NICE National Institute for Health and Care Excellence

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.

Expert testimony papers are posted on the NICE website with other sources of evidence when the draft guideline is published. Any content that is academic in confidence should be highlighted and will be removed before publication if the status remains at this point in time.