and adults process and heal from traumatic memories and distressing life experiences.

Youth Participation

Treehouse Practice is guided by the aims and vision of Young Ireland, National Policy Framework for Children and Young People 2023 -2028. The United Nations Convention on the Rights of the Child (UNCRC), ratified by Ireland in 1992, forms the basis for vision in Young Ireland.

To fully realise children and young people's rights, a robust ecosystem is required. Ensuring that children and young people are a central part of everyone's agenda requires systemic change, placing their rights and well being as a core part of policy and decision-making. (Young Ireland, p.3)

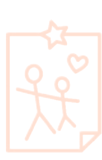
The five national outcomes for children and young people identify the following as good indicators that a child is doing well:

Active and healthy

Achieving in learning and development

Safe and protected from harm

Economic security and opportunity



Connected, respected and contributing to their world

One of the key policy areas that is being prioritized for implementation under this framework is Foster Care, Care and Aftercare. Foster Care, Care and Aftercare is identified as a priority under the national outcome 'Safe and Protected from Harm'

Treehouse Practice is also committed to and guided by the *National Framework for Children and Young Peoples Participation in Decision Making (2021)*, which is underpinned by UNCRC and is based on the child rights Lundy model of participation. The Lundy model provides four interrelated elements to support the right of the child/ young person to express their views and their right to have their views given due weight.

LUNDY MODEL

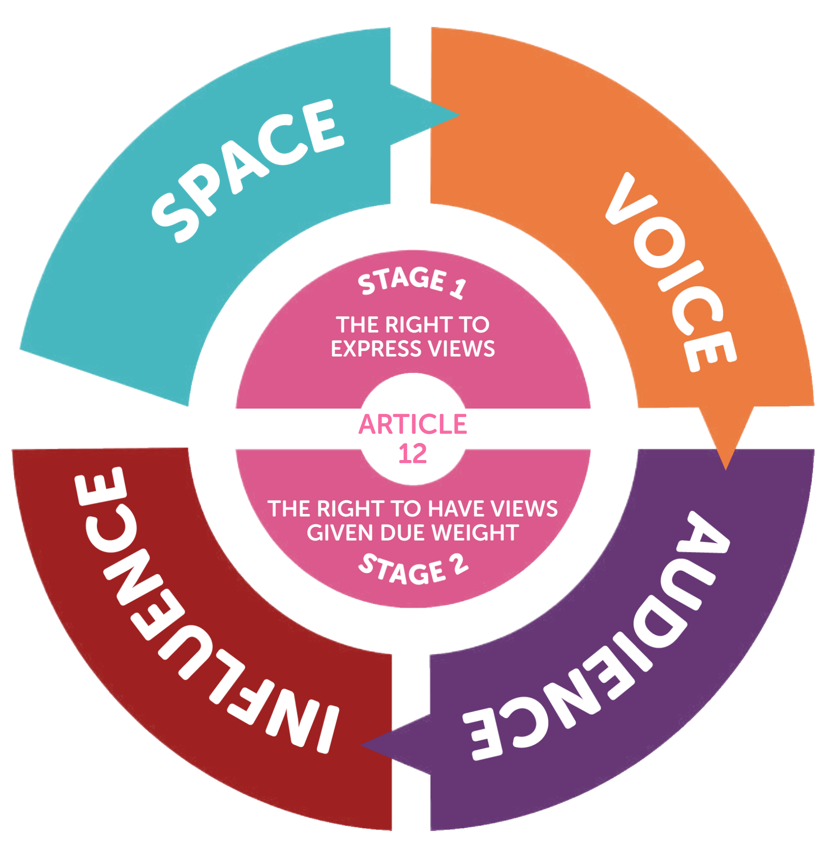
This model provides a pathway to help conceptualise Article 12 of the UNCRC. It focuses on four distinct, albeit interrelated, elements. The four elements have a rational chronological order.

SPACE
Children and young people must be given safe, inclusive opportunities to form and express their views

VOICE
Children and young people must be facilitated to express their views

AUDIENCE
The views must be listened to

INFLUENCE
The views must be acted upon, as appropriate



The core principles adopted by Treehouse Practice to ensure youth participation is meaningful are the following:

1. Child centered and rights based: every child's voice is heard and respected in therapeutic planning and delivery. Children co-create their own therapeutic goals and their wishes and preferences are followed in the therapeutic process.

2. Equity and inclusion: assessment and therapeutic supports are accessible to all children in care regardless of background, ability, ethnicity or sexual orientation. This includes culturally sensitive and neurodiversity affirmative practices.

3. Integrated and continual care: Treehouse Practice addresses mental health, social, emotional, relational and educational needs within an integrated therapeutic care plan. The service is mindful of the need for smooth transitions at key milestones in a young person's life and as such, maintains continuity of therapeutic care up to 25 years to reflect the transition from care to aftercare.

4. Outcomes and feedback: Treehouse Practice maintains a dataset of the status and outcomes of referrals from Tusla, which are shared in a summarized version in the annual reports published yearly. Young people who attend the service can express their views on services in a number of ways: using a postbox, email to a specific feedback email (with support from the adults in their lives), verbally to a clinician (who will document their feedback) or through images/ drawings.

Capacity and Allocations

Referrals received from Tusla vary on a month-by-month basis. Generally, Treehouse Practice receive 5-8 new referrals from Tusla monthly, all of which are responded to within a 7-10 day period. New referrals are discussed fortnightly at our specific referrals and allocations meeting, co-chaired by the Clinical Lead for the Wren (trauma sensitive) team and the referrals and allocations manager. After a referral has been accepted and funding is approved by Tusla, cases are allocated within the clinical team and discussed at the whole-team clinical meeting. Referrals are allocated on a fortnightly basis and new assessments/ interventions are typically commenced within a 6-8 week period following allocation. Treehouse Practice presently has un-used potential in terms of therapeutic support hours and attachment-based assessments and interventions. This means that the number of referrals presently being received does not fill all available capacity within the team. This differs to referrals from other agencies, the HSE in particular, where referrals consistently exceed availability of the team. Priority is given to Tusla referrals but in months where this demand is lower than capacity the team will accept referrals from the HSE in lieu.

Premises/Locations

Treehouse Practice offers assessment services throughout the island of Ireland. The team will commit to travelling to the young person's home or local location if required for this purpose. In terms of therapeutic interventions, in-person appointments occur within the therapeutic home in Sandycove in Dublin and within our shared partner's locations in County Meath. Online interventions are offered to foster carers, schools and social work teams.

Staffing

WREN TEAM

Dr Laura Geoghegan
CLINICAL LEAD AND PRINCIPAL CLINICAL PSYCHOLOGIST

Dr Alanna Donnelly
SENIOR CLINICAL PSYCHOLOGIST

Lynn Mitchell
CLINICAL SPECIALIST OCCUPATIONAL THERAPIST

Lesa Daly
PRINCIPAL THERAPEUTIC SOCIAL WORKER

Johanna Mulligan
CHILD AND FAMILY PSYCHOTHERAPIST

Geraldine Brosnan
CLINICAL LEAD AND CLINICAL SPECIALIST SPEECH AND LANGUAGE THERAPIST

Dr Sara O'Byrne
CEO AND PRINCIPAL CLINICAL PSYCHOLOGIST

Dr Síomha Walsh Garcia
OCCUPATIONAL THERAPIST

ROBIN TEAM

Dr Rebecca Quin
CLINICAL LEAD AND PRINCIPAL SPECIALIST CLINICAL PSYCHOLOGIST

Taylor Magennis
ASSISTANT PSYCHOLOGIST

Dr Caroline Traynor
SENIOR CLINICAL PSYCHOLOGIST

Dr Eleanor Griffith
SENIOR CLINICAL PSYCHOLOGIST

OPERATIONS

Gráinne Butler
FINANCE AND OPERATIONS MANAGER

Máire Kilgallen
PRACTICE ADMINISTRATOR

Nicola Mullett
PRACTICE MANAGER

- The **Operations Team** are responsible for the day-to-day running of the practice.
- The **Wren Team** provide supports to young people with a history of childhood trauma and the support system in their lives.
- The **Robin Team** provides services to neurodivergent young people and the support system in their lives.
- All 3 teams work in harmony with each other, with some clinicians working across both the **Wren** and **Robin** Teams.

There are 15 members of the team at Treehouse Practice, each of whom work in collaboration and partnership with other members of the team. Treehouse Practice clinical teams are made up of Principal and Senior Clinical Psychologists, specialized occupational therapist, clinical specialist speech and language therapist, child and family psychotherapist, principal therapeutic social worker and assistant psychologist.

This strategic project is co-led by Lesa Daly, Principal Therapeutic Social Worker and Dr Sara O'Byrne, CEO and Principal Clinical Psychologist.

Governance and Service Management

Line Management is provided to all staff on a monthly basis within the practice. The service operates a policy of ensuring external supervision is in place for all clinicians, with the identified supervisor different to the line manager. Treehouse Practice funds external monthly supervision for all clinicians. Reflective team supervision is provided on a weekly basis to ensure both strong multi-disciplinary collaboration on cases and a space for clinician self-care and well-being.

Training and CPD opportunities are available to all employees of Treehouse Practice.

Over the last year, Treehouse Practice have funded the following training courses for the staff team:

Masters in family (systemic) therapy

Post-graduate diploma in neurodivergence

Sensory integration practitioner training

Video Interaction Guidance

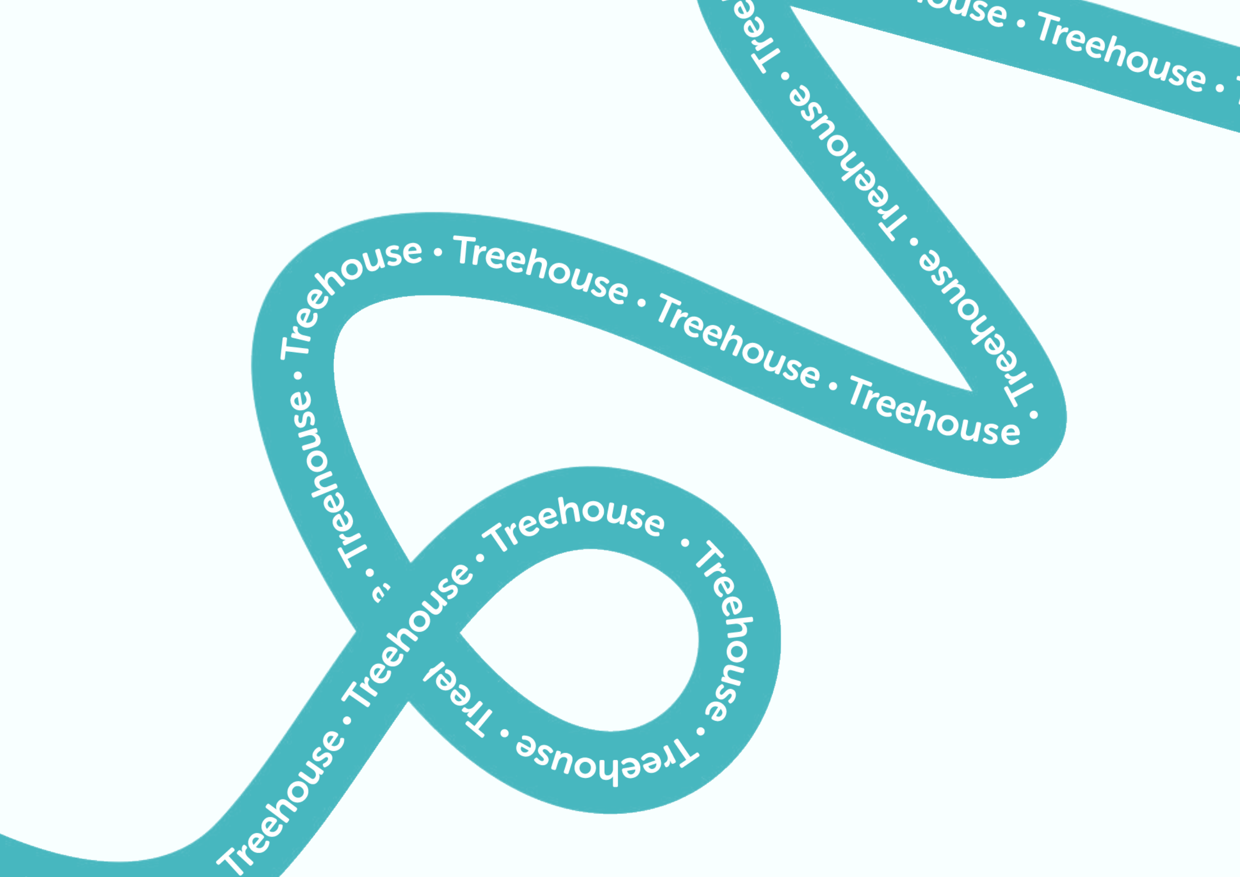
ADOS-2 autism identification assessment

Leadership and reflective practice over 6 days for the whole team

GDPR data governance: Treehouse Practice GDPR and data storage guidelines are submitted with this report.

All staff are compliant with Children First and Fundamentals of GDPR training and copies have been provided to Tusla. All Garda vetting is current for all staff.

A Child Safeguarding statement is in place and in view in the premises.



SECTION

3

Budgets/Costings

Treehouse Practice is seeking funding to support 12 young people and their families where placement stability is at the heart of the referral query. Young people may have experienced prior transitions and/or there is a sense that the placement might be at risk but is not imminently breaking down (i.e. foster carers have not given notice). Referrals will be open to the team for a minimum 12-month period, up to a 2-year-period.

There might be additional capacity to work with more than 12 young people and if this is the case, Tusla will be notified of additional capacity within the team.

The proposal that is provided by Treehouse Practice for each child post-planning meeting is typically an accurate reflection of the scope of work and it is extremely rare that changes would be needed to those proposals. Exceptions might be in the case of an area of neurodivergence not identified by professionals at planning meeting stage. This would be clearly communicated to Tusla at the earliest opportunity.

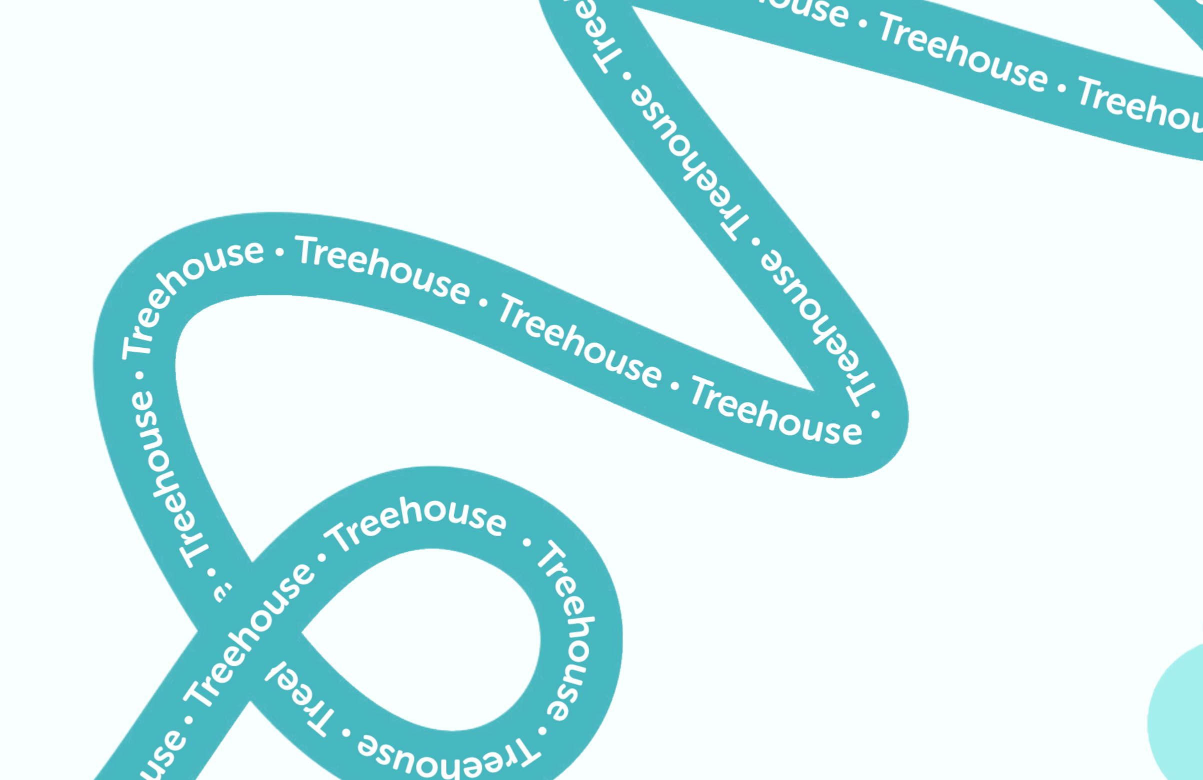
A review of the last 10 Tusla referrals for assessment and intervention has indicated the following average fees for each:

Therapeutic assessment for child, family and system:

€14,273

Bespoke therapeutic intervention package (12 months):

€9888



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Case Study 1

Sean was received into care at 1 year old. Sean had two short term foster placements that ended abruptly prior to moving to his current foster family. Sean moved in with Alan and Denise when he was 18 months old, he was 4 years old at the time of referral to Treehouse Practice. His foster carers were struggling with Sean's behaviour and told the SWD they could not care for him if things did not change. The SWD had begun exploring options for residential care for Sean.

Presenting issues at time of referral:

- Sean did not sleep, he was constantly on the go.
- He regularly did dangerous things e.g. he left the home in the middle of the night while the family were sleeping, he was walking around the estate. Luckily, he was returned by a neighbour.
- He flooded the kitchen, he set the toaster on fire.
- He was aggressive to the family pet.
- He was head banging, lashing out at the foster carers.
- He would throw tantrums while out.
- He would not keep his seat belt on in car; he would pull foster carers hair while driving.
- Foster carers experienced him as controlling, aggressive and beyond their control.
- They queried ASD and believed he needed to attend a school for special needs.
- He had weekly contact with his siblings and mother.

Intervention over a three-year period delivered by an occupational therapist, clinical psychologist, therapeutic social worker and multi-disciplinary team consultations:

- Access was paused to allow time for therapeutic intervention to identify Sean's baseline. Court ordered access was in place at the time of referral. Following several supportive sessions with his birth mother she agreed and understood the need for a pause.
- Weekly sessions with foster carers to support their understanding of Sean's unique attachment and trauma profile.
- Weekly OT sessions for Sean.
- Video Interactive Guidance (VIG) with foster carers individually.
- Psychological support for foster carers together and separately.
- School training and supervision.
- Therapeutic life story exploration alongside foster carers and Sean and in collaboration with his birth mother.
- Sean had OT sessions following his life story sessions to support his bodily regulation.
- Re-established quality family contact for Sean and his two older siblings. They spent two overnights together at a camp.
- Treehouse practice continues to have open communication with Sean's mother on his progress. Sean and his mother ask questions indirectly of each other through Treehouse social worker.

Cost of interventions	Potential cost of placement breakdown (Residential Care)	Cost Saving for Tusla, Child & Family Agency
€ 12,586.00 per year	€ 260,000.00 per year	Less intensive social work inputs needed
€ 37,759.00 total over 3 yrs	€ 780,000.00 over 3 years	E Plus support discontinued
€176,204.00 until Sean reaches the age of majority	€ 10,920,000.00 until Sean reaches the age of majority	No longer listed as a placement at risk

*possible SEA if residential care not available

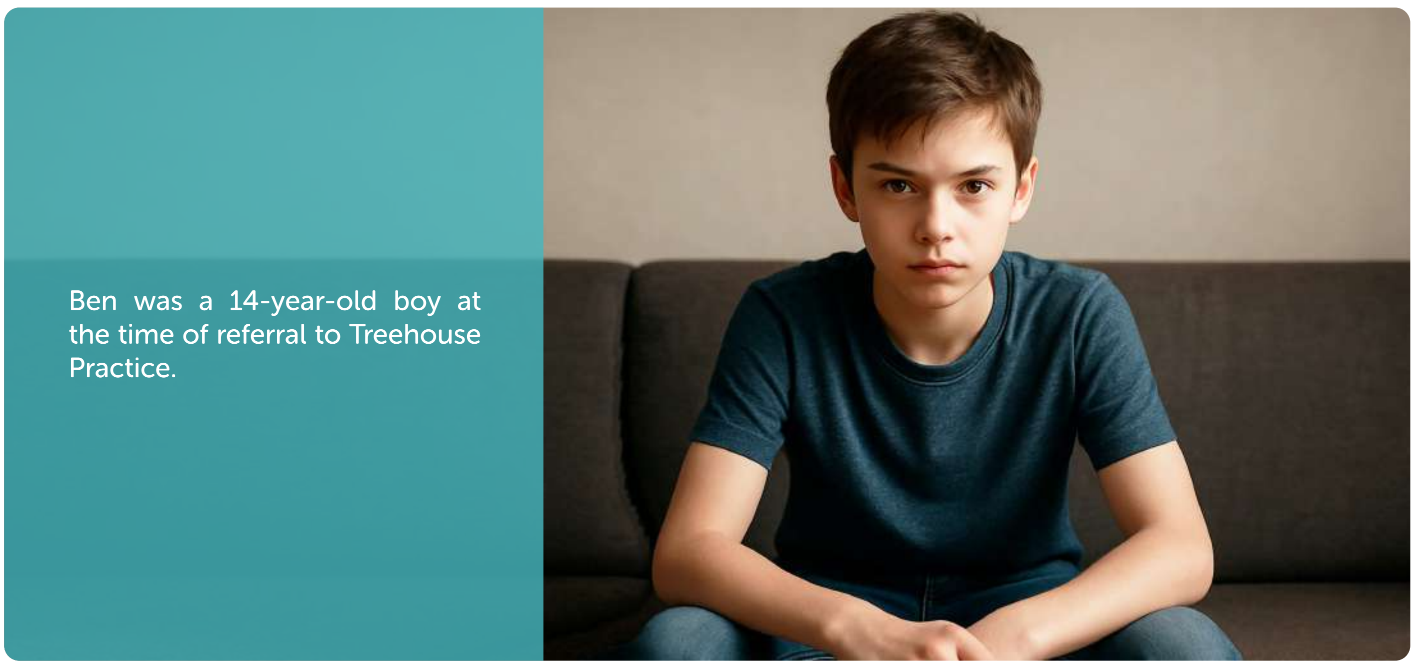
Outcomes for Sean following intervention

Active and Healthy	Sean joined his local GAA team and he enjoys weekly swimming. Sean still has trouble sleeping however the frequency of his risky behaviour has dramatically decreased.
Achieving in Learning and Development	Sean attends mainstream school, and he has just started 1st class this year. He enjoys a supportive school environment.
Safe and Protected from Harm	Following the hard work and commitment shown in therapy by his loving foster carers, his placement is no longer at risk. He enjoys a stable foster family. Given the growth in confidence and competence of his foster carers they no longer require the support of E-Plus.
Economic Security and Opportunity	Sean is settled in a comfortable foster home. He is no longer at risk of housing instability given the potential for multiple moves had his placement broken down.
Connected, Respected and Contributing to their world	Sean and his siblings have reconnected and spend quality family time together. Sean contributed to the planning of contact, writing letters to his brother inviting them to visit him.

The Lundy Model of Child Participation

SPACE	Sean was given both physical space and psychological space to find his voice. This was mainly through occupational therapy and life story exploration. He developed the confidence to express what his wishes were.
VOICE	In the end Sean voiced that he simply missed his brothers. He wanted to see them. He expressed he was not ready to see his mother.
AUDIENCE	The most important person to listen to Sean throughout this process was his mother. She continues to work with Treehouse and gets regular updates. The SWD listened and made family contact happen in a way that best suited Sean. All the siblings now get together with their parent and foster carers.
INFLUENCE	Sean was involved in the planning of family contact. He decided the venue and wrote letters back and forth to his brothers, telling him he missed them. He learned that he has agency and influence to make things happen. The SWD, foster carers and all involved supporting in the background made the re-introduction of sibling contact a success to build on.

Case Study 2



He was a single occupant in a Tusla residential placement. Ben was received into care by way of voluntary consent following very challenging behaviour towards his mother.

It was reported that he was both physically and verbally aggressive towards his mother and staff. Staff had described his behaviour as threatening and controlling. It was also reported he was self-harming.

Ben had been identified as autistic and there were ongoing conversations between Tusla and HSE Disability Services regarding who should provide him with a long-term placement.

Ben had a number of prior assessments and interventions before his referral to Treehouse. Rather than further assessment a 'Case Formulation Clinic', a collaborative thinking space with the wider professional network involved in his day-to-day care, and clinical interviews with Ben's parents, were facilitated to think about how best to support him going forward.

Intervention over a 15-month period delivered by a child & family psychotherapist, psychologists, therapeutic social worker and multi-disciplinary team consultations was planned as follows:

- Case formulation clinic: a collaborative thinking space with those involved in a young person's life, to integrate the learning from previous assessments and generate new ideas for therapeutic planning moving forward.
- Meaning of the Child interview with both parents.
- Supervision and support to the residential team.
- Adult psychotherapy offered to Ben's parents, and accepted by one parent.
- Parent support, both joint and separate.
- Extended Family support, suggested but did not materialise.
- Psychological support to Ben, offered and explored with Ben at his pace.
- Ben returned home 15 months after the initial referral.

Cost of Admission to Care at Time of Referral	Cost of Treehouse Practice Interventions	Potential Cost of Placement Breakdown
• Shut down a respite unit supporting several foster families across two counties for 13 months. • SEA for one week • Behaviour Specialists • Occupational Therapy	• A total cost of €23,300.00 over a 15-month period for the interventions outlined above.	• €260,000.00 per annum for residential care. • Cost of Tusla resources e.g. social worker, administration, access services etc.

Outcomes for Ben following intervention

Active and Healthy	Ben has had more opportunities for social activity and engagement with family and friends following his return home. He has joined family members on holiday abroad and managed well.
Achieving in Learning and Development	This is an ongoing area of need, with Ben hoping to re-engage with education. However, it is acknowledged that given his prolonged absence from school during his care-experience, Ben will likely require support with re-integration to education in an environment that understands his strengths and needs. It is also important that Ben is supported to understand his own story and identity.
Safe and Protected from Harm	Ben experienced isolation and restraint at the beginning of his care experience; his return home has protected him from further isolation and harm. His relationship with his parents is growing stronger, he has connections with family and his parents have more confidence. His parents have engaged with their own supports to ensure they can support Ben's safety and protect him from harm.
Economic Security and Opportunity	Ben has a safe and stable home to live in, with his own personal space and his care needs are met. His parents are supported in building their confidence in caring for Ben, which reduces the risk of further placement breakdown. It is hoped that should Ben re-engage with further education through a pathway that supports his needs associated with neurodivergence, he will be able to explore economic security and opportunity in the future.
Connected, Respected and Contributing to their world	Ben is connected with family and peers including a girlfriend. Ben's views are respected by his family and professionals, in terms of how he wants to engage with supports. Ben is contributing relationally and socially to his world, with hopes to continue his education and activities of interest.

The Lundy Model of Child Participation

SPACE	**Ben was invited to express his views about engaging in therapeutic supports in multiple ways:** • In session with the psychologist, however it is acknowledged there may have been barriers to Ben feeling comfortable expressing his views here. • By informing his keyworker (when in residential service) and parents (when he returned home). • Youth-friendly letters were sent to Ben before his first meeting with the psychologist and later, during times of disengagement; these were addressed directly to Ben and his caregivers were advised to provide him with private space to review the letters and decide how he would like to respond (if at all). • Alternative modes of contact were offered to Ben, such as by phone and videocall so that he could attend from the privacy of his home.
VOICE	**Ben expressed his voice, views and preferences, both verbally and nonverbally. He indicated his preference for topics of discussion, for engagement with therapy, etc:** • By naming this with the psychologist, who provided space for this to be heard. • By deciding not to enter the practice for a session and informing his keyworkers. • By deciding not to attend sessions by informing his parents. • He shared his reluctance to reconnect with his father.
AUDIENCE	**Verbal:** • With Ben, the psychologist provided information about the therapeutic space as a private and confidential space for him (within the limits of confidentiality); Ben was invited to reflect on this in his own time and he engaged in multiple conversations and discussions with the psychologist – being open, compassionate and curious about his views. • Informing Ben that his views are welcome. **Nonverbal:** • Considering where to sit in sessions with Ben, if he preferred not to sit directly face-to-face e.g. sitting alongside, walking. • The pace at which Ben wanted to reconnect with his father were listened to by all parties involved including his father.
INFLUENCE	**When Ben expressed a preference not to engage in sessions, his views were respected:** • Psychologist wrote closing letter to Ben, thanking him for his engagement and noting that he was welcome to re-engage in future if he wished to. • Communicating and advocating for Ben's views to others in his life e.g. professionals, parents. • Ben learned that he could influence decision making regarding his wishes around contact with his father.

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