NICE National Institute for Health and Care Excellence

Expert testimony to inform NICE guideline development

Section A: Developer to complete	
Name:	Simon Hackett
Role:	Principal/ Professor of Applied Social Sciences (academic)
Institution/Organisation (where applicable): **Contact information:**	Durham University, St Mary's College
Guideline title:	Harmful Sexual Behaviour
Guideline Committee:	Public Health Advisory Committee F
Subject of expert testimony:	Definitions, epidemiology and natural history of HSB
Evidence gaps or uncertainties:	[Research questions or evidence uncertainties that the testimony should address are summarised below]
What is known about the natural history and developmental lifecourse of harmful sexual behaviours in childhood and adolescence?	

Section B: Expert to complete	
Summary testimony:	[Please use the space below to summarise your testimony in 250–1000 words. Continue over page if necessary]

This expert testimony highlighted the importance of definitions and terminology that distinguishes between inappropriate, problematic, abusive and violent sexual behaviours in childhood and adolescence. It reviewed the scale of the problem including recent statistical indicators. Attention was given to core aetiological factors implicated in the development of harmful sexual behaviours and to research into the persistence of such behaviours across the life course. Studies into recidivism rates were examined. Most children and young people grow out of harmful sexual behaviours in later adolescence and in adulthood and that the majority of young people committing sexual offences have only one police contact for a sexual offence. Early adolescence is the peak age for sexual offenses against younger children whereas sexual offenses against teenagers surge during mid to late adolescence, while offenses against victims under age 12 decline. A small number of 'sex-offending' youth are at elevated risk to progress to adult sex offenses. Violent sexual offending (coupled with non-sexual crime) in youth predicts rape type offences in adulthood. Sexual offences against younger children at older adolescence predicts 'paedophile' type offending in adulthood. Sex offenders appear to be similar to non-sex offenders in their criminal career patterns; i.e. a group of "life-course persistent" offenders are responsible for the majority of criminal behaviour. However, we know relatively little about the longer term developmental consequences (other than criminal recidivism) for young people with harmful sexual behaviours. Hackett and colleagues' (2014) study of longer term outcomes in a sample of young people with harmful sexual behaviours between 10 and 20 years following the end of professional interventions showed that whilst known criminal reoffending was relatively low, life outcomes were more mixed. Good outcomes were associated with stability in professional support and with positive intimate partner relationships.

References to other work or publications to support your testimony' (if applicable):

Hackett, S., Masson, H., Balfe, M. and Phillips, J. (2013) Individual, Family and Abuse Characteristics of 700 British Child and Adolescent Sexual Abusers, Child Abuse Review, 22, Issue 4, 232–245

Finkelhor, D., Ormrod, R. and Chaffin, M. (2009) *Juveniles Who Commit Sex Offences Against Minors.* Washington, OJJDP.

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Expert testimony to inform NICE guideline development

Section A: Developer to complete	
Name:	Eileen Vizard
Role:	Honorary Senior Lecturer
Institution/Organisation (where applicable): **Contact information:**	Institute of Child Health Population, Policy & Practice Programme
Guideline title:	Harmful Sexual Behaviour
Guideline Committee:	Public Health Advisory Committee F
Subject of expert testimony:	Harmful Sexual Behaviour – children and young people with troubling behaviours/personality disorders who display harmful sexual behaviour
Evidence gaps or uncertainties:	[Research questions or evidence uncertainties that the testimony should address are summarised below]

1. Natural history of troubling behaviours/personality disorders; young people with harmful sexual behaviour and co-morbid mental health issues.

2. Cross cutting themes that may be relevant to this area and of interest to the committee:
    - Minority populations
    - Young women/gender issues
    - Learning difficulties
    - Autism
    - Parents and carers

Section B: Expert to complete

Summary testimony: [Please use the space below to summarise your testimony in 250–1000 words. Continue over page if necessary]

These are 2 extracts from papers I have published plus a reference for another paper which, hopefully, cover the issues on which I shall give evidence to the NICE Committee on 13.9.15:

1. WORD COUNT = 444. JCPP Practitioner Review, Vizard, 2013. 'Conclusions:

Research shows that 16.5% of 11–17 year olds have experienced either contact or noncontact sexual abuse by an adult or peer and that 57.5% of the contact sexual abuse were perpetrated by children or young people themselves, nearly twice as frequent as that perpetrated by adults (34.1%) (Radford et al., 2011). As being sexually abused or perpetrating the abuse is associated with increased psychopathology and involvement in the criminal justice system, significant costs for the public purse are incurred across the life span of both victims and perpetrators (Utting et al., 2007;Welch, 2003).

Assessment of child victims of sexual abuse is now generally accepted as a core function of CAMHS (Child and Adolescent Mental Health Services), probably because so many children presenting to CAMHS with other problems turn out to have been sexually victimized.

However, in contrast, there is widespread reluctance within CAMHS to undertake direct clinical assessments of children who sexually abuse, for reasons which remain unclear. They may fail to appreciate that sexually harmful behavior in younger children can be a marker for later mental health problems including poor emotional and behavioral regulation with an increased risk of poor adult outcomes (McCrory et al., 2008).

The author's clinical experience in this field over several decades suggests that professionals are also disconcerted by the combination of aggression and

vulnerability so often seen in juvenile perpetrators of sexual abuse. Practitioners may also be fearful of interviewing these children and confronting a possible aggressive response as well as a likely denial of responsibility for the sexually abusive behavior.

They may also be reluctant to prepare reports or to give evidence in contested Court proceedings in these cases.

Hence, a more 'forensic' professional stance is needed in relation to working with children and older young people, such that their simultaneously vulnerable and potentially dangerous presentations can be observed, assessed, and reported upon in a neutral manner. This stance should be acquired through training and rigorous supervision of clinical work.

As children who have been sexually abused have been recognized by professionals for longer than those who perpetrate abuse, it is not surprising that treatment programs for the needs of victims are far better established in the United Kingdom than those for child perpetrators (Allnock et al.,2009).

The burden of psychopathology, poor parenting, and possible criminality associated with untreated CSA victims and their juvenile perpetrators has major personal and financial implications for thechildren concerned and for society as a whole (Utting

et al., 2007; Welch, 2003). It follows that effective early intervention with both victimized and oversexualized children will reap major benefits in terms

of preventing sexual abuse and its long-term sequelae (Vizard, 2013, page 511).

2. WORD COUNT = 275. BJPsych, Vizard et al, 2007. Discussion:

'The aim of the current study was to explore the utility of an 'age at onset' trajectory as a means of differentiating between subgroups of juveniles with sexually abusive behaviour, to identify a subgroup with emerging severe personality disorder traits and to delineate the nature of their developmental trajectory in relation to psychosocial and behavioural factors.

Age at onset of sexually abusive behavior.

Moffitt (1993) proposed that those with an early onset of antisocial behaviour are impaired by the interaction of neuropsychological deficits and adverse environments. In support the current study found that those with an early onset of sexually abusive behaviour showed higher levels of early difficult temperament and adverse environmental experiences such as inadequate parenting, maltreatment, placement changes and insecure attachment. These factors also increase the risk of persistent antisocial behavior throughout childhood and adolescence. Interestingly, the sexually harmful behaviour perpetrated by those on the early-onset trajectory tends to be generalized rather than targeted at specific victim groups. This suggests that their behavior may not be primarily sexually motivated at this younger age but may be one feature of an externalising presentation. By contrast, those with a late-onset of sexually abusive behaviour had different psychosocial and behaviour profiles consistent with Moffitt's (1993) hypothesis that late onset antisocial behaviour is less directly influenced by early developmental factors. The higher rates of substance misuse in this group perhaps reflect the greater influence exerted by the peer group. The sexually abusive behaviour of the late-onset group (for example, victimising females or younger children) is consistent with a greater influence of sexual arousal and an inability to achieve developmentally appropriate sexual relationships.' (Vizard et al, 2007, page 31).

References to other work or publications to support your testimony' (if applicable):

1. Vizard, E. (2013). Practitioner Review: The victims and juvenile perpetrators of child sexual abuse-assessment and intervention. *Journal of Child Psychology and Psychiatry*. 54:5, 503-515.
2. Vizard, E., Hickey, N., & McCrory, E. (2007). Developmental trajectories towards sexually abusive behaviour and emerging severe personality disorder in childhood: The results of a three year U.K. study. British Journal of Psychiatry, 190 (Suppl. 49), s27–s32
3. Vizard, E. (2008). Emerging severe personality disorder in childhood. Psychiatry. Part 4. Child Psychiatry, 7, 389–394.

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Expert testimony to inform NICE guideline development

Section A: Developer to complete	
Name:	Jane Silovsky
Role:	Professor
Institution/Organisation (where applicable): **Contact information:**	Centre on Child Abuse and Neglect Department of Paediatrics, OUHSC
Guideline title:	Harmful Sexual Behaviour
Guideline Committee:	Public Health Advisory Committee F
Subject of expert testimony:	Harmful Sexual Behaviour – evidence of effective interventions for children 10 and under
Evidence gaps or uncertainties:	[Research questions or evidence uncertainties that the testimony should address are summarised below]

1. Evidence of effective identification and assessment tools for children 10 and under.
2. Evidence of effective interventions for children 10 and under.
3. Potential harms associated with early identification of harmful sexual behaviour such as labelling/stigmatisation. Impact of legislation on this age group and potential association with sex offender status. The effectiveness of interventions developed to address problematic sexual behaviour compared to generic focussed interventions for children displaying harmful sexual behaviour.
4. Cross cutting themes that may be relevant to this area and of interest to the committee:
    - Minority populations
    - Young women/gender issues
    - Learning difficulties
    - Autism
    - Parents and carers

Section B: Expert to complete

Summary testimony:	[Please use the space below to summarise your testimony in 250–1000 words. Continue over page if necessary]

Abstract:

Problematic sexual behaviors are child initiated behaviors typically involving sexual body parts that are developmentally inappropriate and potentially harmful to self or others. Sexual behaviors fall on a continuum of typical, concerning, problematic, and harmful sexual behaviors. Interpersonal and even aggressive sexual behavior have been found in children 10 and under, even as young as 3 years of age. Harmful sexual behavior do not represent a medical/psychological syndrome or even a specific diagnosis, but rather a set of behaviors considered unacceptable by society and that cause impairment in functioning. Although these behaviors may mimic adult sexual behaviors, clinicians are strongly cautioned against conceptualizing children's behavior within frameworks for adult or adolescent sexual offending behaviors, or even adult intimacy. Origins and maintenance of problematic sexual behaviors, and responsiveness to interventions of children with harmful sexual behavior are quite distinct from adults with illegal sexual behavior. Origins of harmful sexual behaviors are complex, with multiple potential pathways. Contributing factors include child maltreatment, coercive or neglectful parenting practices, exposure to sexually explicit media, living in a highly sexualized environment, exposure to family violence, as well as individual factors. Treatment outcome research demonstrates that caregiver direct involvement in treatment is key to reducing problematic sexual behaviors of children. A meta-analysis of treatment outcome studies found effective components were caregiver treatment addressing managing child behavior, sexual behavior rules, sex education, and abuse prevention (St. Amand, Bard, & Silovsky, 2008). A ten-year follow-up to a randomized clinical trial of a cognitive-behavioral group treatment program with these treatment components for children with problematic sexual behavior and their parents was conducted. Results indicated recidivism rates comparable to children with no history of problematic sexual behavior (2-3%), and significantly lower than the randomized comparison play therapy group (11%; Carpentier, Silovsky, & Chaffin, 2006). Community based treatment directly addressing problematic sexual behavior with the children and caregivers can effectively address treatment needs. Results of the research question the prominent use of inpatient treatment, treatment without caregiver involvement, and treatments designed for adult sexual offenders.

References to other work or publications to support your testimony' (if applicable):

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Expert testimony to inform NICE guideline development

Section A: Developer to complete	
Name:	Sharron Wareham
Role:	Research Practitioner/Team Manager
Institution/Organisation (where applicable): **Contact information:**	Barnardo's
Guideline title:	Harmful Sexual Behaviour
Guideline Committee:	Public Health Advisory Committee F
Subject of expert testimony:	Harmful Sexual Behaviour – the development of standardised assessment tools and intervention resources for girls who have engaged in harmful sexual behaviour.
Evidence gaps or uncertainties:	Data collected continues to undergo higher statistical analysis and as such it is likely early research findings may be added to and developed further. To date there are a smaller number of girls who have completed recommended intervention areas to measure positive personality/attitudinal shift, with the passage of time we would expect to provide more robust evaluation of the assessment measures and workbook.

1. How have you developed your approach and what are the indicators of success.
2. How does this approach differ from more orthodox CBT approaches.
3. Cross cutting themes that may be relevant to this area and of interest to the committee:
    - Minority populations
    - Young women/gender issues
    - Learning difficulties
    - Autism
    - Parents and carers

Section B: Expert to complete

Summary testimony: [Please use the space below to summarise your testimony in 250–1000 words. Continue over page if necessary]

Questions 1 and 2:

The project sought to access girls in mainstream school and other professional agencies. We ran a number of focus groups with girls and educational professionals which allowed us to modify existing tests and/or develop new ones.

We then requested completion of the assessment tools by teenage girls in school/agency settings. It was also pertinent to access young women who have offended non sexually also. At the same time, we gave the assessment tools to girls referred to us for harmful sexual behaviour. To maximise our sample, we also made the assessment tools available to those working with girls and young women involved with other specialist HSB services, including residential facilities.

On completion, we run appropriate statistical analysis on data gathered that allowed us to develop normal ranges for each test. We were then able, for the first time, to systematically consider young women who have harmed others sexually. This is a major step forward as it allows us to target areas of work to reduce risk of harm to themselves or others.

We also collated a range of demographic and behavioural information. This has allowed us to consider the different life experiences of young females involved in HSB. It has then been possible for us to consider girls and young women who have displayed HSB in comparison to adult female offenders/abusers. This is also an important first step as there was no existing research looking at how some girls progress into adult sexual abusing/offending.

It has also been possible to compare girls and young women who have harmed sexually with boys and young men who have harmed sexually. This has allowed us to consider similarities and differences in the attitudinal presentation of boys and girls who engage in this type of behaviour. Again, this work had not previously been undertaken.

The final stage of the project was to develop a specific treatment resource/workbook grounded in research findings. This represents a major advance in the intervention with girls and young women who harm sexually.

The draft workbook has been piloted by our service and selected services in the UK and was subject to an evaluation exercise. In addition to the usual means of evaluation, the assessment measures are administered to girls at the start and finish of the identified treatment programme. Thus, the impact of treatment using the workbook can be assessed.

Further modifications were then made to the treatment resource/workbook to maximise assessed effectiveness prior to publication.

The workbook approach has been developed via consultation, clinical guidance, practise and supervision within the Taith Service Team, Youth offending services and other specialist HSB services.

The approach draws upon CBT although includes attachment and trauma based interventions also. The approach is developmentally led and considers the child's needs within this context. The approach encourages unique case formulation for each child and family alongside recognition of areas of commonality drawn from research findings.

Question 3

Girls who display harmful sexual behaviour

Research into young people who display sexually harmful behaviour has increased greatly over the past 30 years. However, there remain relatively few studies specifically in relation to girls with sexually harmful behaviour.

Available research suggests that around 10% of victims of child sexual abuse are molested by women and girls, (Elliott 1993; Saradjian 1996) although some studies put this figure as far greater, with one study (Rich 2003) indicating that female perpetrators may account for up to 69% of sexual assaults on very young children (below 6 years). However, it appears girls are less frequently identified and referred for treatment, with girls representing a lower proportion of those referred to specialist agencies than these studies would suggest perpetrate sexual abuse. Similarly, current literature reflects a consensus that there is a general tendency to minimise or under respond to sexually harmful behaviour by girls. In practice this can significantly impact on the help offered to victims of sexual assaults by females, as well as reduce the likelihood of intervention for these young women, such that they are more equipped to develop healthy and safe future sexual relationships.

An Office of Juvenile Justice and Delinquency Prevention study (2001) commented on the lack of studies on girls with sexually harmful behaviour and identified a tendency to extrapolate from samples of adult females or samples that combined adolescent males and females. A concentration on male only samples has continued to be noted more recently (Kubik et al, 2002; Epps and Fisher 2004) and girls with sexually harmful behaviour are still regarded as 'a relatively unknown group' (Hendricks and Bijeveld 2006)

Consequently current assessment frameworks and intervention approaches for young people are based largely on professional understanding of boys. However, we know that gender is a crucial variable in the arena of sexual offending/ harmful sexual behaviour.

Much of the literature published on adult female sexual offenders in recent years has concluded that female offenders are different to male offenders in several ways.

They are believed to abuse under different circumstances, as a result of different needs and are influenced by different psychological processes. As yet, however, there is no such research to suggest that girls who sexually harm are the same as adult women who do so. Utilising existing measures that have been standardised either with boys or adult women may not be fully effective in considering risk and the needs of girls with harmful sexual behaviours.

To date, we have developed norms for several measures which focus on aspects of sexual knowledge, openness, personality and sexual attitudes, for example self-esteem, emotional loneliness, and general empathy, as well as attitudes in relation to children and sex and sexual victim attitudes such as the extent to which a young person blames the victim, perceives the victim as being compliant, and/or perceives the victim as being unharmed by the behaviour. These are designed to establish needs and to help identify young girls of higher concern and potentially higher risk of repeating harmful sexual behaviour. The measures were developed based on information gained via focus groups held with adolescent girls and young adult women, as well as discussions with other professionals.

Findings suggest that, compared to non-offending girls, those known to have displayed HSB are not significantly different with regards to levels of self-esteem (although both groups presented as having low self-esteem when compared to boys and adult females), girls within the comparison group however were found to have significantly lower levels of self-esteem when compared to all groups.

Areas where no significant difference was noted between non offending girls and girls displaying HSB were emotional loneliness, fantasy, and distortions regarding children and sex. Again girls within the comparison sample were found to be significantly different when considering elevated distortions regarding children and sex.

Areas where significant differences were found when compared to non-offending girls included the ability of girls displaying HSB to manage personal distress, a reduced ability to gain perspective a reduced ability to display general empathic concern for others and levels of sexual knowledge.

Analysis of demographic data collected indicates girls who display HSB are more likely to have experienced trauma including sexual abuse, physical abuse, emotional abuse and neglect and domestic abuse when compared to boys displaying HSB. However, research findings and our experience has highlighted boys attending the service also have high levels of trauma experiences.

Completion of the TSCC by the girls who participated in the research indicates that if assessed by a clinician, 40% may invite a PTSD diagnosis and 33% may invite a diagnosis regarding anxiety and/or depression. Consideration of early life experiences and traumatic episodes then is key in delivering any longer term intervention to girls displaying HSB.

There is a tendency to view girls who display harmful sexual behaviour primarily as ‘victims’ and boys as ‘perpetrators’. Despite cultural resistance to perceive girls and young females as abusers, over the 3 year project we have seen our referral rate for girls increase significantly from 8% in 2010/2011 to 25% in 2014/2015. Behaviours

displayed by girls participating in the research did not differ significantly to those displayed by boys attending the service.

In our experience girls displaying harmful sexual behaviour tend to be managed within welfare services with 98% of the referrals received in relation to girls being made by Children's Services as opposed to Youth Offending Services. This coincides with the average age of referral for girls being younger when compared to boys. In comparison to boys attending the service the girls we support display similar levels of aggression in their general behaviour although they are not subject to the same level of sanction either within the education systems or Youth Justice System when compared to males. The impact of this while positive for the girls we work with, is problematic for the boys in that exclusion from education impacts significantly upon them receiving many of the factors believed to influence risk in young people displaying harmful sexual behaviour such as limited access to educational input, access to appropriate adult emotional support, limited access to peer relations and an increase in social isolation.

Analysis of the research findings indicates that girls displaying HSB are also vulnerable to CSE. 89% of the girls who participated in the research were found to be at risk of CSE.

Research findings suggest that while there is much communality in the life experiences of boys and girls attending the service, the development of attitudes and beliefs in relation to these experiences seem to be shaped differently in relation to gender. For example, girls who are exposed to domestic abuse in the relationships of significant adults may develop thinking errors around consent and compliance in their own relationships. Whereas boys with similar experiences may have elevations in relation to thinking errors around aggression and hyper masculinity. This may be an area of shared experience but there are very clear differences in terms of intervention to rebalance thinking errors.

Research and practise in relation to girls who display harmful sexual behaviour has highlighted the need for difference in the assessment and intervention approaches depending on gender. It has also highlighted the variations from professionals in the systems and supports offered depending upon gender. Our question now perhaps is what can we learn from working with girls to improve our practise with boys

References to other work or publications to support your testimony' (if applicable):

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