THE PROFILE OF THE CHILDREN AND YOUNG PEOPLE ACCESSING AN NSPCC SERVICE FOR HARMFUL SEXUAL BEHAVIOUR

SUMMARY REPORT

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This report is part of the NSPCC’s Impact and Evidence series, which presents the findings of the Society’s research into its services and interventions. Many of the reports are produced by the NSPCC’s Evaluation department, but some are written by other organisations commissioned by the Society to carry out research on its behalf. The aim of the series is to contribute to the evidence base of what works in preventing cruelty to children and in reducing the harm it causes when abuse does happen.
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SUMMARY OF KEY FINDINGS

• UK figures suggest that the majority of young people who engage in harmful sexual behaviour (HSB) are adolescent males. However, females, younger children, and children and young people with a learning difficulty also exhibit HSB. Much less is known about the needs and characteristics of these groups. Thus, this research was carried out to address this gap, and to inform decisions about the commissioning and delivery of services to these groups.

• The NSPCC set up a service for the following groups of children and young people who have displayed HSB: females, younger children (under 12), and those with a learning difficulty. Of the 198 children and young people assessed/receiving intervention between March 2013 and August 2015:
  – 14 per cent were female (75 per cent of whom were aged 11 and under);
  – one-third were males aged 11 and under with no learning difficulty; and
  – half were males with a learning difficulty (not all formally diagnosed) – 80 per cent of whom were aged 12 and over.

• The HSB displayed by these children and young people was mainly directed towards a specific victim (in more than 85 per cent of cases). There are some differences between the victims of these groups of children and young people compared with those of adolescent males (as identified in a large study by Hackett et al [2013]): the victims were more often family members and less often younger than themselves.
• Statistically significant differences were identified between the girls, younger males, and males with a learning difficulty in their relationship to their victims:
  – Boys with a learning difficulty were most likely to have abused someone outside of their family and less likely to have abused a family member.
  – Girls were most likely to have multiple victims with varying relationships to them (such as both family and non-family members).

• We used standardised measures to explore the trauma, wellbeing, behaviour and wider sexual behaviours of a sub-sample of 74 children and young people. We also carried out interviews with 31 team managers and children’s service practitioners to gain their reflections on the assessment of, and providing tailored intervention to, these children and young people.

• These children and young people presented with a range of emotional, behavioural and peer-related difficulties alongside their HSB. As such, it is worth considering that the child’s HSB represents another form of externalising behavioural difficulties, and that their externalising (“acting out”) and internalising (such as anxiety and depression) difficulties may stem from the same issue, such as their own trauma and/or abuse.

• Many of the children and young people indicated experiencing some level of trauma. A fluid, as opposed to tightly prescribed, service delivery model may, therefore, be required to facilitate assessment and intervention focused on the child’s own trauma and associated symptomatology alongside their HSB.
• A holistic approach to assessment is needed to incorporate the views and experiences of children and young people, their parents/carers, people and professionals within their wider network, and to gain information on functioning from standardised measures. This will allow practitioners to formulate interventions focused on the child/young person’s wide-ranging needs associated with their HSB.

• A holistic, multi-agency approach to intervention is needed, acknowledging and addressing the range of emotional, behavioural and peer-related difficulties faced by these children and young people. Such intervention may also need to be tailored specifically to working with younger children and children/young people with a learning difficulty.
Background, aims and objectives

Harmful sexual behaviour (HSB) is defined as “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” (Rich, 2011).

A nationally representative survey of 2,275 children/young people aged 0–17 in the UK found that 65.9 per cent of contact sexual abuse was perpetrated by someone under the age of 18 (Radford et al, 2012).

One of the largest investigations into the profile of children and young people displaying HSB in the UK was carried out by Hackett, Phillips, Masson and Balfe in 2013 (Hackett et al, 2013). They investigated the characteristics of 700 children and young people referred to nine UK HSB services, finding that the vast majority were white males and the most common age at referral was 15 years. Around one-third of these 700 children and young people were looked after in local authority care, two-thirds had experienced trauma or abuse of at least one kind and, specifically, 50 per cent of young males were found to have been, or were suspected of having been, sexually abused. While a wide range of HSB was noted from this group, the majority chose a known, but unrelated, victim.

Hackett et al’s (2013) research sample was dominated by adolescent males without a learning difficulty, yet they identified that a third of all referrals to an HSB service were for children aged 13 or under and 38 per cent of the sample were identified as having a learning difficulty. HSB is not, therefore, limited
Indeed, research by Smith et al (2013) found that English local authorities reported a five-year increase in HSB cases by females (18 per cent of local authorities perceived an increase), children/young people with a learning difficulty (27 per cent perceived an increase), and children aged 8–12 (18 per cent perceived an increase) and under eight years (27 per cent perceived an increase).

It is, therefore, important that further research is carried out to understand more about the needs and characteristics of these children and young people, particularly as some differences have been identified between them and adolescent males. For example, younger children, females, and those with a learning difficulty appear to have experienced higher rates of sexual abuse than adolescent males (see, for example, Hutton and Whyte, 2008; Vizard, 2013) and tend to display more coercion than force in relation to their HSB (see, for example, Frey, 2010). Children and young people with learning difficulties are also more likely to have problems around social isolation, reduced self-control, and have less sex education and sexual knowledge (Browne and McManus, 2010). They may also be involved in less penetrative HSB and violence during the incident than adolescent males (Almond and Giles, 2008).

Understanding more about females, younger children, and children and young people with a learning difficulty who display HSB will help to develop specialist HSB services for these young people. Such services are currently lacking, as are policies that make reference to the specific needs and vulnerabilities of children and young people with a learning difficulty (Hackett et al, 2005).
This research was designed to fill a gap in understanding of the needs of these specific groups and, therefore, had two main aims:

1. To explore and describe the profile of children and young people accessing an HSB service designed to work specifically with females, younger children, and children and young people with a learning difficulty.

2. To gain the reflections of the practitioners delivering this service in regards to providing a tailored HSB assessment and intervention service for these children and young people.
Methodology and analysis

The NSPCC established a service for the following groups of children and young people (aged 5–18) who had displayed HSB: males under the age of 12; males with a learning difficulty (diagnosed or undiagnosed); and any female displaying HSB. This service had been established to complement an existing service that worked with adolescent males (aged 12–18). Demographic information was collected on all of the 198 children and young people accessing this NSPCC service between March 2013 and August 2015, along with information on their HSB and whether they had disclosed being a victim of sexual abuse.

Standardised measures were used to assess:

- the child/young person’s trauma symptoms in relation to a number of areas, such as depression and anxiety (using the Trauma Symptom Checklist for Children [TSCC] or for Young Children [TSCYC]);

- the types of wider sexual behaviours they exhibit, not focusing solely on their HSB (using the Child Sexual Behaviour Inventory [CSBI] or Adolescent Clinical Sexual Behaviour Inventory [ACSBI]); and

- their general strengths and difficulties in relation to conduct problems, hyperactivity, emotions, peer relationships and prosocial behaviour (using the Strengths and Difficulties Questionnaire [SDQ]).
Where children, young people and their parents/carers gave research consent, their measure data was included in this study. In total, 74 children/young people (37 per cent of the children/young people accessing the service) were included in this research:

- 29 per cent (8 out of 28) of the females accessing this service;
- 46 per cent (32 out of 69) of the younger males; and
- 34 per cent (34 out of 101) of the males with a learning difficulty.

The small number of girls taking part in the research was compounded by a lack of completed measures in some cases, hence caution is required with interpretation, although the findings below do support general trends from existing research.

Interviews were completed with 10 out of the 11 NSPCC team managers working on the service at that time and 21 NSPCC children’s service practitioners (31 interviews in total). These interviews gained practitioners’ and managers’ reflections on the assessment of, and providing tailored intervention to, these children and young people. They also reflected on the additional challenges of working with these children and young people within an HSB service.

The attached Technical Report contains fuller details of the following: the research consent process; the standardised measures used and their associated completion rates; statistical analysis; the interview process, sampling and analytical approach; research ethics considerations; and limitations of the research.
Key findings

Characteristics of, and the HSB displayed by, children and young people accessing the NSPCC service

Table 1 displays the characteristics of the 198 females, males with a learning difficulty, and young males (without a learning difficulty) being assessed/receiving intervention within the NSPCC service between March 2013 and August 2015. Of these:

- 14 per cent were female (75 per cent of whom were aged 11 and under);
- one-third were males aged 11 and under with no learning difficulty; and
- half were males with a learning difficulty (not all formally diagnosed) – 80 per cent of whom were aged 12 and over.

Table 1: Characteristics of the females, males with a learning difficulty, and young males (without a learning difficulty) accessing the NSPCC service

<table>
<thead>
<tr>
<th></th>
<th>Aged 11 and under</th>
<th>White</th>
<th>Learning difficulty</th>
<th>In local authority care</th>
<th>Disclosed own sexual abuse</th>
</tr>
</thead>
<tbody>
<tr>
<td>Females (n=28)</td>
<td>75%</td>
<td>79%</td>
<td>32%</td>
<td>21%</td>
<td>29%</td>
</tr>
<tr>
<td>Males with a learning difficulty (n=101)</td>
<td>20%</td>
<td>75%</td>
<td>36%</td>
<td>15%</td>
<td></td>
</tr>
<tr>
<td>Males under 12 years without a learning difficulty (n=69)</td>
<td></td>
<td>84%</td>
<td>30%</td>
<td>17%</td>
<td></td>
</tr>
</tbody>
</table>

The percentage of children/young people noted as having disclosed their own experiences of sexual abuse is likely to be an underestimation due, in part, to missing information for half of the children and young people in relation to this. It is unknown how
many children/young people disclosed sexual abuse during the course of the programme and for how many there were suspicions of sexual abuse.

As can be seen in Figure 1 below, the HSB displayed by these children and young people was mainly directed towards a specific victim (in more than 85 per cent of cases). Where there was no direct victim of the child/young person’s HSB, they were referred to the service for reasons like displaying overly sexualised language and/or behaviour, or concerning pornography use.

Figure 1: Details of the HSB displayed by the children and young people accessing the NSPCC service
Beyond the exploration of whether there was a direct victim of the young person’s HSB, however, the data collected for this research did not allow for a more detailed understanding as to the specific nature of the referral HSB (for example, whether it involved penetration or violence). In 48–52 per cent of cases, the victim was younger than them.

Statistically significant differences (for example, a difference at a level greater than chance) were identified between the girls, younger males and males with a learning difficulty in their relationship to their victim as follows:

- Boys with a learning difficulty were the least likely to display HSB towards a family member ($\chi^2 = 6.88, p<0.05$) and most likely towards a non-family member ($\chi^2 = 6.20, p<0.05$) compared with girls and boys under 12.

- Girls were the most likely to have multiple victims with varying relationships to them (such as family members and non-family members; $\chi^2 = 5.70, p<0.05$) compared with boys under 12 and boys with a learning difficulty.

There were no statistically significant differences between the girls, younger males and males with a learning difficulty in whether their HSB involved a direct victim(s) and in the age of their victim(s).

The sub-sample of 74 children and young people who gave research consent and whose characteristics are explored below are largely representative of the total sample of 198 service users (see Technical Report for details).
Males with a learning difficulty

Sexual behaviour

A wide range of sexual behaviours were reported on the adolescent clinical sexual behaviour inventory (ACBSI) by the parents/carers of 14 boys aged 12–18. The most frequent of these behaviours related to the young person talking about and asking for information on sex, and knowing more about sex than others of their age. Parent/carer reports also indicated loneliness and a lack of self-esteem/poor self-image among many of these young people. In contrast, less sexual behaviour was reported on the child sexual behaviour inventory (CSBI) for seven young boys under the age of 12, but the clinical levels of these behaviours cannot be explored as there are no norms to compare them with due to the boys’ learning difficulties.

Strengths and difficulties

As can be seen in Figure 2 below (in the dark grey bars), the vast majority of the boys with a learning difficulty had high or very high levels of total difficulties, conduct problems and peer problems, and just over half had emotional problems and low or very low levels of prosocial behaviour (as reported on the SDQ). In contrast, less than half of these children/young people had problems with hyperactivity. It appears from this graph that the levels of difficulties displayed by these boys were higher than the levels of difficulties displayed by young boys (under 12 years) without a learning difficulty (in the light grey bars). The levels of difficulties on the total SDQ scale and all subscales appear to be much higher than in the parent-reported data for the wider general (normative) population. These differences were not statistically tested.
population of British boys aged 5–15 years (Meltzer et al, 2000), as can be seen in the striped bars on the graph.

Trauma symptoms

The trauma symptoms checklist for children (TSCC) was completed by 18 males. The most common thoughts and feelings reported by at least a third of these children/young people related to symptoms of post-traumatic stress (for example, “Remembering things that happened that I didn’t like”), anxiety (for example, “Feeling afraid something bad might happen”) and dissociation (for example, “Going away in my mind, trying not to think”). Eight young males reported getting into fights “sometimes” to “almost all of the time”, six reported feeling afraid someone would kill them and feeling afraid of females, and five children/young people reported feeling afraid of men, wanting to hurt themselves and other people, and not trusting people because they might want sex. It is not possible to compare the scores on this measure with population norms, as this measure has not been tested to gain normative scores in a sample of children and young people with a learning difficulty.

Parent/carer reports on the trauma symptoms checklist for young children (TSCYC) highlighted many frequent behaviours relating to anger (for example, “Breaking things on purpose”, “Becoming very angry over little things”) and post-traumatic stress-arousal (for example, “Having trouble sitting still”, “Not being able to pay attention”) among at least four of the seven young males. It must be noted, however, that a relationship between high anger scores and conduct problems, and high post-traumatic stress-arousal scores and ADHD has been
found on this measure (Briere, 2005), which may explain these findings among this group of young males.

Figure 2: Percentage of boys with a learning difficulty (of all ages) and boys under 12 (without a learning difficulty) displaying high or very high levels of difficulties on the SDQ total and subscale scores, compared with normative population scores from boys aged 5–15

*Note: prosocial behaviour is scored differently to the other subscales and the figures on this graph refer to close-to-average/slightly lowered levels of prosocial behaviour combined.

Practitioners’ reflections on HSB assessment and intervention with children and young people with a learning difficulty

Practitioners noted a number of cases where children and young people were referred but their learning needs did not become apparent until the assessment was underway. They also highlighted difficulties understanding the learning needs of some children.
and young people due to a lack of information at referral stage and cases with no prior assessment or diagnosis. This presents a challenge for practitioners to understand the young person’s ability and level of need and, in turn, their suitability for intervention for their HSB. Where a young person has severe learning needs, it can be difficult to make a judgement about the type of intervention to provide and whether to focus the intervention on the young person or their wider network:

“You get the referral and it won’t mention anything about learning difficulties and then you get in a room with the child and you think, this young person is not functioning where you might expect for their age. Are they understanding things? And like I say, often then when you speak to other people it’s not that other people haven’t noticed, it’s just that nobody has sort of pulled [all of the information about the young person] together.”

(Practitioner)

To help with assessment, practitioners highlighted the usefulness of gaining information from schools regarding the techniques they use to communicate with the child/young person. However, practitioners and team managers presented differing opinions regarding the usefulness of the AIM2 assessment (see www.aimproject.org.uk/?page_id=79) scoring system to determine the level of supervision required by these children and young people. While some felt the scoring system was useful, others felt the young person’s learning needs could inflate or deflate scores
and they would, therefore, use it with caution or not at all:

“Sometimes the conclusion [from the AIM assessment] doesn’t necessarily fit because what you might have is that the young people’s vulnerability might be greater because of their learning difficulty. So I think you have to add an element of professional judgement to the scoring as well.”

(Team manager)

Many practitioners spoke about using a composite assessment combining the AIM2 and AIM Under 12’s (see www.aimproject.org.uk/?page_id=77) assessment models to allow for a more holistic assessment of need.

Additional challenges during the assessment of children and young people with learning needs and HSB included: difficulty knowing how to talk about sex at an age and developmentally appropriate level; often needing longer to engage with the young person and to complete the assessment process than someone without learning needs; and difficulties understanding the function of the HSB for the young person as it can be hard for them to articulate this:

“Under stress and pressure, all the young people we work with find it hard to express themselves verbally […] once you start touching on the more difficult topics […], and that’s more extreme when you’re thinking of a young person with learning
disabilities. So you’ve got to be more creative when you’re thinking about how you can get answers from them [...]. And it does take more time because [...] you’re thinking more creatively, you’re thinking more visually and you’ve got to think about the amount of time that that young person can concentrate for because that’s often reduced. So you may need to take a bit longer to do the assessment, you probably need to build in more getting to know you time”

(Practitioner)

When delivering an intervention, practitioners noted how the focus of sessions and methods used would differ according to the severity of the young person’s learning needs and the type of learning difficulty they present with (for example, developmental delay vs autism). The focus and content of intervention sessions may need to be greatly simplified and relate to more basic topics, such as boundaries and keeping the self and others safe. A variety of methods may be used to work with the young person and this may less often involve face-to-face discussion compared with working with young people without a learning difficulty. Practitioners also noted the importance of working with the network of people around the young person to ensure external controls and safeguards were in place.

Additional challenges noted by practitioners when delivering an intervention to children and young people with a learning difficulty largely related to knowing whether the child/young person truly understood the messages being given and whether
they would be able to apply them outside of the sessions:

“The difficulty again is that although in the sessions they can say all the right things that make you think they can apply that learning, outside of the sessions they can’t and it’s about how do we then keep that young person safe.”

(Practitioner)

Practitioners needed to take time to understand and work within the young person’s level of concentration, repeat and recap messages given within and between sessions, and know when to draw the intervention to a close to prevent drift.

**Boys under the age of 12 without a learning difficulty**

**Sexual behaviour**

Of the 20 young males with a completed CSBI, over half (55 per cent) showed very high, clinically significant levels of total sexual behaviours and 70 per cent showed very high, clinically significant levels of sexual behaviours, which may indicate their own sexual abuse and/or exposure to sexual behaviours/poor sexual boundaries within the family (SASI subscale). In particular, almost half of these children were described as “standing too close to others”, “touching another child’s sex (private) parts”, and “knowing more about sex than other children their age”. While a range of sexual behaviours were displayed, these most commonly related to boundary problems, voyeuristic behaviour, sexual knowledge, exhibitionism, sexual interest and sexual intrusiveness.
Strengths and difficulties

Figure 2 above showed that the majority of young boys (displayed in the light grey bars) had high or very high overall levels of difficulties, conduct problems and peer problems as reported on the SDQ. However, less than half of these children had high or very high levels of hyperactivity and emotional problems, hence on the converse, the majority of younger boys had close to average or only slightly raised levels of hyperactivity. Around half also had close to average or only slightly lowered levels of prosocial behaviour.

Trauma symptoms

Over half (55 per cent, n=11) of the young boys with a completed TSCC or TSCYC (n=20) had a worrying or clinical level of need on between one and six subscales of these measures. For around half of these children, difficulties related to anger, anxiety, depression, post-traumatic stress and dissociation (see Figure 3 below). Ten out of the 13 boys completing the TSCC (aged eight and over) reported getting into fights “sometimes” to “almost all of the time”, five reported wanting to hurt others, and three reported wanting to hurt themselves and wanting to kill themselves.

When children and their parents/carers both completed a valid measure (TSCC and TSCYC; n= 9), their reporting of the severity of trauma symptoms did not correspond. Parents/carers have been known to over-report symptoms in their child, and children are known to under-report their trauma symptoms (Briere, 2005); this pattern of responding was evident in this research.
Practitioners’ reflections on HSB assessment and intervention with young children

When assessing young children under the age of 12 who display HSB, practitioners spoke about the need for holistic assessment that focuses more on information gathering from the child’s network than directly from the child. The AIM Under 12 assessment model was felt to be a useful assessment tool for facilitating this. Practitioners described assessment sessions with the child as focusing more on getting to know them and building a relationship with them using creative techniques like play. The focus of assessment was also said to place more emphasis on the child as a victim of their parenting and environment compared with assessments of adolescent boys:
“I think that’s maybe the difference in focus upon the assessment, that you are looking a lot more at the young person as a victim of their environment, parenting, their development [than adolescent males].”

(Practitioner)

Challenges during assessment related to knowing how to talk to young children about sex in an age-appropriate way, and needing more time to settle younger children into a session compared with adolescents. The co-working of assessments was also perceived as being potentially more intimidating for younger children than adolescents.

Practitioners described intervention work with younger children as often taking a non-directive or semi-directive approach (although some directive working was described), using play more often than with other groups of young people. In many cases, the focus of intervention sessions with younger children tended to be placed on addressing the child’s own trauma and victimisation. This may be done at the start of the work to give the child space to then think about their HSB. Creative techniques used to deliver intervention were again described by practitioners, and work with parents and carers was perceived as vital.

Females

Sexual behaviour

Two girls had completed CSBIs and both showed clinically high levels of total sexual behaviours and sexual behaviours relating to sexual abuse and/or family sexuality. While a range of sexual behaviours were displayed, they loosely related to boundary
problems, sexual intrusiveness, voyeuristic behaviour and sexual interest.

**Strengths and difficulties**

Two of the six girls with a completed SDQ showed some level of difficulty in all of the areas measured. Five of the girls had slightly raised, high or very high levels of conduct problems, and three had slightly low, low and very low levels of prosocial behaviour. However, the levels of difficulties on the remaining areas of the SDQ were not particularly high for these girls.

**Trauma symptoms**

Of the five girls with no learning difficulty who had a completed TSCC and/or TSCYC, three had a worrying or clinical level of difficulties in two to five areas. For all three girls this related to high levels of anger, and for two this related to depression along with distress and preoccupation on the sexual concerns subscales. Three of the five girls completing the TSCC reported wanting to hurt themselves, wanting to kill themselves, and getting into fights “sometimes” to “almost all of the time”.

**Practitioners’ reflections on HSB assessment and intervention with girls**

As with younger children, practitioners spoke about the importance of focusing on girls’ own victimisation and experiences throughout assessment. While the AIM Under 12 assessment model was described by practitioners as a useful assessment tool for children of both genders, some practitioners questioned the validity of using the AIM2 scoring system with girls, given that it was originally designed for boys:
“My view is the research behind what brings a girl into this behaviour and a boy would suggest that it is quite different. […] I think there may be more support around the sort of female victimisation thing and that’s maybe not recognised when you are looking at the research that went into developing AIM. It was developed for boys. […] It’s not that the framework is not helpful because I think you would still want to think about all those areas, but then your scoring is not valid.”

(Practitioner)

When describing the intervention work carried out with girls displaying HSB, practitioners did not discuss the impact of gender on the focus of their work or the methods used. Instead, practice appeared to be influenced more by age and the presence of a learning difficulty.

Responding to the needs of the children and young people

When describing the intervention work carried out with children and young people, practitioners and team managers spoke about the importance of responding to individual need and being able to tailor intervention to the individual child/young person. A number of different approaches to intervention were mentioned, including play therapy, directive and non-directive approaches, CBT approaches (although there were contrasting views on adopting a CBT approach with this group of children and young people), and motivational interviewing techniques.
In spite of potential differences in the delivery of intervention, however, a number of overarching core principles were identified when practitioners described the focus of the intervention work carried out under this service. This included:

1. Identifying pathways into the HSB, triggers for the behaviour, and understanding the needs the HSB is being used to meet.

2. Addressing past trauma and victimisation, and helping the child/young person process this and move on.

3. Developing the child/young person’s emotional literacy and emotion regulation.

4. Helping them feel happier and more able to cope with their everyday lives; for example, developing social skills and support networks.

5. Providing them with an age-appropriate understanding of sexual behaviour and relationships.

Some of these points are exemplified in the following quotes from the practitioners delivering this service:

“[I think a key one [core principle of intervention] is emotional regulation: helping young people develop some internal controls over their reactions and their behaviours, particularly in situations that are stressful, and [to] cope with anxiety.]”

(Practitioner)
“What you need to be able to do is help the child to develop a lifestyle where they get their needs met in a way that doesn’t require them to behave in that way. Then it kind of extinguishes the behaviour. Because if the behaviour is a kind of feel good behaviour, if you already feel good you don’t need that behaviour.”

(Practitioner)

Practitioners also spoke about the importance of carrying out work with the parents and families of these children and young people. This is to ensure there are the relevant safety controls and boundaries in place within the family to help prevent further HSB and keep the child and other children safe:

“You cannot work with a child in isolation; it does not work. The key to this is these children do not have any of the internal controls that we need them to develop. And until they have, the only way to keep them safe and other people safe is to have the external controls in place: that’s school and parents and people in the community groups; anyone who can create that circle around them and make sure that everything is safe and managed."

(Practitioner)

This was coupled with the need to address the contributory factors within the family leading to the child or young person’s HSB, thus attempting to prevent its reoccurrence:
“The harmful sexual behaviour doesn’t just develop in vacuum, it develops within the given family environment, so you need to work with the whole environment, you need to look at the child and parent interaction and attachment interaction as well. Especially with [children] under 12 who are much more dependent on parents.”

(Practitioner)

There, therefore, appears to be a core set of principles underpinning the interventions offered. These aim to address the range of emotional, behavioural and sexual difficulties displayed by these children and young people, and to respond to some of the many needs indicated by the standardised measures data collected for this research.
Discussion and conclusion

As reported in previous studies (for example, Hackett et al, 2013; Smith et al, 2013), the majority of the children and young people accessing the NSPCC’s service were white males. However, young females, children and young people from minority ethnicities, and those with a learning difficulty were represented among these to varying degrees. Further research may consider how representative referrals of young people with these characteristics are to HSB services compared with their prevalence within national and regional populations. Interestingly, more of the males accessing the NSPCC service were living in local authority care compared with females accessing this service; a rate comparable to that reported by Hackett et al (2013) of around a third.

The findings from the current research suggest that the children and young people accessing this service display a range of sexual/sexualised behaviours, and have additional needs and difficulties alongside their HSB. As their HSB usually involved a direct victim and, thus, directly harmed another person, the need for a service for these children and young people is as strong as that for adolescent males. However, the findings suggest differences in the victims of these children/young people compared with the predominantly adolescent males studied by Hackett et al (2013). This is because the victims of these children/young people were more often family members and less often younger than themselves compared with the findings reported by Hackett et al (2013). The findings also suggest that the profile of these children/young people and the sexual/sexualised behaviours they display may
vary according to their gender, age and presence of a learning difficulty. The reflections from the practitioners delivering this service show how these factors are taken into account when assessing and delivering intervention with these children and young people, and how service delivery may vary in order to respond to differing need.

**Sexual abuse histories**

Compared with the findings from Hackett et al’s (2013) research, the rates of sexual abuse disclosed by the children and young people accessing the NSPCC service was less than expected (17–29 per cent compared with around 50 per cent in Hackett’s research). However, findings from the Child Sexual Behaviour Inventory (CSBI) suggest that the behaviours of many of the females and younger children in this research were indicative of sexual abuse. This, coupled with a large amount of missing data on sexual abuse disclosure in this study, suggests the detected rates are likely to be a vast underestimation of the actual sexual abuse rate. Indeed, the practitioners working on this service noted how assessment and intervention work with girls and younger children would often focus more on the young person as a victim of their own experiences of abuse and parenting. Nevertheless, not all HSB stems from sexual abuse, and the sexual interest and sexually intrusive behaviours displayed by these children may result from overt sexual behaviours and displays of sexuality in the family home, alongside a lack of family sexual boundaries.
Trauma and mental wellbeing

Many of the children and young people studied in this research indicated some level of trauma symptoms and/or worrying thoughts and feelings, similar to the findings of Hackett et al (2013). For females and younger boys, these difficulties related largely to anger and depression, and for younger boys and boys with a learning difficulty they may indicate difficulties with post-traumatic stress and dissociation. However, not all of the children/young people displayed significant/clinical levels of trauma-related symptoms. Additionally, the levels of emotional difficulties identified using the SDQ were low or only slightly raised in around half of the children and young people. We cannot assume on the basis of the findings from this research, therefore, that all of the children and young people accessing this service have clinical levels of emotional difficulties or trauma (based on assessment using standardised measures).

Behavioural difficulties and problems with peers and prosocial behaviours

Conduct problems and peer problems were consistently high among all three groups of children and young people accessing this service. Their levels of behavioural difficulties, emotional problems and peer problems appear higher than those identified in the wider population, consistent with Vizard’s (2013) findings that conduct disorders and emotional and behavioural difficulties are higher among young people who perpetrate child sexual abuse. However, the females in the current research displayed apparently fewer difficulties, while the boys with a learning difficulty displayed higher levels and a greater range of difficulties.
Implications of the findings for service commissioning and delivery

The young boys, boys with a learning difficulty, and girls included in this research displayed a wide-range of emotional, behavioural and peer-related difficulties alongside their HSB. As such, the child’s HSB may be just one of their externalising behavioural difficulties and their externalising (“acting out”) and internalising (such as anxiety and depression) difficulties may stem from the same issue. This could be their own experience of trauma and abuse (sexual or non-sexual) and/or inconsistent or poor caregiving, and may also link to their problems with peers. This has implications for assessment and intervention as discussed below.

In addition, some differences between the three groups studied have been identified in terms of the nature of their HSB. This intelligence should inform local policies and service delivery for addressing their needs. However, there does appear to be a core set of underlying principles when working to address HSB across all ages and levels of need, relating to trauma, emotional literacy and regulation, providing an age-appropriate understanding of sex and HSB, and helping the child/young person to feel happier and more fulfilled in life. While the specifics of service delivery may vary around these core principles, a fluid approach to service delivery may be required in order address the child/young person’s own trauma alongside their HSB.
Adopting a holistic approach to assessment

Information gathering from the child, their carers and family, and the people within their wider network (such as school and other professionals) would facilitate a thorough exploration of the drivers behind, and pathways into, their HSB. It would also help to build a picture of any additional internalising and externalising difficulties (for example, depression, anxiety or problems with peers). The NSPCC practitioners noted the importance of information gathering in a holistic way during assessment, citing the AIM Under 12 assessment framework as a useful tool for facilitating this. Gaining information from all parties will help to build a more accurate picture of the child/young person’s behaviours, strengths and difficulties.

Standardised measures can provide a useful contribution to the information gathering process, but practitioners must recognise the tendency of children and young people to under-report symptoms and their parent/carers’ to over-report symptoms (Briere, 2005). Structured information gathering should, therefore, be coupled with the practitioner’s own professional judgement of the child/young person and family dynamics. By assessing the child/young person’s early life experiences and levels of trauma, the range of sexual/sexualised behaviours they have displayed, and their needs and functioning in a range of areas, such as the home, school and with peers, treatment formulation can be better tailored to individual need.
Adopting a holistic approach to intervention

Given the wide-ranging emotional, behavioural and peer-related difficulties experienced by these children/young people, the need for a multi-agency, holistic approach to intervention is highlighted. This may include work with parents/carers and the wider family network before and during intervention, as emphasised in the NICE draft guidelines for working with children and young people displaying HSB (NICE, 2016). Indeed, the practitioners noted how working with parents and carers is a key factor in determining the success of this intervention work. This is because working with parents and carers helps to ensure that key messages and safety controls are in place during and after intervention to keep the child and other children safe within their environment. Addressing the child/young person’s behaviour in various other domains, including the school, and improving peer interactions and relationships also appears to be vital. In order to enable successful multi-agency, multidisciplinary working, as recommended by the NICE HSB draft guidelines (NICE, 2016), clear communication pathways and a framework for multi-agency working are needed. An NSPCC-led operational framework for harmful sexual behaviour has been developed (Hackett et al, 2016) in order to improve local responses to HSB and facilitate such multi-agency working.
A flexible service delivery model may also be required that does not focus solely on providing either an HSB service or a therapeutic service to address the child’s own victim experiences, but allows for elements of both to be intertwined where needed. This would allow for a therapeutic intervention to address the trauma and abuse experienced by those displaying HSB. The practitioners interviewed for this research spoke about the importance of acknowledging and addressing the trauma and abuse experienced by many of the children and young people during the intervention, particularly younger children and females. Some practitioners described how this would be addressed at the start of intervention, prior to them focusing on the child’s HSB, in order to allow the child space to reflect on their own behaviour. Intervention may also need to be tailored specifically to working with younger children, girls, and children/young people with a learning difficulty, whereby each group may require greater emphasis or input within different areas. Indeed, the practitioners and team managers noted how the focus of intervention and methods used to work with these children and young people may differ according to their age and learning needs.

**Implications of the findings for research**

Further outcomes-focused evaluation of intervention services aimed at addressing HSB in children and young people with a range of characteristics and need (such as adolescent males, females or children with learning difficulties) is needed. This would help to understand the impact and outcomes of these intervention programmes on reducing HSB, along with any wider-reaching implications for the general wellbeing of service users. Currently, there
is limited evidence within the literature to indicate ‘what works’ in addressing HSB among children and young people (NICE, 2016). Future research should also aim to provide closer scrutiny of the HSB leading to referral to a HSB service (for example, the nature of this HSB) so that the nature of this can be explored and understood in more detail.

Any future evaluation of HSB services aimed at younger children and those with a learning difficulty should be mindful of potential difficulties in gaining service-user research/evaluation consent. This may be due to increased gate-keeping by practitioners given their higher perceived vulnerability compared to adolescent males. Such evaluations may, therefore, require close liaison with practitioners so that any concerns they may have about approaching service users for evaluation consent can be understood and addressed. Evaluations may also need to run for long time periods to ensure adequate sample sizes.
References


NICE (2016) *Harmful sexual behaviour among children and young people*. NICE guideline


Background to the research

The children and young people involved in this research were all referred to the NSPCC’s Turn the Page ‘Extended Referral Criteria’ HSB service. While the Turn the Page service was initially designed for adolescent males without a learning difficulty, the service’s referral criteria was extended to allow NSPCC practitioners to assess and provide tailored intervention for males under the age of 12, males with a learning difficulty (diagnosed or undiagnosed), and any female displaying HSB. This second strand of the Turn the Page service became known internally as the ‘Extended Referral Criteria’ and is referred to in this way throughout this report.

The intervention delivered on the main Turn the Page service is based on the Change for Good intervention model (McCory and Walker-Rhymes, 2011), which provides a structured cognitive behavioural therapy (CBT) approach to intervention. The Extended Referral Criteria strand of this service, however, is unstructured, offering practitioners a flexible way of working with these children and young people to respond to their problematic or harmful sexual behaviour.

Practitioners come from a range of professional backgrounds and may draw upon various approaches and techniques (including the Change for Good model) to provide intervention tailored to the needs of the young person. Assessment for this service is based on the AIM (Assessment, Intervention and Moving on) assessment models (see www.aimproject.org.uk/), which encourage a partnership
approach between the different agencies working with the child/young person.

The current research was internally commissioned by the NSPCC to inform the development of the Turn the Page Extended Referral Criteria service, achieved by gaining a better understanding of the profile of service users and the challenges of service delivery. The findings have been published in this external report to address the gap in the research literature regarding our understanding of younger children, girls and those with a learning difficulty who display HSB, and to provide some points for consideration to service providers aiming to work with this group. It was beyond the scope of this research to explore the outcomes for the children and young people referred to, and receiving intervention on, this HSB service.
Methodology and analysis

Demographic information was collected on all of the 198 children and young people accessing the Turn the Page Extended Referral Criteria service between March 2013 and August 2015, along with information on their HSB and whether they had disclosed being a victim of sexual abuse. This data was analysed by looking at the frequencies in which the characteristics occurred among the whole sample in order to gain a better understanding about the general demographic profile of children and young people being referred to this HSB service.

Towards the beginning of their involvement with the service (for assessment and/or intervention), NSPCC practitioners asked parents/carers and children/young people for their consent to take part in this research. If given, the practitioner then administered three standardised measures to be completed by parent/carers. Children and young people aged eight and above with a suitable level of reading and writing comprehension were also given one measure to complete.

The standardised measures were used to assess the child/young person’s trauma symptoms (in relation to a number of areas, such as depression and anxiety), the types of wider sexual behaviours they exhibit not focusing solely on their HSB, and their general strengths and difficulties in relation to conduct problems, hyperactivity, emotions, peer relationships and prosocial behaviour. With the exception of the measure of adolescent sexual behaviour, all of the standardised measures used have been found to show good reliability and validity (Briere, 2005; Briere, 1996; Friedrich, 1997; Goodman, 1997), meaning we can have more
confidence that they accurately measure what they claim to be measuring. It must be noted, however, that the subscales on the TSCYC do not correlate as well as would be expected with the subscales on the TSCC (Briere, 2005). The ACSBI has not been extensively tested for reliability and validity and, therefore, the responses were analysed qualitatively for this research instead of looking at scores. The completion rate and a brief description of each measure are given in Table 2 below.

Where possible, scores on the standardised measures were compared with those found in the wider population (normative samples) to determine the service users’ level of need. It was not possible to use the clinical scores/levels on the CSBI, TSCC or TSCYC with children and young people with a learning difficulty as these children/young people were not included in the populations used to develop normative scores for these measures. Information gained from the individual questions on these measures was also explored in more detail to gain a deeper understanding of needs and behaviours.

The TSCC and TSCYC have validity scales to identify likely over- and under-reporting. This reduced the number of forms that we could analyse. For example, for boys under 12, we were not able to include six of the completed TSCCs or one of the completed TSCYCs in the analysis of the data collected as they were deemed invalid due to under- or over-responding, thus reducing the reliability of the information given. This left us with 13 useable TSCCs and 19 useable TSCYCs.
In total, 74 children/young people (37 per cent of the children/young people accessing the service) were included in this research; 29 per cent (8 out of 28) of the females accessing this service, 46 per cent (32 out of 69) of younger males, and 34 per cent (34 out of 101) of males with a learning difficulty.

Some service users did not give research consent for various reasons (which were not recorded), and others were not asked by the practitioner if the practitioner felt the research would be overwhelming for them. The low research consent rate may relate to the increased vulnerability of the children and young people accessing this service based on their age and learning needs, and, therefore, a desire by parents/carers and practitioners to ‘protect’ them from engaging in further work.
Characteristics of the research sub-sample

The characteristics of the children/young people included in the research are compared with the full population of service users in Figures 4 and 5 below. They are largely representative of the wider sample of children and young people accessing the service in terms of age, gender, ethnicity, ‘looked-after’ status, learning difficulty, and disclosure of their own sexual abuse.

Their HSB also appears to be very similar, although there are some differences in their relationships to the victims of their HSB. These comparisons suggest that the findings from the research can be extrapolated to all service users with some level of confidence, although some caution is needed in light of the differences in victim relationship.²

² Chi-square analysis revealed that, on the whole, there were no statistically significant differences between the children and young people taking part in the research (n=74) and those who did not participate (n=124). However, there were differences in their relationship to the victim of their HSB in that more of the young people in the research displayed HSB towards a family member they did not live with and less often towards a non-family member than those who did not participate.
## Table 2: Measures used in the research

<table>
<thead>
<tr>
<th>Measure</th>
<th>Measure description</th>
<th>Females – no learning difficulty</th>
<th>Females – with a learning difficulty</th>
<th>Boys aged 12 and under – no learning difficulty</th>
<th>Boys (all ages) – with a learning difficulty</th>
</tr>
</thead>
<tbody>
<tr>
<td>Trauma Symptoms Checklist for Young Children (TSCYC) Briere (2005)</td>
<td>Report on the child’s (aged 3–12) post-traumatic stress and trauma symptoms in the past month. Eight clinical scales: anxiety; depression; anger/aggression; post-traumatic stress-intrusion; post-traumatic stress-avoidance; post-traumatic stress-arousal; dissociation; sexual concerns; and a summary post-traumatic stress scale. Two validity scales: atypical response (over-reporting of symptoms) and under-response (potential to under-report symptoms).</td>
<td>3</td>
<td>1</td>
<td>19 (one of the original 20 was invalid due to under-reporting)</td>
<td>7</td>
</tr>
<tr>
<td>Child Sexual Behaviour Inventory (CSBI) Friedrich (1997)</td>
<td>Report (preferably by female carer) on the frequency of the child’s (aged 2–12) sexual behaviours over six months. A total CSBI score and two subscale scores: developmentally related sexual behaviours (DRSB) indicating that the child is displaying normative and age appropriate sexual behaviours; and sexual abuse specific items (SASI) that are likely to be related to the child’s experience of sexual abuse or exposure to sexual behaviours.</td>
<td>2</td>
<td>0</td>
<td>20</td>
<td>6</td>
</tr>
<tr>
<td>Measure</td>
<td>Measure description</td>
<td>Females – no learning difficulty</td>
<td>Females – with a learning difficulty</td>
<td>Boys aged 12 and under – no learning difficulty</td>
<td>Boys (all ages) – with a learning difficulty</td>
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<tr>
<td>Trauma Symptoms Checklist for Children (TSCC) Briere (1996)</td>
<td>Self-report measure of post-traumatic stress and associated psychological symptomatology for 8–17-year-olds. Six clinical scales: depression; anxiety; post-traumatic stress (PTS); anger; dissociation (including two subscales: overt dissociation and dissociation– fantasy); sexual concerns (including two subscales: sexual concerns – preoccupation and sexual concerns – distress). Two validity scales: under-responding (a tendency towards denial) and hyper-responding (generally over-responding to items on the measure).</td>
<td>4</td>
<td>1</td>
<td>13</td>
<td>18</td>
</tr>
</tbody>
</table>

Note: 6 of the original 19 were invalid due to over- or under-responding.
Figure 4: The demographic characteristics of all service users compared with those taking part in the research

<table>
<thead>
<tr>
<th></th>
<th>Evaluation on sub-sample (n=74)</th>
<th>Total sample (n=198)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mean age (years)</td>
<td>11.3</td>
<td>11</td>
</tr>
<tr>
<td>Males (%)</td>
<td>89</td>
<td>86</td>
</tr>
<tr>
<td>White (%)</td>
<td>95.9</td>
<td>94</td>
</tr>
<tr>
<td>Looked-after child (%)</td>
<td>25</td>
<td>32</td>
</tr>
<tr>
<td>Learning difficulty/disability (%)</td>
<td>50</td>
<td>56</td>
</tr>
<tr>
<td>Disclosed own sexual abuse (%)</td>
<td>19</td>
<td>18</td>
</tr>
</tbody>
</table>
Figure 5: The harmful sexual behaviour displayed by all service users compared with those taking part in the research
Interviews

NSPCC children’s service practitioners and team managers delivering the Turn the Page Extended Referral Criteria service were invited to take part in an interview. These interviews gained practitioners’ and managers’ reflections on the assessment of, and providing tailored intervention to, these children and young people. They also reflected on the additional challenges of working with these children and young people within an HSB service.

Sampling NSPCC children’s service practitioners and team managers for interviews

All of the current children’s service practitioners and team managers working on the Extended Referral Criteria strand of the NSPCC’s Turn the Page service were invited to take part in a semi-structured interview. In total, 10 out of 11 team managers volunteered to give an interview, and interviews were carried out with all of these. Of those practitioners who had delivered intervention on this service and volunteered to give an interview (n=33 out of 55 practitioners), 21 were selected for an interview following sampling (two practitioners from each service delivery team, with the exception of one team where only one practitioner volunteered to be interviewed). Practitioners were sampled based on the length of time they had worked on this service, their previous experience working with sexual abuse cases, and whether they work/worked on any of the other NSPCC sexual abuse services. This sampling strategy was designed to allow for a range of views to be captured in the interviews, taking into account the diverse backgrounds and levels of experience among NSPCC practitioners.
Characteristics of the practitioners and team managers participating in an interview

Five of the team managers taking part in the interviews had worked on the Turn the Page Extended Referral Criteria service for its three-year duration and the rest had worked on it for one to two years. Almost all of the team managers had previous experience working with local authorities and there was only one team manager who did not have a specific background in working with sexual abuse prior to working on this service.

The children’s service practitioners taking part in an interview had been working on this service for between six months and three years, some of whom had worked with many service users and others who had worked with few. Ten of the 21 practitioners also worked on other sexual abuse services within the NSPCC (seven of whom worked on a therapeutic service for children and young people who had experienced sexual abuse). Practitioners presented with varying amounts of previous experience working with HSB or child sexual abuse and with a range of backgrounds, which included:

- Local authority (n=5)
- Probation services for sexual offenders or youth offending teams (n=3)
- Providing therapeutic services for sexual abuse victims and their families (n=5)
- Providing other services for children and young people with HSB (n=4)
- Newly qualified/no previous experience working with child sexual abuse prior to the NSPCC (n=4)
Interview analysis

Interview transcripts were analysed using the NVivo software following the ‘Framework’ approach to analysis (Ritchie and Spencer, 1994). This is a matrix-based analytic approach that uses a thematic framework to classify and organise interview data according to main themes and related sub-themes. Interview transcripts were explored to identify key themes, concepts and emergent categories based on practitioners’ and managers’ views and experiences of delivering this service. Framework was chosen as the form of analysis for this research as it provides a manageable way of organising a large amount of interview data into clear themes and sub-themes, following a rigorous and transparent approach (see Ritchie and Lewis [2009] for more information).

Ethical considerations

The research was approved by the NSPCC Research Ethics Committee, which follows Government Social Research (GSR) standards. A key ethical consideration was ensuring we had informed consent or assent from service users given their young age and/or learning needs. Parents/carers were required to provide informed consent for any child under the age of 16 to take part in the research, as well as any young person aged 16–17 with a learning difficulty. The child/young person was then spoken through age-appropriate information and consent sheets by their practitioner to discuss the purpose of the research and gain their consent (aged eight and over with the capacity to consent) or assent (aged under eight and/or with a learning difficulty that reduces their capacity to consent). If a child or young person did not consent or assent, or if the practitioner was unsure whether they had, they were not enrolled into the research, even if their parent had consented.
If the young person was aged 18 and over (therefore an adult) but did not have the capacity to provide informed consent then they were not invited to participate, as relying on parents’ consent with the young person’s assent only would have been unethical given their age.

All parents/carers and children/young people were informed that they did not have to take part in the research in order to access the Turn the Page programme and that they could withdraw at any time. To help ensure that younger children and those with a learning difficulty were still included in this research given that they may not have been able to complete standardised measures, we relied mainly on parent/carer completed measures.

**Limitations of the research**

This research is based on a small proportion of the children and young people who accessed the Extended Referral Criteria strand of the Turn the Page service, yet the sample appeared largely representative of service users. Data was collected early in the assessment/intervention process, which may have influenced how open and honest the child/young person and their parents/carers were when responding to the standardised measures. As the level of need differed according to parent/carer or child/young person reports on the TSCC and TSCYC, the over-reliance on parent/carer reporting within this research may have skewed the findings.