Harmful sexual behaviour among children and young people

NICE guideline

Draft for consultation February 2016

This guideline aims to ensure children and young people who display harmful sexual behaviour, including those on remand or serving community or custodial sentences, are assessed as soon as possible.

Early assessments are important as these type of problems are often not recognised until the child or young person has been charged with a sexual offence. A person-centred approach is also important to ensure they receive the support they need and are not unnecessarily referred to specialist services, which can lead to them being stigmatised.

'Young people' refers mainly to those aged 10–18, but also includes people up to the age of 25 who have special educational needs or a disability. 'Children' refers to children under 10, which is the age of criminal responsibility in England.

Who is it for?

- people with social care, health and wellbeing as part of their remit
- social workers, social and residential care practitioners and foster carers
- child and adolescent harmful sexual behaviour and mental health services
- neighbourhood policing teams, community support police officers and youth offending teams
- youth services
- primary and secondary schools
- national adolescent forensic services and specialist harmful sexual behaviour services, sexual health, drug and alcohol services and mental health services

- primary care services.

It may also be of interest to people who have been affected by, or are experiencing, harmful sexual behaviour, and other members of the public.

This guideline contains the draft recommendations, information about implementing the guideline, context, the guideline committee's discussions and recommendations for research. Other information about how the guideline was developed is on the guideline's page on the NICE website. This includes the evidence reviews, the scope, and details of the committee and any declarations of interest.

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Recommendations

People have the right to be involved in discussions and make informed decisions about their care, as described in your care.

Making decisions using NICE guidelines explains how we use words to show the strength (or certainty) of our recommendations, and has information about prescribing medicines (including off-label use), professional guidelines, standards and laws (including on consent and mental capacity), and safeguarding.

1.1 Universal services

1.1.1 Professionals working in universal services who are responsible for a child or young person's welfare should refer them for an early help assessment if they are concerned about their sexual behaviour. This includes: health visitors, Family Nurse Partnerships, GPs, school family liaison officers, teachers, school nurses, nursery staff and social workers. Possible signs of problems include:

- Use of sexualised language that is inappropriate for age and developmental status.
- Sexualised behaviour that is inappropriate for age and developmental status (see the Brook Sexual Behaviours Traffic Light Tool or Hackett's model[1]).
- Use of pornography that is inappropriate for the person's age and developmental status.

1.2 Early help assessment

1.2.1 Offer an early help assessment to identify whether or not a child or young person's needs can be met by universal services or whether a specialist referral is needed. (See Early help: whose responsibility? Ofsted and the

[1] Hackett S (2010) Children and young people with harmful sexual behaviours, in Children behaving badly?: Peer violence between children and young people (eds Barter C and Berridge D), John Wiley & Sons: Chichester.

Department of Health's Working Together to Safeguard Children, The Children's Act 1989 and The Children's Act 2004.) Offer this as soon as a problem emerges.

1.2.2 Early help professionals should identify a lead practitioner who can:

- act as a single point of contact for the child or family
- coordinate early help and subsequent assessments and develop the care plan so that unnecessary or repetitious assessments are avoided
- coordinate delivery of the agreed actions
- reduce overlap and inconsistency in the services provided.

1.2.3 Use a locally-agreed assessment tool in conjunction with the early help assessment form for children and young people referred for sexualised language or behaviour. Take account of the child or young person's age, developmental status and gender and, if relevant, any learning disabilities or autism.

1.2.4 Consider using one of the following assessment tools as part of the early help assessment process to see if the child or young person needs referral to harmful sexual behaviour services:

- The Brook Sexual Behaviours Traffic Light Tool. This identifies a range of behaviours between infancy and adulthood and distinguishes between 3 levels of behaviour – using a traffic light system to indicate the level of seriousness.
- Models that place a child or young person's sexual behaviour on a continuum indicating various levels of seriousness, such as Hackett's model[2].

1.2.5 Focus on the child or young person's strengths and abilities, as well as their vulnerabilities and level of risk. Do not just focus on their sexual behaviour.

[2] Hackett S (2010) Children and young people with harmful sexual behaviours, in Children behaving badly?: Peer violence between children and young people (eds Barter C and Berridge D), John Wiley & Sons: Chichester.

1.2.6 Recognise that harmful sexual behaviour is usually an expression of a range of problems or underlying vulnerabilities that they need help with and that can be identified by assessment.

1.2.7 If the child or young person does need help, but not from (or not just from) specialist harmful sexual behaviour services, refer them to other services, as appropriate. For example:

- For pre-school children see recommendations 1 to 5 in NICE's guideline on social and emotional well-being: early years.
- For children in primary education see recommendation 3 in NICE's guideline on social and emotional well-being in primary education.
- For children and young people in secondary education see recommendations 4, 5 and 6 of NICE's guideline on social and emotional well-being in secondary education.

1.2.8 For children and young people who may have a conduct disorder, see NICE's guideline on anti-social behaviour and conduct disorders in children and young people.

1.2.9 See sections 1.3.4 and 1.9.5 of NICE's guideline on post-traumatic stress disorder.

1.2.10 Involve children, young people and their families and carers in the design and delivery of services offering early help.

1.3 Risk assessment for children and young people referred to harmful sexual behaviour services

1.3.1 Local safeguarding children boards and NHS England should identify specialist staff to undertake a risk assessment of children and young people displaying harmful sexual behaviour. Examples include:

- service providers such as CAMHS or community paediatric services
- professionals working in young offender institutes and young offender teams
- social workers

- psychiatric nurses, psychologists and psychiatrists.

1.3.2 Specialists should use risk assessment tools suitable for the child and young person's developmental age and gender. Aim to assess their needs and level of risk. When assessing adolescents use, for example, J-SOAP II, ERASOR, J-SORRAT-II or AIM2, plus clinical judgement. Take into account:

- Factors that led to the behaviour and the context in which it is expressed.
- Other difficulties, including mental health difficulties, previous maltreatment or trauma.

1.3.3 Provide children and young people at risk of continuing or escalating sexual behaviours with ongoing re-assessment and support that promotes their social and emotional wellbeing.

1.4 The practitioner's role in liaising with families before developing an intervention

1.4.1 Think about the impact a child or young person's harmful sexual behaviour may have on all family members. Provide support or a referral as needed.

1.4.2 Consider the following before providing interventions:

- Meeting families and carers to discuss any concerns they may have, including any potential barriers to attendance.
- Providing families and carers with information about the intervention and including them in the programme when appropriate.
- Adopting a flexible approach to accommodate the child or young person’s changing development needs as they mature, to maintain their interest and involvement.
- Including supervised social activities that promote self-esteem and socially appropriate behaviour, in addition to the intervention itself.

1.5 Principles and approaches for interventions

1.5.1 Structure interventions, but make them flexible enough to meet changing needs, including the developmental status and age of the children and young people. For example, provide longer or more frequent sessions for those with learning disabilities. Include regular progress reviews by practitioners delivering the intervention.

1.5.2 Encourage caring relationships between the child, young person and their carer. Use interventions that can help create a sense of belonging and trust and ensure the child or young person feels safe, valued and protected. (See also NICE's guideline on children's attachment).

1.5.3 Help children and young people develop a strong sense of personal identity. This includes helping them to maintain their cultural and religious beliefs.

1.5.4 Arrange for the child or young person to have access to mental health services if needed.

1.5.5 Deliver interventions in community and family settings, where possible, rather than using out-of-home care placements.

1.5.6 Be aware of the child or young person's family and background and include individual, family and group sessions as appropriate.

1.5.7 Consider using family-oriented cognitive behavioural therapy and additional support programmes, if applicable.

1.5.8 Offer interventions to children and young people in all care settings, including those who are in care or foster homes and those in out-of-home placements.

1.5.9 Make sure children and young people not in a family situation, or living in out-of-home placements, are in contact with relevant practitioners on a regular basis. See NICE's guideline on looked after children and young people.

1.5.10 Make sure the principles of care and other recommendations from NICE's guideline on children's attachment are a component of the support offered. See also:

- sections 1.5 to 1.11 in NICE's guideline on challenging behaviour and learning disabilities
- recommendations 1.4.1 to 1.4.13 and section 1.5 in NICE's guideline on autism: the management and support of children and young people on the autism spectrum
- NICE's guideline on violence and aggression: the short-term management in mental health, health and community settings.

1.5.11 Base interventions on a formal assessment of the needs and strengths of the child or young person. Interventions should be based on an overarching framework covering: play activities such as drawing or teaching–learning models; sex and relationships education; peer relationships; developing an abuse narrative. They could include:

- Psychoeducational approaches:
  - learning to acknowledge and identify inappropriate behaviour
  - learning sexual behaviour rules
  - learning self-control techniques
  - cognitive re-structuring.
- Emotions and empathy:
  - emotional control and management programmes
  - working with denial
  - empathy development.
- Social and communication skills and assertiveness training to improve social and emotional wellbeing.
- Safety planning and risk management. This includes abuse prevention and relapse prevention.

1.5.12 Consider the following interventions for parents and carers:

- Education about what is developmentally normal sexual behaviour for their child.
- How to prevent and respond to problematic sexual behaviour.
- General parenting strategies, including how to identify boundaries.
- When and how to provide parental supervision to minimise the opportunities for harmful sexual behaviour.

1.6 Residential care

1.6.1 Provide ongoing support when the child or young person moves back into the community (see section 1.5). See also NICE's guideline on transition from child to adult services (expected publication February 2016).

1.7 Person-centred approach

1.7.1 Ensure services support children and young people of all ages including:

- all genders
- those with neurodevelopmental disorders (such as a learning disability or autism spectrum disorder)
- those who are prepubescent
- all ethnicities.

1.7.2 Promote continuity of care and, wherever possible, ensure the child or young person has contact with the same staff, so they can develop trust in their care team.

1.7.3 Encourage and support children and young people to participate in a wide range of peer, school and community activities to help build a sense of belonging.

1.7.4 Ensure children and young people have the opportunity to enjoy a stable educational experience that encourages aspiration and supports them in achieving their potential by helping them to stay in mainstream education.

1.7.5 Support young people by preparing them for adulthood and the transition to adult services by developing links between child and adult services.

See NICE's guideline on transition from child to adult services (expected publication February 2016).

1.8 Multi-agency approach

Multi-agency, multidisciplinary team

1.8.1 Use established mechanisms, such as local children's safeguarding boards, to develop a multi-agency, multidisciplinary team with the skills, knowledge and resources to undertake an early help assessment. (See Common Assessment Framework in the Department of Health's Working together to safeguard children, Early help: whose responsibility?, and The Children's Act 1989.) Include:

- social care services
- public health services
- youth offending teams
- education services
- child and adolescent mental health services
- police
- primary healthcare
- organisations in the voluntary and community sectors.

Multi-agency, multidisciplinary working

1.8.2 Agree an approach between agencies to harmful sexual behaviour. Include a range of referral and care pathways within and across agencies to meet the needs of children and young people and their families and carers.

1.8.3 Document the referral process and make sure this information is given to practitioners in the social care, education, health and criminal justice systems.

1.8.4 Use multi-agency arrangements to request a review of the care plan if the child or young person's level of need is not being met or the referral and assessment procedure is being unnecessarily delayed.

1.8.5 Ensure multi-agency, multidisciplinary teams:

- have links to clinical and non-clinical services and can make prompt referrals
- collaborate with specialists when children and young people have difficult or complex needs (for example, children at risk of offending and those with learning disabilities, autism or conduct disorders)
- establish relationships with statutory, community and voluntary organisations that work with at-risk children and young people, to provide a broad range of support services
- meet regularly to plan, implement and evaluate care pathways for the children whose care they are overseeing
- understand that the care plan is the responsibility of the whole multi-agency team and not individual practitioners.

Information sharing

1.8.6 Agree a protocol for information sharing between all agencies. Base this on local child protection procedures and address legal and confidentiality issues.

1.8.7 Practitioners responsible for early help assessments should be familiar with the child or young person’s health and social care record and get consent to access neonatal and early health information. This includes information on developmental delays or a diagnosis of autism.

1.8.8 Practitioners responsible for early help assessments should get consent to access and use additional information as needed, including the child or young person's:

- social care history
- educational records
- incident reports of concerning behaviour
- police records.

1.8.9 Ensure lead practitioners (see recommendation 1.2.4) can access information on the child or young person's family situation and factors that

may affect parenting capacity and attachment, such as drug and alcohol abuse. (See NICE's guideline on children's attachment and recommendations 1.4.12–1.4.14 in NICE's guideline on when to suspect child maltreatment.) They should include this in the early help assessment.

1.8.10 Share information from the early help assessment with other agencies through the multidisciplinary team, as appropriate.

1.8.11 Ensure information is collected and shared in a sensitive and professional manner, as set out in The Caldicott guardian manual.

Terms used in this guideline

This section defines terms that have been used in a specific way for this guideline. For general definitions, please see the glossary.

Children

In this guideline, 'children' refers to anyone aged under 10. This is below the age of criminal responsibility in England.

General assessment tools

Tools that can be used by a range of professionals to identify children and young people who potentially demonstrate harmful sexual behaviour, such as the Brook Traffic Light tool. These tools are not used in any further assessment of children or young people with a firm 'diagnosis' of harmful sexual behaviour.

Harmful sexual behaviour

This guideline uses the NSPCC definition of harmful sexual behaviour: 'One or more children engaging in sexual discussions or acts that are inappropriate for their age or stage of development. These can range from using sexually explicit words and phrases to full penetrative sex with other children or adults.' (Harmful sexual behaviour: what is harmful sexual behaviour NSPCC).

Risk assessment tool

In this guideline, this term is used for tools to estimate the risk of sexual re-offending to decide what action to take in terms of finding appropriate placements,

interventions and resources. It includes tools designed to identify adolescent sex offenders who are at risk of re-offending such as J-SOAP-II, J-SORRAT-II and ERASOR.

Young people

In this guideline, 'young people' refers to those aged 10–18. It includes those on remand and those serving community or custodial sentences. It also includes people aged up to 25 who display harmful sexual behaviour and have special educational needs or a disability. This age extension is in light of the Children and Families Act 2014.

Putting this guideline into practice

Putting a guideline fully into practice can take months to years. This depends on how much change in practice or services is needed. Implementing change is most effective when aligned with local priorities.

Here are some pointers to help put NICE guidelines into practice:

1. **Raise awareness** through routine communication channels, such as email or newsletters, regular meetings, internal staff briefings and other communications with all relevant partner organisations.

2. **Identify a lead** with an interest in the topic to champion the guideline and motivate others to support its use and make service changes, and to find out any significant issues locally.

3. **Carry out a baseline assessment** against the recommendations to find out whether there are gaps in current service provision. Think about what data you need to measure improvement and plan how you will collect it. You may need to work with other health and social care organisations and specialist groups to compare current practice with the recommendations. This may also help identify local issues that will slow or prevent implementation.

4. **Develop an action plan** with the steps needed to put the guideline into practice. Recognise that it may take several years. Include milestones and the business case, which will set out additional costs, savings and possible areas for disinvestment. A

small project group should develop the action plan. The group should include the guideline champion, a senior organisational sponsor, staff involved in the associated services, finance and information professionals.

5. **Implement the action plan** with oversight from the lead and the project group with project management support.

6. **Review and monitor** how well the guideline is being implemented through the project group. Share progress with those involved in making improvements, as well as relevant boards and local partners.

NICE provides a comprehensive programme of support and resources to maximise uptake and use of evidence and guidance. See our into practice pages for more information.

Also see Leng G, Moore V, Abraham S, editors (2014) Achieving high quality care – practical experience from NICE. Chichester: Wiley.

Context

Research indicates that many children and young people charged with criminal offences relating to harmful sexual behaviour had previously been referred to children's services, but their sexual behaviour was either not recognised or dismissed (Examining multi-agency responses to children and young people who sexually offend Criminal Justice Joint Inspection).

Data also indicate that children and young people with learning disabilities are over-represented among this group ('Examining multi-agency responses to children and young people who sexually offend'; The needs and effective treatment of young people who sexually abuse: current evidence Department of Health).

Little is known about prepubescent children or young people whose sexual behaviour has not reached a level that would be regarded as criminal. There is also a lack of understanding of where these children and young people fit into the social care system, making it difficult to provide an effective response ('The needs and effective treatment of young people who sexually abuse: current evidence').

Anecdotal evidence suggests that problematic sexual behaviours (where there is no victim) can be an expression of other problems or underlying vulnerabilities. It also suggests that early help assessments, without involving specialist harmful sexual behaviour services, can help. But there is little evidence of effectiveness on interventions addressing problematic sexual behaviour.

This guideline covers children and young people under 18 who display harmful sexual behaviour. It includes those on remand and those serving community or custodial sentences. It also includes people up to the age of 25 who have special educational needs or a disability, as set out the Children and Families Act 2014.

More information

To find out what NICE has said on topics related to this guideline, see our web pages on: carers, children and young people, people with learning disabilities, mental health and behavioural conditions, mental health and wellbeing, safeguarding and service transition.

The committee's discussion

Links to evidence sources are given in square brackets; see evidence reviews for details.

Background

This guideline uses the NSPCC definition of harmful sexual behaviour: 'One or more children engaging in sexual discussions or acts that are inappropriate for their age or stage of development. These can range from using sexually explicit words and phrases to full penetrative sex with other children or adults.' (Harmful sexual behaviour NSPCC).

Using the term 'harmful sexual behaviour' avoids labelling young children as sexual offenders. However, it does not reflect the diversity of children who engage in sexualised behaviours. For example, it is critical to differentiate between abusive sexual behaviours (for example, oral, anal and vaginal penetration) and sexual

behaviour that is problematic (for example, compulsive masturbation or addiction to online pornography).

There has been significant debate about how to describe children and young people displaying harmful sexual behaviour without labelling them as sex offenders. Difficulties in defining such behaviour are compounded by a general lack of knowledge of childhood sexuality and what constitutes normal sexual development.

The committee acknowledged the concept of harmful sexual behaviour is fragmented and overlaps with other definitions such as child sexual exploitation.

The Department of Health's Working together to safeguard children definition of sexual abuse (which covers physical, emotional and sexual abuse, and neglect) does not acknowledge that children and young people can display harmful sexual behaviour, and so is not used.

Children and young people's sexual behaviour problems are diverse. Various terms have been used to refer to children who engage in developmentally unexpected sexual behaviours. These include: abuse-reactive, sexually reactive, sexually aggressive, sexualised children, children who molest, sexually abusive children and young sexual offenders.

It is important to distinguish between abusive and problematic sexual behaviour. The former often indicates an element of manipulation or coercion. Problematic sexual behaviours, on the other hand, are not abusive. But they may interfere with the child or young person’s psychosexual development and result in stigmatisation and victimisation, as well as making others feel uncomfortable.

The committee noted that the approach to adult sex offenders has moved from a focus on abnormal and problematic behaviour (a deficits approach) to a more holistic focus on strengths and skills. The committee agreed that practitioners have been slow to adopt a similar approach to children and young people who display harmful sexual behaviour.

It agreed with evidence from expert paper 1, and from members' own experience, that many children and young people's display of harmful sexual behaviour naturally comes to an end as they mature.

Little is known about base rates for continued problematic sexual behaviours in prepubescent children. Only a small number go on to commit more serious sexual offences and the committee recognised the need to distinguish between chronological and developmental age when deciding how to assess and then intervene with this group.

The committee also agreed that it is important to distinguish between prepubescent and adolescent children and young people, because some behaviours among prepubescent children may be considered normal, but of concern if they continue into adolescence. Likewise, behaviours that would be considered normal in adolescents may be regarded as highly unusual in prepubescent children and therefore merit a need for referral.

In addition, the committee recognised the need to distinguish between prepubescent and adolescent children and young people and the status of both groups within the criminal justice system in England, where the age of criminal responsibility is 10 years.

The committee noted that young people with ongoing or long-term health or social care needs may need to move into adult services at age18 – or 25, if they have special educational needs or disabilities. It agreed that these transitions need to be managed as part of the assessment and intervention process.

The committee discussed the issue of pornography. There is a gap in the literature about children and young people's exposure to it and how it influences sexual behaviour. The committee believes exposure to pornography may be seen as a form of trauma that may give rise to problematic or harmful sexual behaviour.

See also Gaps in the evidence numbers 10–12.

Section 1.1 Universal services

The discussion below explains how we made recommendation 1.1.1. Recommendations in this section are linked to review 2.

Current practice

The committee agreed that it was the role of any professional concerned about the welfare of a child or young person to make a referral to appropriate services for assessment and intervention (see Early help: whose responsibility Ofsted).

Section 1.2 Early help assessment

The discussion below explains how we made recommendations 1.2.1–1.2.10. Recommendations in this section are linked to: ES2.1; EP1, EP5.

See also Gaps in the evidence number 2.

Current practice

The principles of early help assessment are based on the Common Assessment Framework (see 'current practice' in the Committee discussions section relating to section 1.8). Early help is key to identifying and addressing needs not being met by universal services.

Other helpful tools include: The use of whole family assessment to identify families with multiple problems (Department for Education) and the Youth Offending Asset assessment (Youth Justice Board for England and Wales).

Members said that, in their experience, early help professionals and professionals not trained in harmful sexual behaviour need more information and resources to identify harmful sexual behaviour.

Evidence for effectiveness

The committee based these recommendations on the Department of Health's guidance on how to use the Common Assessment Framework and expert consensus that recognised the need for early help to prevent escalation.

There is no evidence on how effective general assessment tools are at identifying harmful sexual behaviour but the committee agreed that one should be used as part

of the early help assessment. The aim would be to screen for age and developmentally inappropriate sexualised behaviour and language to decide whether to refer on to specialist harmful sexual behaviour services.

Tools commonly referred to in the literature, or used in practice, include: the Brook Traffic Light Tool and Hackett's continuum model of children and young people's sexual behaviours, patterns and cycles [ES2.1].

Evidence for cost effectiveness

There was no cost effectiveness evidence for this set of recommendations. The committee did not make it a priority for modelling. It considered the cost impact to be negligible because it is widely considered to be good working practice.

Additional factors taken into account

The committee considered that such assessments could prevent the need for specialist services, a statutory assessment under The Children's Act 1989, or involvement of the criminal justice system. Assessment aims to identify the child or young person's needs, underlying vulnerabilities and trauma experiences.

The committee agreed that interagency assessments should use a joined-up process that focuses on outcomes.

Assessments should acknowledge chronological age and developmental status, and what constitutes healthy sexual behaviour among children and young people. This is particularly true when discussing children and young people with a neurodevelopmental disorder such as autism or a learning disability.

The committee also agreed that although harmful sexual behaviour declines as the child or young person matures, the life chances of many of those previously involved in such behaviour are poor. So they may need ongoing assessment and input, particularly in relation to educational and employment opportunities.

The committee acknowledged that those working with children and young people displaying harmful sexual behaviour need a greater understanding of the benefits of an early help assessment.

Sexual behaviours exist on a continuum that ranges from normal and developmentally appropriate to highly abnormal and violent [EP1]. There is little evidence on interventions that address behaviours that fall short of thresholds needing a response from the criminal justice system or that could be described as problematic.

Locating sexual behaviour on a continuum that is related to development age is an important part of the general assessment process, and can help practitioners and families to make distinctions between different behaviours.

The committee acknowledged that using general assessment tools with prepubescent age groups that were designed for older groups could be harmful.

The committee agreed with expert paper 5. This recommends that when assessing children and young people displaying harmful sexual behaviour, practitioners should distinguish between children and young people in general and those with special educational needs and disabilities, or with autism. It noted that although the latter form a significant minority, there is a lack of tools for assessing them.

The committee agreed that an initial assessment using a general assessment tool would help make practitioners aware that the sexual behaviour of children and young people exists on a continuum. Depending on the results, the assessment would determine whether a referral to specialist services is necessary. But if the tool is not designed for the particular subgroup being assessed the results may not be accurate.

On the other hand, failure to undertake such an assessment may result in an unnecessary intervention that could label and stigmatise the child or young person.

Resource impact and implementation issues

Use of the early help assessment is regarded as good working practice. It provides a shared assessment and planning framework for all children’s services in England. Because of this, the committee does not consider these recommendations will have any additional resource impact.

The committee agreed that the benefits of improved child protection and an early, more appropriate referral are very likely to offset any potential resource impact.

Section 1.3 Risk assessment for children and young people referred to harmful sexual behaviour services

The discussion below explains how we made recommendations 1.3.1–1.3.3. Recommendations in this section are linked to: ES1.17, ES1.28, ES2.2, ES2.3, ES2.4, ES2.5, ES2.6, ES2.7, ES2.8, ES 2.9, ES2.11, ES2.14; EP4, EP7, EP8.

See also Gaps in the evidence number 2.

Current practice

Risk assessment tools are used to assess specific risks and needs arising from a child or young person's harmful sexual behaviour. In the UK, different models are used depending on whether they come into contact with child welfare, mental health or the criminal justice system.

Children and young people charged by the Crown Prosecution Service, including those who have charges pending, cannot receive a harmful sexual behaviour assessment or intervention relating to their current alleged offence. This is because of ongoing criminal proceedings. Youth Justice Board statistics show that the average time from the date of an offence being committed until completion of court proceedings is 89 days. But for sexual offences this takes, on average, 328 days. Depending on the severity of offence the young person will either receive a community or a custodial sentence

Current UK practice is dominated by the AIM2 model developed for practitioners in the criminal justice system. It brings together elements from the more general approach outlined in the Framework for the Assessment of Children in Need and their Families (Department of Health) and the Youth Offending Asset assessment (Youth Justice Board for England and Wales). It also takes into account clinical factors. Limited attempts have been made to test the predictive validity of AIM2. This means that most agencies in the UK are using a largely untested model to underpin their assessments of risk and further research is urgently needed.

The AIM2 has led to a more standardised approach. But how it is used varies and it is unclear how it might be applied outside the criminal justice system. So the committee was unable to make a strong recommendation for its use.

Evidence for effectiveness

The committee considered the evidence of effectiveness for various risk assessment tools in terms of predicting sexual and non-sexual re-offending. It noted that 10 of the 11 quantitative studies in the evidence review were based on adolescent boys with a mean age of 15 who had been convicted of sexual offences.

Only 1 study included girls and a younger age group (boys 12.3 years and girls 11.9 years) who had recently begun to display harmful sexual behaviour [ES2.3]. All the studies were from North America, which may limit their applicability in the UK. They were all at risk of bias from the methods used.

The committee considered:

- J-SOAP-II (5 low to moderate quality studies on future sexual re-offending). The evidence was inconsistent: 3 predicted sexual re-offending, 2 did not.
- ERASOR (4 moderate to high quality studies). Three predicted sexual re-offending, 1 did not.

J-SORRAT-II (2 quantitative studies, 1 low and 1 moderate quality). One study found it was able to predict future sexual re-offending among adolescent male sex offenders, the other found no effect.

The committee noted that although the evidence is contradictory [ES2.3, ES2.4, ES2.5, ES2.6, ES2.7, ES2.8, ES2.9], the tools look promising as a means of assessing young people's risk of sexual and non-sexual reoffending.

There was no evidence that tools focusing on strengths (BERS-2) enhance the accuracy of ERASOR to predict sexual re-offending among adolescent males who have committed a sexual offence [ES7].

The committee also considered evidence from 2 quantitative studies (moderate quality) on the SAVRY and YLS/CMI tools. It noted that SAVRY was unable to predict sexual or non-sexual reoffending for adolescent male sex offenders. The

YLS/CMI tool did not predict sexual reoffending but did predict non-sexual violence, and any potential for non-sexual re-offending [ES2.8, ES2.9].

The committee considered evidence on AIM and AIM2. Developed in the UK, AIM2 is designed to help practitioners consider young men's risk of sexual re-offending and also help with problem formulation and intervention planning. It was developed for use across health and social care systems and between local and regional safeguarding boards.

The committee also considered the evidence of effectiveness for AIM2 and the adapted AIM (2 moderate-quality quantitative studies) used to predict the risk of sexual reoffending among adolescent boys with and without intellectual disabilities who were also known to commit sexual offences [ES2.2, EP7]. Both studies predicted a risk of sexual re-offending. Although the evidence is limited, the committee acknowledged that it was a promising tool and was relevant because it had been developed in the UK. So it recommended further research on AIM2.

The committee also considered 11 qualitative studies: 3 papers were rated high, 6 moderate and 2 low quality. Two moderate quality studies stated that AIM2 offered a more standardised approach to assessment, and encouraged better cooperation between young offender teams and social care departments in the UK. But practitioners reported frustration because they were not properly trained to use it. In addition, there was some confusion about its purpose and how the findings might be applied in practice [ES2.14].

Evidence for cost effectiveness

There was no cost effectiveness evidence for this set of recommendations.

Additional factors taken into account

There are no fully validated models or frameworks to suggest what core elements should be included in risk assessment tools.

The quantitative evidence focused on sexual abuse and was largely drawn from North America. It reported on small clinical populations of relatively high-risk young people referred for specialist treatment. The assessment models used were adapted from models used for male adult sex offenders.

Assessing the risk of sexual re-offending among young people is particularly challenging because of the enormous changes they undergo at this age. The committee also noted a key finding from research that indicates that many young people who engage in offending behaviours stop them as they mature[3].

The committee noted 2 specific risk trajectories evident in samples of young sexual abusers: general antisocial behaviours and harmful sexual behaviour. Most young people charged with sexual offences do not re-offend sexually, although the rate of non-sexual re-offending is substantially higher than average.

The committee agreed that risk assessment tools should consider a range of key elements, including the factors that led to the behaviour. The tools should also address the need for ongoing support and re-assessment [ES1.6, ES1.28].

The committee discussed risk assessment tools for different subgroups and acknowledged the lack of tools and models for different population groups.

The committee agreed that risk assessment tools and models designed for adolescent sex offenders should not be used with prepubescent children displaying harmful sexual behaviour.

There are few empirical studies of assessment tools and interventions directed at the small proportion of girls and young women who sexually abuse others [EP4]. Research has indicated that female offenders differ from male offenders in various ways. For example, harmful sexual behaviour in girls is more likely to be motivated by aggression against them. The committee acknowledged the valuable work being done in this area by Barnardo's Taith project.

Evidence paper 4 discussed how boys and girls with harmful sexual behaviour are treated differently. For example, boys are more likely to be removed from mainstream school.

[3] Moffitt T (1993) Adolescence-limited and life course persistent anti-social behaviour: a developmental taxonomy. Psychological Review 100: 674–701.

Trade off between benefits and harms

Benefits include the adoption of a consistent approach. In addition, these tools allow practitioners from different agencies and professional backgrounds to share information.

Harm would occur if assessment of the level of risk is not accurate. This could lead to an over-punitive or over-restrictive approach. Or it could leave the child or young person without the support they need to prevent further harmful sexual behaviour, so posing a risk to themselves and others.

Resource impact and implementation issues

The committee noted that AIM2 was developed for the UK, but has to be paid for and involves specialist training. In comparison, J-SOAP-II, J-SORRAT-II and ERASOR are free and specialist training is not needed, so they would have less impact on resources. But their applicability in England is unknown.

Overall, the committee could not recommend 1 tool over another and noted that most effectiveness evidence came from North America. Internationally, the 2 tools with the highest degree of empirical support are ERASOR and J-SOAP II, although the evidence for predicting sexual re-offending is not consistent across studies. Further studies are needed on larger samples. Also, studies are needed to compare the use of different models with the same samples.

In the absence of more consistent evidence, the committee agreed that it might be best if practitioners use either AIM2 alone or both ERASOR and J-SOAP II concurrently. In each case, the developers also recommend that practitioners use their own clinical judgement. Only the most promising tools were included in the recommendations as examples of what was available.

The committee also agreed by consensus that local safeguarding boards and NHS England are best placed to identify who should undertake a risk assessment and these names were added to recommendation 1.3.1.

Section 1.4 The practitioner's role in liaising with families before developing an intervention

The discussion below explains how we made recommendations 1.4.1–1.4.2. Recommendations in this section are linked to: ES1.16, ES1.18, ES1.20, ES1.21, ES1.22, ES1.23, ES1.24; EP9, EP10.

Current practice

[To be completed after consultation.]

Evidence for effectiveness

There was no quantitative evidence of effectiveness for the role of practitioners. Six qualitative studies and 2 expert testimonies identified key features and approaches that practitioners could use to reduce barriers to services and improve communications between the practitioner and children, young people, parents and carers.

The committee agreed with qualitative evidence from 2 high quality studies that offering families and carers the opportunity to meet the programme practitioner before an intervention starts may help to overcome any fears about getting involved in and continuing with the programme [ES1.23, ES1.24].

The committee agreed with evidence from 2 qualitative studies (moderate to high quality) that family and carer participation and support is crucial to getting young people involved with interventions. It also helps reinforce intervention messages in the home [ES1.20].

The committee agreed with evidence from 2 qualitative studies of moderate to high quality on the need for practitioners to accommodate a child or young person's changing needs and offer a flexible service to maintain their interest [ES1.16, ES1.22].

The committee agreed with qualitative evidence from 3 high quality studies and evidence papers 9 and 10 that the therapist's relationship with the child or young person is vital if an intervention is to be effective [ES1.21]. Members also agreed

that, in their experience, interventions were only as good as the person providing them.

The committee noted the evidence from 3 moderate to high quality studies that 'victim empathy' is a useful component of both harmful sexual behaviour interventions and therapeutic interventions [ES1.18].

Evidence for cost effectiveness

There was no cost effectiveness evidence for this set of recommendations.

Trade off between benefits and harms

The committee agreed that the main benefit would be greater involvement with the intervention and improved outcomes for the child or young person, their family and carers.

Resource impact and implementation issues

The committee agreed that this recommendation would have a resource impact, particularly in terms of arranging meetings that are not part of the therapeutic intervention. But members agreed that increasing attendance and improving the relationship between the child or young person and the practitioner could lead to better outcomes and offset any resource implications.

Section 1.5 Principles and approaches for interventions

The discussion below explains how we made recommendations 1.5.1–1.5.13. Recommendations in this section are linked to: ES1.1, ES1.2, ES1.3, ES1.4, ES1.5, ES1.6, ES1.7, ES1.8, ES1.10, ES1.11, ES1.12, ES1.13, ES1.14a, ES1.14, ES1.15, ES1.16, ES1.17, ES1.19, ES1.25, ES1.26, ES1.27, ES1.28; EP2, EP3, EP5, EP9, EP10.

No gaps in the evidence were identified that related specifically to this section.

Current practice

Current practice is based on cognitive behavioural therapy models used to treat adult men who have sexually offended. Developed originally in the US, these models came to prominence in the UK probation and prison services from the late 1980s.

Evidence for effectiveness

The evidence of effectiveness was from North America and may be only partially applicable to a UK population. The interventions reviewed mainly focused on sexual offenders in treatment settings and will have limited applicability to children and young people outside the criminal justice system.

Many types of intervention are used to help children and young people displaying harmful sexual behaviour but not all of them have been evaluated.

The committee considered evidence statements covering 13 quantitative studies (4 randomised controlled trials, 3 controlled studies and 6 before-and-after studies). It noted that although the studies were grouped for analysis according to type of intervention, many included elements drawn from a range of approaches. This included cognitive behavioural therapy (CBT) and multi-systemic therapy. It also considered qualitative evidence from 26 studies (11 low, 9 moderate, 6 high quality studies).

Of the 13 quantitative studies, 9 (2 randomised controlled trials, 1 controlled study and 6 before-and-after studies) of variable quality reported on the effectiveness of CBT-based approaches. These comprise a range of components delivered to both individuals and groups and focus on the sexually abusive behaviour.

Four studies looked at multi-systemic therapy. Two randomised controlled trials and 1 controlled study ranging from low to moderate study quality reported that multi-systemic therapy significantly reduced the risk of adolescent sexual re-offending compared with CBT or usual care. One controlled study of moderate quality, using adventure-based therapy for adolescent male sex offenders, reported no difference between the intervention and control group for re-offending rates for violent sexual offences.

The committee considered the evidence on CBT interventions from 4 low to moderate quality quantitative studies. These were abuse-focused and targeted the sexual behaviour of juvenile sex offenders using 1 or several components of CBT. This included:

- satiation therapy, a method for reducing deviant sexual arousal

- verbal satiation – repeatedly talking about deviant sexual fantasies to reduce sexual arousal from such fantasies.,
- vicarious sensitisation, a form of conditioning used to treat teenage boys who molest younger children
- cognitive restructuring therapy to help people to think differently about a situation, event, thought, or belief.

The committee noted the positive direction of all 4 studies but agreed that, on balance and from members' expert opinion and experience, it could not recommend these types of interventions [ER1, ES1.1, ES1.2, ES1.3, ES1.4, ES1.5].

The committee agreed with evidence from 3 low to moderate quality qualitative studies that stigma and ostracism may arise if a child or young person is labelled as a sex offender. It was keen to highlight that children and young people with harmful sexual behaviour are not 'mini adult sex offenders' and that offering interventions that are abuse-focused is potentially stigmatising [ES1.25].

The committee considered a study of moderate quality that compared CBT with play therapy with boys (61%) and girls (39%) aged 5 to 12. This targeted a range of harmful behaviours and included families and carers. It reported no significant difference between the 2 approaches. Both improved the children's ability to socialise while reducing their behavioural, affective and sexual behaviour problems [ES1.7].

The committee noted that other less specialised interventions – in addition to play therapy or CBT – may be more appropriate for this age group and reduce the likelihood of these children being stigmatised.

The committee agreed the positive outcomes were likely to have resulted from the types of components that were included in each approach. This included: behaviour modification and psychoeducational principles in the CBT group; and client-centred and psychodynamic play therapy principles in the play therapy group [ES1.7].

The committee also considered evidence on 2 CBT programmes for young people displaying a range of harmful behaviours and personality disorders: SAFE-T (Sexual Abuse, Family Education and Treatment Programme) and Thought Change System.

Both interventions included family members and carers. (The evidence comprised 2 low to moderate quality quantitative studies.)

Both reported a decrease in harmful behaviours, with the SAFE-T programme reporting a 72% reduction in re-offending rates for sexual assault [ES1.6 and ES1.8].

The committee considered the evidence of effectiveness for multi-systemic therapy compared with CBT-based usual care for adolescent sex offenders from 2 moderate quality quantitative studies. The studies reported improvements in problem sexual behaviour, psychiatric symptoms, anti-social behaviour, family and peer relations and school performance [ES1.11, ES1.12, ES1.13, ES1.14].

Multi-systemic therapy focuses on the family, which means its use will be limited because a significant number of children and young people who display harmful sexual behaviour are in out-of-home placements. Its main goal is to reduce the risk of re-offending by enhancing family and peer relationships. A big benefit is that carers become better at identifying friends who were having a negative influence on their adolescents and advising their children to stop associating with them.

However, other research suggests that multi-systemic therapy may be more effective with particular subgroups of young people with harmful sexual behaviour and not others.

For example, there is a strong link between antisocial peer groups and young people whose harmful sexual behaviour is often directed towards peers and accompanied by other non-sexual criminality. This group is different to those whose harmful sexual behaviour targets younger prepubescent children. The latter are less likely to have a social life or strong peer friendship groups. The committee welcomed the ongoing trial of Multi-Systemic Therapy – Problematic Sexual Behaviour in the UK and agreed that this may, in future, offer more conclusive results. It noted that previous evaluations of the programme in the USA were carried out by its designers.

The committee noted the results from 1 moderate quality study that evaluated an adventure based programme (LEGACY) to treat young sex offenders. This reported no difference for re-arrest rates for violent sex offences between groups but appears to be beneficial in reducing future risks of non-sexual reoffending [ES1.15].

Drawing on evidence from expert papers 2 and 5, members agreed that the duration and intensity of interventions should be adapted for those with learning disabilities. (For example, by having more frequent, shorter sessions, or longer sessions as necessary, or fewer participants in group sessions.)

The committee agreed with the evidence from 1 moderate quantitative study and 3 moderate to high quality qualitative studies that understanding the factors that lead to harmful sexual behaviour is an important part of relapse prevention [ES1.6, ES1.17].

The committee noted the evidence from 1 moderate quantitative study and 2 low to moderate qualitative studies highlighting the concerns of families and young people about not getting support to maintain their progress. The committee agreed this was an important component of services [ES1.6, ES1.28].

The committee agreed with the qualitative evidence from 5 studies (2 low, 1 moderate, 2 high quality) that communication skills, social skills training and emotional restraint are important components of interventions [ES1.19, ES1.27].

The committee agreed with the evidence from 6 qualitative studies (3 low, 1 moderate, 2 high) that interventions involving children and young people in supervised social activities helps promote self-esteem and socially appropriate behaviour [ES1.15].

The committee noted evidence from 1 high quality qualitative study that interventions in group settings for the child and young person and their family and carer can reduce a sense of isolation and provide valuable support. But it may also be problematic for those who find it difficult to talk about such issues in front of others [ES1.26].

Evidence for cost effectiveness

The committee made the recommendations on cognitive behavioural therapy, multi-systemic therapy and play therapy a priority for economic modelling.

The model results showed a cost per QALY of under £20,000, but the committee questioned these estimates and thought that not all these therapies would in fact be

cost effective. This is particularly true for children and young people who did not need a custodial sentence. That is because the studies that underpinned the modelling were from the North America where comparators are different.

Given that the multi-systemic therapy trial in the UK has yet to report, the committee suggested that it would be prudent to continue with current approaches – but make them work better. Getting better results at the same cost would automatically be cost effective.

If the current trials show that more expensive methods are more effective than current methods, the approach advocated here could be updated.

Additional factors taken into account

The sexual behaviour of children and young people exists on a continuum that ranges from normal and developmentally appropriate to highly abnormal and violent. Various approaches are needed to address these different behaviours. But there is little evidence on interventions that address behaviours that fall short of thresholds needing a response from the criminal justice system.

The qualitative evidence identified programmes offering support such as relapse prevention, anger management, victim empathy, communication and social skills training. But it also documented the emergence of family-level interventions and the role of the therapist as important components.

The qualitative evidence also highlighted the components of an intervention that participants, their families and professionals feel have value. But it is not clear which components are most effective for different groups.

Members agreed that, from their own experience, comprehensive, multi-component interventions that focus on the child or young person's family and background are more promising than those that focus solely on the abusive behaviour.

The committee also agreed that having to choose between cognitive behavioural therapy and multi-systemic therapy is not realistic and that there are advantages to both. Members acknowledged that multi-systemic therapy is a more complex approach that needs the child or young person to be in a family situation and so may

not always be relevant. This was not the case with cognitive behavioural therapy. But members agreed that there is a greater need for follow-up when using cognitive behavioural therapy.

The committee did not put the list of interventions in order of priority, because the assessment should give practitioners guidance on what type of intervention to offer. Members agreed that what was needed was a 'toolbox' of approaches that could be tailored to individual needs. For children and young people with less complex needs, the assessment may indicate a more general intervention that does not focus on the harmful sexual behaviour.

Section 1.6 Residential care

The discussion below explains how we made recommendation 1.6.1.

Recommendations in this section are linked to: ES1.6, ES1.15, ES1.28; EP5, EP9, EP10.

Current practice

The Glebe House model, a specialist children's home, is an example of current practice in this area. It is based on a therapeutic community model for adolescent males with a known history of harmful sexual behaviours.

Young people in a young offender's institute with a custodial sentence for a sexual offence do not always receive harmful sexual behaviour services. Local youth offending teams should provide this service but it can take months to arrange: the team has to get a transfer to a young offender's institute offering specialist harmful sexual behaviour services. It is not uncommon for a transfer from one custodial setting to another to take place a few months before the release date.

The committee noted that even where harmful sexual behaviour services are commissioned, the threshold for provision varies and is occasionally too high. For example, young people who receive a custodial sentence for harmful sexual behaviour may not be offered these services if their sentence is under 6 months.

In addition, young people aged between 12 and 17 who receive a 12-month detention training order would not be eligible, because half the sentence will be

spent in custody and the other half will be supervised by the youth offending team in the community.

One model used in the secure estate does, however, allow all young people displaying harmful sexual behaviour, whether or not it is part of the offence, to be referred. This is regardless of the length of time they spend in custody. In this model, any agency involved with the young person can refer and self-referrals are also accepted. Everyone is offered a consultation plus a transition package, regardless of whether they are discharged into the community or transferred to adult prison.

Evidence for effectiveness

The committee noted that a small number of children and young people displaying harmful sexual behaviour may warrant placement in specialist residential or secure settings. It drew on evidence from expert paper 6 as an example of a specialist children's home that uses a therapeutic community model.

The committee agreed that, if possible, residential settings should draw on the values and approaches of a therapeutic model originally developed in the field of social psychiatry by Rapoport and Roscow[4]. This is based on 5 social psychology principles: attachment, containment, communication, involvement and agency.

The committee agreed that interventions in residential settings should be based on the principles outlined in this guideline, including the principles and approaches set out in sections 1.6 and 1.7.

The committee agreed that residential settings should also provide a range of services, including ongoing support, to enable a child or young person to successfully integrate back into the community. In addition, out-of-home care should not undermine young people’s relationships with their own family and community. The committee referred to evidence previously noted for sections 1.6 and 1.7 and to ES1.6 and ES1.28.

[4] Rapoport R, Roscow I (1960) Community as doctor. New York: Arno Press.

Section 1.7 Person-centred approach

The discussion below explains how we made recommendations 1.7.1–1.7.5. Recommendations in this section are linked to: EP9, EP10, EP12, EP13.

Current practice

The principles of person-centred care are underpinned and supported by The Children's Act 1989, the Equality Act 2010 and the United Nations Convention on the Rights of the Child 1989. The Convention is an international agreement that protects the rights of children and young people and provides a framework for the development of services for them. The UK government ratified it in 1991 and recognises children’s rights to expression and to receive information.

The committee noted that current service provision for children and young people displaying harmful sexual behaviour is fragmented, inconsistent and often uncoordinated, particularly between the child welfare and youth justice systems. It also agreed that there needs to be a greater focus on, and clarity about, the principles of good practice and that care should be centred on the child and young person's needs.

The committee acknowledged the difficulties of providing care for these children and young people and that some mainstream services and practitioners marginalise them.

The committee acknowledged the cultural taboos around the subject. Based on members' expert opinion, and supported by evidence from expert testimony [EP10], it agreed a common response to harmful sexual behaviour was one of fear, denial and revulsion. This is followed by a desire that the child or young person be immediately moved elsewhere.

The committee discussed and also received expert testimony on a recent review of services [EP10] that corroborated its concerns. For example, services and practitioners often focus on the presenting behaviour and the risk to others.

The committee agreed that practitioners need to balance the risk the child or young person poses to their own wellbeing and the risk they pose to others. Practitioners also have to decide between taking no action and an overreaction that could

stigmatise the child or young person. Although the committee agreed that managing the risk a child may present to another is important, failure to identify the child or young person's own needs may exacerbate the risk further.

An NSPCC-led operational framework for harmful sexual behaviour is currently being piloted and this could be a useful tool in the future, but the committee was unable to recommend it at the time of publication.

Evidence for effectiveness

The committee recognised that the recommendations were not based on evidence of effectiveness or cost effectiveness.

Based on expert testimony and its own experience, the committee advocated an approach that reflects current legislation and what it believes will best address their needs.

Evidence for cost effectiveness

The committee agreed that adherence to the principles of a person-centred approach would reduce the risk that these children and young people pose to themselves and to others. It would also ensure the focus is on them as a person. The committee thought it very likely that the child will benefit in the short and longer term if these principles were adhered to because they will:

- have access to services that meet their needs and prevent problems escalating
- receive care from the same practitioners, helping them to develop relationships and form attachments (particularly important for looked after children) [EP9].

These principles are enshrined in legislation and good practice and so should be followed. Cost effectiveness evidence would be helpful in the future.

Additional factors taken into account

The age of criminal responsibility in England is 10. So delays in assessment and intervention could have serious consequences for a child or young person below this age.

Members discussed their experiences of working with severely traumatised children and young people displaying harmful sexual behaviour. They also discussed the detrimental effect of a failure to provide continuity of care in terms of gaining their trust and forming attachments. This was corroborated by expert testimony from a service user [EP9].

The committee agreed that these children and young people should be offered suitable interventions that reflect the level of concern and the complexity of their needs at the earliest opportunity. This could range from referral for an early help assessment to a response from specialist harmful sexual behaviour services.

The aim should be to provide stability, continuity and holistic care, and this should be reflected in the recommendations. The committee discussed the diversity of children and young people who display harmful sexual behaviour. It includes boys and girls and those with learning disabilities and autism. It heard some evidence that practitioners without expertise in this area assume it only involves adolescent boys.

There was often no recognition of the underlying issues, such as mental health difficulties, or that the child or young person's behaviour is likely to be an expression of internal trauma or other underlying vulnerabilities.

Resource impact and implementation issues

The committee considered that these recommendations would have little resource impact because they form the basis of current health and social care practice.

Section 1.8 Multi-agency approach

Multi-agency, multidisciplinary team

The discussion below explains how we made recommendation 1.8.1.
Recommendations in this section are linked to: ES2.9; EP10, EP13

Current practice

From the committee's experience, a suitable route for developing multi-agency approaches would be interagency assessments using the Common Assessment Framework, the local children’s safeguarding board and the Troubled Families Programme.

The committee acknowledged a number of statutory arrangements are relevant to the needs of children and young people displaying harmful sexual behaviour. This includes the responsibility of local authorities under section 10 of The Children's Act 2004 to promote interagency cooperation to improve the welfare of children in need. Local children's safeguarding boards also have statutory responsibilities for children in need of protection and those with highly complex needs and are responsible for developing thresholds for action (see Early help: whose responsibility? Ofsted).

The committee agreed that an early help assessment using the Common Assessment Framework can help identify what additional help the child or young person and their family need, apart from those provided by universal health and social care services. This framework provides a standard format for gathering and recording information about the child or young person's strengths and needs, based on discussions with the family. It also forms the basis for their care plan.

The committee agreed that for children and young people who do not fall under the remit of child protection, there needs to be clear ownership of the issue and greater clarity about which agencies should take responsibility. It noted that the current referral and assessment procedure is usually seen as the responsibility of 1 person or agency alone. Members agreed that the needs of many of these children and young people will not be met if channelled through 1 agency alone, and a 'team around the child' approach is what is needed.

The committee agreed the early help assessment should be done by a lead professional who supports the child and family, acts as an advocate on their behalf, and coordinates the delivery of services. The lead could be a GP, family support worker, school family liaison officer, school nurse, social worker or health visitor – the decision should be made on a case-by-case basis, with input from the child or young person and their family.

The committee discussed whether to recommend that a GP should be the named person for those outside the care system, and the child or young person's social worker should take on this role for those in the care system. It agreed that this would be too prescriptive and may result in some children or young people not being referred or assessed.

The committee noted that various services are needed to respond to this group of children and young people, particularly those for whom a statutory response is not necessary. It recommended that a variety of referral and care pathways should be in place. It also agreed that a brief consultation (or triage meeting) over the phone or face to face with a concerned parent or teacher and a specialist practitioner could be enough.

The committee acknowledged that the involvement of health agencies will vary, because support is provided in a multi-agency context.

The committee discussed the role of children and adolescent mental health services (CAMHS) in this area. Members noted that, in their experience, CAMHS staff are reluctant to get involved with children and young people displaying harmful sexual behaviour because they believe they do not have the right skills. The committee disagreed and believed many services offered by CAMHS are similar to those provided by harmful sexual behaviour services. It agreed that the issue could be overcome by closer collaboration between agencies and regular training and supervision (see 'Early help: whose responsibility?').

Evidence for effectiveness

The committee agreed with the evidence from 7 qualitative studies (3 high quality, 3 moderate quality and 1 low quality) that early assessment should be 'joined up' with any subsequent therapeutic interventions, to ensure continuity between assessment and intervention. Members also considered their own experiences and agreed that failures in interagency working remain a barrier to achieving a successful outcome and is often a key factor in serious case reviews (see New learning from serious case reviews: a two year report for 2009–2011 Department for Education).

Evidence for cost effectiveness

The committee agreed that failures in interagency working could have a serious 'knock on' effect and that local safeguarding boards need to commit resources to developing harmful sexual behaviour services. Failure to provide these services could result in a limited response to referrals and may also have implications for cost effectiveness.

Additional factors taken into account

The committee reflected on expert testimony [EP10 and EP13] that described regional arrangements for harmful sexual behaviour services as well as agreements across agencies.

It agreed that the practice of closing a social work file on a child or young person once they have been referred to harmful sexual behaviour services implies that only that service has a responsibility for them. Members described how, in some instances, this results in the referral being declined by that service as staff do not have the resources to address any non-sexual health needs. They agreed there is a need for greater recognition that a range of agencies are usually needed to provide support.

Trade off between benefits and harms

The committee agreed that if nobody took lead responsibility for assessment and referral this could have a serious impact on delivery of the care plan. The 'knock-on' effect could be further harm to the child or young person, or risk of harm to others.

Resource impact and implementation issues

Many local safeguarding children boards and child protection committees across the UK now include young people displaying harmful sexual behaviours in their interagency procedures and policy documents. Many also offer short courses on young sexual abusers as part of their interagency training programmes.

The committee therefore saw local safeguarding boards as a potential vehicle for ensuring a coordinated approach to meeting the needs of this group. This would mean using existing practices and procedures and would have the added benefit of efficiency savings by ensuring there is no duplication of services. So it will have very little resource impact.

Failure to provide local expertise will mean that children and young people with more serious sexual behavioural issues are likely receive ad hoc assessments and interventions, probably in out-of- area placement. This could prove expensive. It could also lead to delays in providing a more effective intervention in the child or young person's locality and at an earlier stage.

The committee also noted that there is no coherent national commissioning framework on harmful sexual behaviour for people living in secure accommodation and few secure children's homes or young offender institutions offer these services.

Multi-agency, multidisciplinary working

The discussion below explains how we made recommendations 1.8.2–1.8.5 Recommendations in this section are linked to: ES2.10; EP9, EP10.

Current practice

Committee members discussed their experience of working across agencies and disciplines within the harmful sexual behaviour service sector. Their experiences were generally positive because they had worked in successful and relatively well-functioning multi-agency teams. But they knew that this was not always the case and that there was room for improvement in many locations.

The committee recognised these recommendations were not based on evidence of effectiveness or cost effectiveness, but were framed by Department of Health and Ofsted guidance on interagency working and were generated by consensus from their own experience and from 2 expert testimonies [EP9 and EP10].

Evidence for cost effectiveness

There was no empirical evidence of cost effectiveness.

The committee agreed that children and young people who display harmful sexual behaviour are likely to have complex needs that can only be met by numerous health and social care agencies. Having a well-established multi-agency response will lead to multiple cost savings to society, including savings from otherwise lost educational and employment opportunities over the child or young person's life.

Additional factors taken into account

Access is needed to specialists when working with children and young people with complex needs, such as those with autism or conduct disorders. Agreeing interagency care plans would not be possible without a multidisciplinary team of professionals who meet regularly to agree and evaluate outcomes.

Resource impact and implementation issues

The committee agreed that these recommendations do not have a resource impact because they are informed by Department of Health guidance and form the basis of current health and social care practice.

Information sharing

The discussion below explains how we made recommendations 1.8.6–1.8.11.

Recommendations in this section are linked to: ES2.10.

Current practice

The committee agreed that information sharing between agencies remains a contentious issue. It discussed the need for clear, effective protocols that are regularly evaluated. In particular, these protocols should highlight the adverse consequences of not sharing information – a point made in every serious case review, including cases of violent or sexual assault and rape.

Evidence for effectiveness

The committee recognised that the recommendations were not based on evidence of effectiveness but reflected the committee's experience of serious case reviews (see New learning from serious case reviews: a two year report for 2009–2011 Department for Education). The issues are also highlighted in the Department of Health's report Working together to safeguard children.

Evidence for cost effectiveness

There was no cost effectiveness evidence for this set of recommendations. The committee did not make it a priority for modelling because it considered the cost impact to be negligible and it is widely regarded as good practice.

Additional factors taken into account

Using information-sharing protocols is regarded as good practice, as outlined in 'Working together to safeguard children'.

Resource impact and implementation issues

The committee considered that the resource impact of setting up and agreeing information sharing protocols would be negligible, particularly compared with:

- the negative consequences associated with poor information sharing and interagency working identified in case reviews
- the costs and quality-adjusted life year (QALY) losses attributed to sexual offences and rape in the economic modelling report.

In addition, information sharing via the Common Assessment Framework does not have a significant resource impact because it uses established pathways and protocols.

Evidence reviews

Details of the evidence discussed are in evidence reviews, reports and papers from experts in the area.

The evidence statements are short summaries of evidence. Each statement has a short code indicating which document the evidence has come from.

Evidence statement (ES) ES1.1 indicates that the linked statement is numbered 1 in review 1. **ES2.1** indicates that the linked statement is numbered 1 in review 2. **EP1** indicates expert paper 1 'Definitions, epidemiology and natural history of HSB'; **EP2** indicates expert paper 2 'Developmental pathways towards sexually harmful behaviour and emerging personality disorder traits in childhood'. **EP3** indicates expert paper 3 'Harmful sexual behaviour of children'; **EP4** indicates expert paper 4 'Girls who display harmful sexual behaviour – developing assessment tools and intervention resources'; **EP5** indicates expert paper 5 'Glebe House'; **EP7** indicates expert paper 7 'Harmful sexual behaviour – children and young people with learning difficulties who display harmful sexual behaviour'; **EP8** indicates expert paper 8 'AIM project'; **EP9** indicates expert paper 9 'Service user expert testimony'; **EP10** indicates expert paper 10 'Practitioner and advocate expert testimony'; **EP11** indicates expert paper 11' The development of an operational framework for children and young people who sexually harm'; **EP12** indicates expert paper 12 'An overview of policy and practice'.

Section 1.1: ER2

Section 1.2: ES2.1; EP1, EP5

Section 1.3: ES1.17, ES1.28, ES2.2, ES2.3, ES2.4, ES2.5, ES2.6, ES2.7, ES2.8, ES2.9, ES2.11, ES2.14; EP4, EP7, EP8.

Section 1.4: ES1.16, ES1.18, ES1.20, ES1.21, ES1.22, ES1.23; ES1.24; EP9, EP10

Section 1.5: ES1.1, ES1.2, ES1.3, ES1.4, ES1.5, ES1.6, ES1.7, ES1.8, ES1.10, ES1.11, ES1.12, ES1.13, ES1.14, ES1.15, ES1.16, ES1.17, ES1.19, ES1.25, ES1.26, ES1.27, ES1.28; EP2, EP3, EP5, EP9, EP10

Section 1.6: ES1.6, ES1.15, ES1.28; EP5, EP9, EP10

Section 1.7: EP9, EP10, EP12, EP13

Section 1.8: ES2.9; EP10, EP13

Gaps in the evidence

The committee's assessment of the evidence on harmful sexual behaviour identified a number of gaps. These are set out below.

1. A comparison of the effectiveness of cognitive behavioural therapy, multi-systemic therapy and other models, such as Good Lives and AIM2, for children and young people who display harmful sexual behaviour.

(Source ER1)

2. Empirically evaluated tools to assess need and predict the risk of harmful sexual behaviour among children and young people in the community including:

- different age groups (that is, children under 10 and young people 10 and older).
- those with learning disabilities or autistic spectrum disorders
- those from black and minority ethnic communities
- those at the less severe end of the harmful sexual behaviour spectrum.

(Source ER2)

3. Evidence for interventions aimed at younger children (prepubescent or under 10) and for those aimed at children under 10 with problematic sexual behaviour.

(Source ER1)

4. Evidence on actuarial models used to assess children and young people who display harmful sexual behaviour.

(Source ER1)

5. Base rates for continued problematic sexual behaviours in prepubescent children.

(Source EP1)

6. Factors that encourage children and young people to go on to commit more serious sexual offences.

(Source EP1)

Recommendations for research

The guideline committee has made the following recommendations for research.

1 Long-term implications of harmful sexual behaviour

What are the outcomes over the life-course for children and young people displaying harmful sexual behaviour? What factors are associated with those who grow out of the behaviour as they mature?

Why this is important

Longitudinal evidence spanning the life-course of children and young people who display harmful sexual behaviour is needed to understand when to intervene and to improve methods of identifying potentially modifiable risk and protective factors. That way we can also avoid mislabelling younger children as ‘sexual offenders’ and subjecting them to intrusive and stigmatising interventions when they are primarily victims.

2 Interventions for different groups of children and young people

What interventions are effective with children and young people from different population groups?

Why this is important

Most of the evidence is from small clinical populations of adolescent sex offenders. More research is needed to understand what works with different subgroups of children and young people who display varying degrees of sexualised and potentially harmful behaviour, not only those who have already offended. This includes research on:

- prepubescent children
- young women
- children and young people with learning disabilities and autism
- minority ethnic and migrant communities
- looked after children (including those in non-family based settings).

More evidence could help target resources more effectively and ensure programmes are tailored to meet children and young people's differing needs.

There is also a need for evidence that is relevant to the UK and has a low risk of bias.

3 Interventions for children and young people living in out-of-home placements or secure accommodation

Are there targeted interventions that are effective in particular situations, for example, with children and young people who are not living with their birth family because of safety concerns and for those living in secure accommodation?

Why this is important

Most studies focus on small clinical populations of adolescent male sex offenders. They do not differentiate, for example, in terms of whether or not they are (or were) looked-after children or have a conduct disorder. There is a need for evidence that is relevant to the UK and has a low risk of bias.

Evidence on interventions for looked-after children needs to include those in non-family based settings. For this group there is also a lack of evidence on interventions to promote placement stability and permanence, as well as on interventions specifically relating to harmful sexual behaviour. The former is needed because a stable home life may help reduce the risk of harmful sexual behaviour.

4 Early interventions to prevent problems escalating

What interventions are effective in diverting children and young people away from further harmful sexual behaviour before a legal response is needed?

Why this is important

There is a need for more evidence on what is effective in diverting children and young people away from further harmful sexual behaviour at the earliest stages of its development.

A range of research designs could be used, including retrospective studies. These could draw on what is already known about missed opportunities to intervene and what the trajectory has been for those children and young people who were missed. The use of qualitative studies alongside randomised controlled trials should be considered.

5 Tools to assess need and level of risk in different groups

How well do different assessment tools assess both need and level of risk for children and young people from different population groups who display harmful sexual behaviour?

Why this is important

Assessment is at the heart of effective intervention planning and risk management. Without good assessment tools, levels of risk may be misclassified. Assessment results also provide a basis for decisions about therapeutic interventions, treatment and care plans and placements.

For those in the criminal justice system, an assessment provides a clear guide to sentencing and multiagency management (for example, Multi-Agency Public Protection Arrangements).

The lack of evidence on current assessment methods means that we know little about:

- the problems caused by mislabelling a child or young person
- the impact of the assessment process on the child and young person and their families and carers.

6 Interventions to help prevent use of online pornography

What interventions are effective at targeting compulsive and harmful use of online pornography?

Why this is important

Little is known about children and young people who display problematic sexual behaviour as a result of looking at online pornography. Even less is known about what interventions might work to prevent compulsive use of this material. An epidemiological study describing the characteristics of young people who engage in this type of offence is needed in the first instance.

Glossary

Cognitive behaviour therapy

Cognitive behaviour therapy for people displaying harmful sexual behaviour typically includes: identifying previous circumstances leading to sexual arousal, accepting responsibility for offensive behaviour, social skills training, empathy and relapse prevention.

Cognitive restructuring therapy

Methods that help people to think differently about a situation, event, thought, or belief.

Common Assessment Framework

A standard approach to an interagency assessment of a child or young person's needs, in addition to those being met by universal services, and deciding how those needs should be met. The early help assessment is based on the Common Assessment Framework

Conduct disorder

A serious behavioural problem that can last a long time and can affect a child or young person's ability to lead a normal life. It is characterised by behaviour that violates either the rights of others or major societal norms. Behaviour problems can manifest as aggression to people and animals, destruction of property, deceitfulness or theft and a serious violation of rules (The American Classification of Psychiatric Disorders).

Developmental age

A child or young person's social, emotional, physical and intellectual maturity compared with typical behaviours and characteristics for their chronological age.

Early help assessments

Early help assessments identify what help a child and family may need to prevent their needs escalating. They are for children and families who may need support from several agencies.

Holistic

Treatment of the whole person, taking into account mental health and social factors, rather than just their behaviour or symptoms of a disease.

Multi-systemic therapy

Multi-systemic therapy is an intensive community- and home-based approach to a broad set of adolescent problem behaviours, including harmful sexual behaviour. The emphasis is on interventions that target specific, well-defined problems. The aim is to empower carers to address family members' needs.

Neurodevelopmental disorders

These disorders that typically manifest early in development, often before the child enters school, and are characterised by developmental deficits that produce impairments of personal, social, academic, or occupational functioning. Examples are: learning disability, autism spectrum disorder, speech and language disorders and ADHD (attention deficit hyperactivity disorder).

Prepubescent

A child who has not yet reached puberty.

Problematic sexual behaviour

Unusual and socially unexpected behaviour. It may not involve victimisation and consent issues may be unclear. The person may display a lack of reciprocity or a sense of everyone being equal and may show levels of compulsion. Problematic sexual behaviours do not harm others but create some risk for the child or young person themselves, make others uncomfortable or interfere in healthy psychosexual development.

Satiation therapy

A procedure that involves the pairing of prolonged masturbation (1 hour) with a verbal commentary by the patient of his or her deviant sexual fantasies.

Sexually abusive

A term mainly used to describe sexual behaviours initiated by a child or young person in which there is an element of manipulation or coercion, or the subject of the behaviour is unable to give informed consent.

For other public health and social care terms see the Think Local, Act Personal Care and Support Jargon Buster.

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