Making the case

Transforming services for those affected by child sexual abuse and exploitation
Imagine a childhood disease that affects one in five girls and one in seven boys before they reach 18: a disease that can cause dramatic mood swings, erratic behaviour, and even severe conduct disorders among those exposed; a disease that breeds distrust of adults and undermines the possibility of experiencing normal sexual relationships; a disease that can have profound implications for an individual’s future health by increasing the risk of problems such as substance abuse, sexually transmitted diseases, and suicidal behaviour; a disease that replicates itself by causing some of its victims to expose future generations to its debilitating effects.

Imagine what we would do.

As a society if such a disease existed we would spare no expense. We would invest heavily in basic and applied research. We would devise systems to identify those affected and provide services to treat them. We would develop and broadly implement prevention campaigns to protect our children.

**Wouldn’t we?**

James Mercy,
Centre for Disease Control, Atlanta
In 2016, the Department of Health commissioned the Family Nurse Partnership (FNP) National Unit and the Tavistock and Portman NHS Foundation Trust to explore how services for survivors of child sexual abuse (CSA) and child sexual exploitation (CSE) might be improved.

This pack summarises findings from the project. It is designed as a resource for all organisations working with families who experience Child Sexual Abuse and Exploitation (CSAE)

**The pack is split into three broad sections:**
- The case for change, highlighting the prevalence and effect of CSAE
- An overview of the project and what it achieved
- A guide on how to implement a trauma-informed case-holding model
Part one:
The case for change
The scale of the issue

In the UK today, CSAE is not a rare or uncommon event. Lifetime prevalence of CSA is thought to be 15-27% for girls and 5-8% for boys and an estimated minimum of 16,500 children and young people are at risk from CSE.

But these statistics may just be the tip of the iceberg...
Identifying CSAE is difficult: children and young people are often reluctant to disclose what has happened to them and some are not believed when they do disclose. Reviews and studies have identified that there is also a lack of professional awareness and understanding of CSAE and its effects – and huge local disparity in the provision of specialist CSAE services.

Many cases of CSAE go unreported, and although the rate of recorded sexual offences against children and young people has risen in recent times, few of those that are reported lead to child protection proceedings or conviction of perpetrators.

Assessing the true scale of the issue is therefore complex and challenging.

Source: Finkelhor et al 2013; Kelly and Karna 2017
Children’s Commissioner for England estimated minimum 16,500 C&YP at risk of CSE (March 2011)
I find it hard to trust people. I don’t mind who it is, but it depends on my being able to trust them or not. I find it hard to trust people. I don’t know whether to tell them or not. I have to get to know them first.
The impact of CSAE can be devastating – and lifelong

Many of those affected by CSAE experience physical violence, injuries and illness (e.g. Sexually Transmitted Infections (STIs)) or pregnancy, and 50-80% of those who experience CSA show symptoms of Post-Traumatic Stress Disorder (PTSD), anxiety or depression.

CSAE can also lead to self-destructive behaviours, feelings of isolation and stigma, substance misuse and sexualised or disruptive behaviour.

There is growing recognition that CSAE sits alongside other Adverse Childhood Experiences (ACEs) such as witnessing domestic abuse, parental mental-ill health/substance misuse, and that exposure to multiple ACEs can have lasting impact on physical and mental health and wellbeing.

Adult survivors of CSAE have an increased risk of mental health problems, higher rates of PTSD, lower life satisfaction, greater risk of sexual risk-taking behaviours, and increased dependence on welfare.

NICE recommend a range of interventions for children, young people and families following child abuse and neglect. For children who have been sexually abused, trauma-focused Cognitive Behavioural Therapy over 12-16 sessions is one of the first line treatments, particularly to address anxiety, sexualised behaviour or PTSD.

For those aged 4 to 17 interventions like NSPCC’s “Letting the Future in” can offer support tailored to the child’s needs; for girls aged 6 – 14 an assessment should take place followed by individual focused psychoanalytic therapy or group sessions.

While CSE is relatively rare when compared to intra-familial sexual abuse, in recent times, there has been a concerted effort to prevent, address and treat survivors of CSAE.

https://academic.oup.com/jpubhealth/article/36/1/81/1571104]
‘My thoughts and my self-harm. I still have times when I want to self-harm myself and the thoughts in my head saying, “I don’t want to be here”. It’s like the other day, I had a thought “I don’t want to be here. I want to be killed”. Obviously I didn’t mean it but…'}
What survivors say

Children and young people affected by CSAE are clear what they need:

- **Vigilance**: to have adults notice when things are troubling them
- **Understanding and action**: to be heard and understood; and to have that understanding acted upon
- **Stability**: to be able to develop an on-going stable relationship of trust with those helping them
- **Respect**: to be treated with the expectation that they are competent rather than not
- **Information and engagement**: to be informed about and involved in procedures, decisions, concerns and plans
- **Explanation**: to be told be about the important decisions, the results of assessments and reasons when their views have not met with a positive response
- **Support**: to have help in their own right as well as a member of their family
- **Advocacy**: to be provided with help in putting forward their views

[from Working Together to Safeguard Children page 11, HM Government (March 2015)]
'Making the case' was designed as a response to these issues. It aimed to develop models for improving the provision and co-ordination of, and access to, services for those affected by CSAE through the introduction of a ‘case-holder’ approach.
Part two: Learning from the project
The project

- The Department of Health commissioned the Family Nurse Partnership (FNP) National Unit and the Tavistock and Portman NHS Foundation Trust to explore how services for Children and Young People (C&YP) who have been sexually abused and exploited can be improved.
- Chanon Consulting and Way Ahead Team contributed to data gathering, evaluation and report preparation.
- Working with three local areas – Birmingham, Rotherham and North Central London (Barnet, Camden, Enfield, Haringey, Islington) – the project explored how a ‘case holding’ approach could deliver a more joined-up, supportive and holistic service to those affected by CSAE.
- The project aimed to help shape and try out case-holder models working with children and young people who have been sexually abused or exploited – including engaging with them earlier, providing more accessible, consistent trauma-informed support, and working to achieve improved outcomes with a recovery focus.
- You can find the full report and executive summary here [taviport.co/CSAreport](taviport.co/CSAreport).
The three areas introduced ‘case-holder’ approaches which sought to address the complexities and difficulties experienced by children, young people and their families in accessing early consistent support through improved design and co-ordination of the response and better access to services (NHS, CSC, CJS, police, education, VCS)

The approach was intended to improve services for children and young people who do not meet CAMHS or social care thresholds, and to provide earlier intervention and support through a trusting and consistent relationship with one worker (the ‘case-holder’) walking alongside the child/young person and their family, listening to their experiences and views, focusing on recovery rather than abuse, and providing help in navigating the system

Three different approaches evolved in the three areas. The ‘case-holder’ models developed were just one set of approaches to improving services for those who have experienced CSAE, giving children, young people and their families a consistent person to work with. But the scale of the problem justifies examination and piloting of a range of intervention and support responses
The three pilot areas were chosen due to their experience of working with children who had experienced child sexual abuse (Birmingham and London CSA) and Rotherham with a focus on CSE.

Each site put their own implementation teams in place, designating a project lead, ensuring leadership and governance arrangements.

The three areas were brought together through workshops to offer mutual support, share learning and to hear from leading experts on trauma-informed approaches.

A small national team provided support using:

- relational working methods – a collaborative, respectful, interpersonal, negotiating approach,
- service improvement methodology – supportive, appreciative inquiry; evolving; adaptive; responsive; reflective,
- child/young person and outcomes – focused with clinical trauma and expertise on child sexual abuse

And informed throughout by the voice of the child/young person.
We would like to give them someone like [my keyworker] who comes in from outside, but sees them every week and then maybe they could start talking to them. Yeah.
The approach (2)

In all three areas, local stakeholders, including children, young people and families were consulted to:

- Understand existing systems and services
- Hear directly from those affected on their experiences and thoughts on potential improvements
- Identify existing good practice as well as gaps
- Evaluate the processes used to deliver change
- Assess the potential for replicating models

Data collection was undertaken through site visits, fieldwork and interviews in three phases:

- Development of template and site visits to provide expert support to projects
- Face-to-face or telephone interviews in three project areas with C&YP, parents, children’s social care commissioners, service managers and practitioners
- Presentation of interview data, overall evaluation analysis
The project in Birmingham had four key areas of focus:

- To test the feasibility of a case-holder service for children and young people referred to children’s social care (CSC)
- To seek the views of children, young people and families on a case-holder service
- To build capacity in the workforce to enable practitioners identify and respond to CSAE through training on trauma and the importance of ACEs
- To develop a library of resources for practitioners and parents/carers to enable earlier identification of CSAE and a single online portal to access services
Birmingham

Model and outcomes

What was achieved:

• 15 families were offered a case-holding service. Around half accepted. The service helped to address gaps in care for all levels of need, to take a more holistic view and to improve the overall experience and outcomes for both the child and the family

• A suite of training materials was developed, including a set of 20 short training films for professionals and parents to promote early identification. 819 professionals were trained during the course of the project

• Agreement was reached that CSA and CSE should be addressed together, with children, young people and their families having one consistent person supporting them throughout the process, offering therapeutic input, consistency and guidance through the system, from initial reporting to potential prosecution

• Numbers involved were small (15), making it difficult to draw firm conclusions, but it is likely that this is a more child-centred way of working, driven by the needs of the child and with a renewed focus on all sources of trauma, rather than just focusing on the short-term safety of the child or young person

• Results were encouraging and the enhancements well-received, and are certainly sufficient to justify further work on the model

• The project also led to much closer collaboration between the VCS, statutory services and commissioners
North Central London

Model and outcomes

The project in North Central London had three key areas of focus:

• To enhance the existing CSA medical clinic by creating a holistic team assessment with doctor, advocate and/or CAMHS practitioner. This initial assessment was followed by short-term input from the case-holder to provide early emotional support and help in navigating local services and liaison with the wider multi-agency network.

• To implement findings of the review of the London CSA pathway [https://www.england.nhs.uk/london/2014/11/02/review-of-pathway-cyp/](https://www.england.nhs.uk/london/2014/11/02/review-of-pathway-cyp/)

• To enable early intervention support to be offered, including a multi-disciplinary team meeting before the clinic which looks at all the current and referred cases and to agree an action plan for each
She accepted being bullied and went along with behaviours and activities which she would not have initiated on her own, for the sake of feeling that she had friends (parent)
What was achieved:

• An agreed action plan was drawn up for every child or young person presenting in the immediate aftermath of sexual abuse

• Early emotional and mental health support was put in place from the first clinic appointment, with each child/young person offered up to six sessions of intervention (regardless of whether there was a diagnosis of mental illness)

• Each case was followed up after six months to ensure support remained in place

• Earlier help to process trauma also reduced the impact on families

• There has been a significant increase in referrals from police to the service, leading to:
  – 144 medical reviews and assessment from paediatrician – forensic examination followed by access to emotional and psychological support, advocacy and family therapy
  – a CAMHS clinician providing consultation and liaison services

• The project led to improved multi-agency and professional co-operation, and the removal of barriers to accessing both advocacy and CAMHS support

Rotherham

Model and outcomes

The project in Rotherham had five key areas of focus:

- To improve the multi-agency response to complex cases of CSE by provision of a case holder provided by Children’s Social Care (if the local authority threshold is reached) or Barnardo’s
- To improve access to CAMHS by developing a visible and transparent system-wide pathway
- To develop the skills of practitioners working with families
- To identify and respond to child sexual abuse and exploitation based on a strengthened understanding of attachment and attunement
- To learn the lessons from previous inquiries, Operation Scorpio in particular.
Rotherham

Model and outcomes

What was achieved:

- A new referral route for assessment by CAMHS has been established
- A senior CAMHS practitioner, specialising in CSE, was appointed to bridge the gap to the existing CSE outreach team, leading to ‘wraparound’ support and protection for the child or young person and family
- 55 children and young people were offered a consultation over eight months. Fourteen were found to be in need of ongoing support from CAMHS. The CAMHS practitioner offered Consultation and Liaison support for 80 other cases (advice and guidance was provided on individual cases rather than face-to-face work)
- A trauma-informed approach was developed to help both parents and professionals to understand mental health issues related to the child/young person’s experience
Rotherham

Model and outcomes

What was achieved:

- Waiting times for initial assessments have dropped below national average and there is better communication between teams
- There has been mutual learning across the system, leading to reduced need for referral to CAMHS
- A 10 week course was commissioned to help professionals understand attachment theory, attunement and trauma – the course has proved highly popular and effective in raising awareness
- A review of learning from Operation Scorpio helped to strengthen the integration of police into the CSAE partnership
- A comprehensive action plan was developed with strategic ownership, helping to address the need for joined-up commissioning, and provides greater clarity of social care thresholds
I had a CAMHS worker. He was helping me and then that was stopped because of it being too…. he put me on medication because of my depression which was helping and then obviously he was leaving. I didn’t see him again.
A number of powerful lessons were learned from the project as a whole:

CSAE is a deeply traumatic experience which can have lifelong impact. Taking a proactive, trauma-informed, child-centred approach appears to have huge benefits for children, young people and their families, helping to reduce the harmful effects that may otherwise stay with them throughout their lives.

A trauma-informed case-holder service was found to provide earlier, more consistent, trusted, caring, holistic support. It can help to transform the service response for CSAE survivors and their families.

Putting the voices of survivors at the heart of responding to the trauma of CSAE is critical.

Listening and responding in a compassionate, empathetic, consistent, trauma-informed and timely way can make a significant difference.

It is important to understand and address ACEs and their underlying causes, and to raise awareness of the impact of trauma and what can be done to tackle it. Earlier identification can lead to earlier intervention which can, in turn, reduce the need for specialist support and improve long-term outcomes for the child or young person.
We found significant gaps in access to, and availability of, therapeutic and other essential services, with limited support available (long waits, high thresholds based on diagnosis and severity, rejected referrals).

Implementing major change to systems, structures, procedures and professional practice proved challenging at a time when agencies were already undergoing major change and feeling the impact of economic austerity.

There appears to be insufficient understanding of trauma and its impact by people working with those affected by CSAE, which can lead to a lack of empathy and understanding of behaviours, incorrect diagnosis/less effective treatment, increased stigma and inappropriate response (e.g. taking action through the CJS in response to a misdemeanour of the child without understanding the reason which led to it).

The term ‘case holding’ was not clearly understood by all stakeholders. Further definition, clarification and consensus about the role is necessary if the project is to be scaled up. More work is also needed to help establish what the return on investment might be. But outputs and outcomes from the project are sufficiently promising to justify this additional work.
Part three: how to implement a trauma-informed case-holding model
Introduction

This section suggests an approach to establishing a case-holder model, based on learning and experience from the ‘Making the case’ project.
Assess the local context

- Analyse the local context in relation to CSAE to highlight strengths to build on and challenges to address
- Carry out a needs assessment to reflect the scale of the issue, frequency of victimisation and cumulative impact of multiple ACEs
- Ask children, young people and families what they need in order to be supported. Respond to what you hear
- Apply a public health and ‘place-based’ approach to estimate the level of need and the implications of taking no action
- Consider CSA and CSE together and, where possible and appropriate, commission and provide services jointly
We had to explain our situation to three different workers. Then when the third worker was beginning to build a relationship, she was changed and we were given another worker. And I said “No, I’m not going through it all again. I am not willing to because I can’t keep coming in this room every few weeks, breaking down and telling these people my life story. It’s not right.” So I think if you have a worker you should stick with that worker. They are on about confidentiality, well, if that was confidentiality……half the office know about us.
Increase understanding of trauma and its impact

- Take steps to ensure that all key stakeholders – practitioners, policy makers, local system leaders, commissioners and parents – have a greater understanding and awareness of the impact of trauma, attachment and resilience, and the impact that ACEs have on long-term health, wellbeing and behaviour.
- Take a trauma-informed approach when working directly with children, young people and families.
- Apply routine enquiry about violence and abuse in all age groups as this can lead to an increase in disclosures and help-seeking.
- Include sensitive enquiry about neglect, violence and physical, sexual or emotional abuse when assessing children in specialist services.
- Factor in training in relation to trauma into all relevant curricula aimed at all relevant local professionals. Learning needs are likely to be significant.

Scope existing services and develop a local model

- Map local services (statutory and VCS) to see what is available already. Update this as services develop
- Compare local need against existing service provision to identify gaps. Include waiting times, number of referrals refused, thresholds for referrals, views of C&YP and families
- Consider wider support systems including universal services (eg: early years, primary care, schools & colleges, youth services) rather than just specialist services
- Address the root causes of trauma and put preventive strategies in place (e.g. through support for parents, awareness raising and provision of information about CSAE)
- Where possible, specify the use of routine enquiry in relevant contracts (such as mental health in children and young people’s services) so that system and practitioner skills and confidence in enquiring about and understanding of a child or young person’s adverse and abusive experience is strengthened and services are able to provide an appropriate and timely support
- Embed awareness of ACEs and the need for earlier intervention and help in all relevant professional training programmes
- Develop a local trauma-informed local model which puts services in place to meet local needs, underpinned by local references and stakeholder views—and the views of the victims of CSAE in particular

[See https://www.nspcc.org.uk/globalassets/documents/research-reports/mapping-therapeutic-services-sexual-abuse-uk-2015.pdf Identify current gaps in services]
Revise approach to commissioning and funding

- Embed a trauma-informed approach in commissioning strategies and ensure voices of those affected by CSAE are used to inform commissioning decisions
- Take both the short and long-term impacts of trauma into account in local planning and commissioning. Make sure this is reflected in education and training strategies
- Ensure relevant contracts reflect and are sensitive to the likelihood of trauma, particularly services such as substance misuse and sexual health and all those involving children and young people
- Include sufficient capacity in CAMHS for senior practitioners to advise and liaise on a wide range of cases. Being able to offer advice to staff working with those with highly complex needs, including troubleshooting and care planning, can give practitioners working directly with the family the confidence and skills needed to provide support, thereby reducing referrals for specialist care
- Ensure services are accessible and available in a range of settings and consider offering financial support for low income families to help them with travel costs as some may find these to be a barrier to accessing treatment

[See https://www.nspcc.org.uk/globalassets/documents/research-reports/mapping-therapeutic-services-sexual-abuse-uk-2015.pdf Identify current gaps in services]
"I would definitely give them a keyworker to talk to and not keep it to yourself because it makes you even more worser inside and then obviously I would tell them .....to go and express it, even if you don’t want to tell your parents, at least tell your keyworker or a teacher"
Clarify leadership and accountability

- Clarify the ownership and strategic understanding of CSAE, led by people who can articulate the impact of CSAE on survivors, their families and the wider system are key to driving the changes needed to provide earlier and more effective trauma support. Have ACE and trauma-informed practice training available for senior local authority, health and relevant statutory service (e.g. police) leaders and monitor its uptake
- Ensure that strong leadership is in place to unblock the barriers and ensure that resourcing, training and partnership work are in place to enable the system and practice changes required
- At the outset, ensure outcomes, definitions of success, roles and responsibilities and risks and mitigation are discussed and agreed by all stakeholders. Buy-in from all parties is crucial to ensuring a consistent approach, effective communication and well-implemented change. Push for pooled resources to ensure equality of accountability
- Ensure that you have senior strategic support and oversight from the Local Safeguarding Children’s Board and Health and Wellbeing Board
- Ensure that Local Transformation Plans for children and young peoples’ mental health and Sustainability and Transformation Plans (STPs) reflect needs of those affected by CSAE
- Take a trauma-informed approach when planning, commissioning and providing services. Make sure this is reflected in local accountability and workforce development arrangements
- Make sure that trauma-informed training and response action plans are developed and implemented locally

[See https://www.england.nhs.uk/mental-health/cyp/transformation/]
[https://resources.nwgnetwork.org/resources and http://www.barnardos.org.uk/what_we_do/our_work/sexual_exploitation.htm]
Key components of a successful case-holding

- Consults with, listens and responds to the voices of children, young people and families who have experienced CSAE at every stage. Hears and reflects their views in all aspects, role design and choosing who ‘case-holder’ workers will be: personal attributes are as important as relevant professional background and experience
- Puts in place clear information-sharing protocols to facilitate interagency working, prevent repeat assessments and to ensure victims don’t have to retell their stories
- Is part of a whole-system public health approach, with ALL health staff trained in trauma-informed approaches to tackling CSAE, AND non-health staff who may interact with those affected (e.g. teachers, the fire service)
- Sufficient time and capacity are dedicated to engaging staff and the community in local service transformation
- Provides high-quality supervision to help staff working directly with those affected by CSAE deal with what they encounter
- Committed to measuring performance and driving improvement: outcomes for survivors are monitored and reported on; trends analysed and learning shared across system

(A) needs one person to ‘hold her’ – not lots of people. And not short term, because the person needs to ‘bring the child in’ [build A’s trust] so she is in a place that she can understand what’s right and wrong [she is not to blame], about what happened to her, and about being able to carry on her life.
Key attributes of a high quality

Personal attributes are as important as relevant qualifications and experience:

- Consistent – one individual who forms trusting and stable relationship
- Tenacity – constantly highlights and promotes best interests of survivors
- Resilience – able to cope with highly emotive, distressing issues and challenging local circumstances
- Compassion – is highly sympathetic to impact of CSAE on survivors and families
- Empathy – sees system through the eyes of survivors
- Non-Judgemental – does not judge survivors or their behaviour
- Collaborative – works closely and transparently with all relevant local agencies
- Trauma-informed – has high level of expertise and training in impact of trauma and awareness of ACEs
How case holder model supports a child or young person affected by CSA

- A child or young person discloses CSAE
- Immediate action taken by police, CJS and CSC; medical care provided by NHS (including forensic evidence if recent abuse, sexual health) – all have received training on trauma and understand the need for early intervention
- A child or young person and parent(s) referred to case-holder who works for a VCS organisation
- Case-holder carries out an assessment of the child or young person, agrees frequency and location of contact with him or her and their family
- Case-holder makes links with all key agencies including Social Care, CAMHS and/or specialist VCS organisation (depending on need), liaises with school/college, acts as conduit with police and CJS
- The child or young person is referred to CAMHS for an early assessment and found to be in need of specialist treatment for PTSD which is provided by CAMHS
- Case-holder liaises with other workers who are able to provide support to the young person, including the school/college, school nurse, GP
- Case-holder advocates on behalf of the young person and family and provides consistent, regular advice, solves problems as they arise, monitors progress, supports the young person through criminal justice processes
Starting up:

10-step checklist

1. Set out a clear vision with the voices of children and young people at its core
2. Establish strategic partnership and governance arrangements with key stakeholders (Social Care, police, CSC, education, NHS, CJS, VCS). Secure leadership buy-in and clarify objectives at the outset
3. Carry out an assessment of need for CSAE support services with Public Health, Local Communities, Social Care, wider Children’s Services, CAMHS with Voluntary Sector input
4. Map what services are available (include skills mapping), identify strengths and gaps
5. Define what the trauma-informed approach and case-holder model is that is to be implemented, how, by whom and build in on-going review and quality assurance
6. Ensure that the voices of children, young people and their families are heard – put an engagement strategy in place early on, ensuring it is fully resourced and referred to
7. Clarify what data are available and put in place information sharing agreements
8. Agree project leadership and accountability, and put resource and implementation plans in place
9. Develop a training and implementation plan to rollout awareness raising of ACEs and trauma-informed understanding and approaches, building a system that is skilled in dealing with, and responsive to trauma
10. Commission services in line with the model agreed, monitoring access, usage and outcomes – with a cyclical approach to review and adaptation
Further reading

International Centre at University of Bedfordshire:
Researching Child Sexual Exploitation, Violence and Trafficking https://www.beds.ac.uk/intcent

Child Sexual Abuse Hub toolkit:
A practical guide for commissioners and practitioners to establish a CSA Hub, Emma Harewood and Holly Baine

Centre of expertise on Child Sexual Abuse, Barnardo’s https://www.csacentre.org.uk/

CSE Response Unit, NWG for CSE https://www.nwgnetwork.org/cse-response-unit/#

Contact FNP/Tavistock and Portman NHSFT
Tavistock Centre, 120 Belsize Lane, London, NW3 5BA
Tel: 020 7435 7111
communications@tavi-port.nhs.uk
https://tavistockandportman.nhs.uk/
### Abbreviations

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
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<tbody>
<tr>
<td>ACEs</td>
<td>Adverse Childhood Experience</td>
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<td>CAMHS</td>
<td>Child and Adolescent Mental Health Services</td>
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<td>C&amp;YP</td>
<td>Children and Young People</td>
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<td>CBT</td>
<td>Cognitive Behavioural Therapy</td>
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<td>CCG</td>
<td>Clinical Commissioning Group</td>
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<td>CJS</td>
<td>Criminal Justice Services</td>
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<td>CSA</td>
<td>Child Sexual Abuse</td>
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<td>CSC</td>
<td>Children’s Social Care</td>
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<td>CSE</td>
<td>Child Sexual Exploitation</td>
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<td>CSAE</td>
<td>Child Sexual Abuse and Exploitation</td>
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<td>NICE</td>
<td>National Institute of Health and Care Expertise</td>
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<td>PTSD</td>
<td>Post Traumatic Stress Disorder</td>
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<td>SEND</td>
<td>Special Educational Needs and Disabilities</td>
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<tr>
<td>STP</td>
<td>Sustainability and Transformation Plan</td>
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<tr>
<td>VCS</td>
<td>Voluntary and Community Sector</td>
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I think it would be better if everything was dealt with in one place. Parents, like me, could have some counselling there. I should be able to have counselling at the same time at the same place because then it doesn’t interfere with getting him back to school and disrupt his life even more than it already has been.