NICE National Institute for Health and Care Excellence

NICE guideline

Harmful sexual behaviour among children and young people

NICE guideline

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Your responsibility

The recommendations in this guideline represent the view of NICE, arrived at after careful consideration of the evidence available. When exercising their judgement, professionals are expected to take this guideline fully into account, alongside the individual needs, preferences and values of their patients or service users. The application of the recommendations in this guideline are not mandatory and the guideline does not override the responsibility of healthcare professionals to make decisions appropriate to the circumstances of the individual patient, in consultation with the patient and/or their carer or guardian.

Local commissioners and/or providers have a responsibility to enable the guideline to be applied when individual health professionals and their patients or service users wish to use it. They should do so in the context of local and national priorities for funding and developing services, and in light of their duties to have due regard to the need to eliminate unlawful discrimination, to advance equality of opportunity and to reduce health inequalities. Nothing in this guideline should be interpreted in a way that would be inconsistent with compliance with those duties.

Contents

Overview

This guideline covers children and young people who display harmful sexual behaviour, including those on remand or serving community or custodial sentences. It aims to ensure these problems don't escalate and possibly lead to them being charged with a sexual offence. It also aims to ensure no-one is unnecessarily referred to specialist services.

'Young people' refers mainly to those aged 10 to 18 but also includes people up to 25 with special educational needs or a disability.

This guideline does not discuss people who have experienced sexual abuse. NICE will publish a guideline on child abuse and neglect in September 2017.

Who is it for?

- Social workers, social and residential care practitioners and foster carers
- Child and adolescent harmful sexual behaviour and mental health services
- Neighbourhood and community support police officers and youth offending teams
- Schools and youth services
- National adolescent forensic services
- Primary care, sexual health, drug and alcohol services
- People who exhibit harmful sexual behaviour, their families and other members of the public.

Recommendations

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

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

1.1 Multi-agency approach

Multi-agency, multidisciplinary team

1.1.1 Ensure multi-agency, multidisciplinary teams promote continuity of care and, wherever possible, ensure the child or young person has contact with the same staff over time, so they can develop trust in their care team.

1.1.2 Ensure young people who are nearly 18 are prepared for the transition to adult services by developing links between child and adult services. See NICE's guideline on transition from child to adult services.

1.1.3 Ensure multi-agency, multidisciplinary teams:

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

Multi-agency, multidisciplinary working

1.1.4 Use established mechanisms, such as the local safeguarding children board, to develop local safeguarding policies and procedures and agree a harmful sexual behaviour operational framework between agencies. (See Department for Education's Working together to safeguard children, Ofsted's Early help: whose responsibility?, Children Act 1989 and Children Act 2004.)

1.1.5 Local safeguarding children boards should ensure:

- Lead agencies are identified to commission specialist harmful sexual behaviour services.
- Thresholds are established for when to refer a child or young person for an early help assessment or to specialist harmful sexual behaviour services.
- Named safeguarding leads and practitioners working in relevant services are told what the referral thresholds are. This includes those working in education, children's social services, health and youth criminal justice (such as young offender teams and youth justice boards) and voluntary sector organisations.
- Named safeguarding leads working in universal services use locally agreed resources as part of their policy and procedures to determine whether a child or young person should be referred for an early help assessment. (See recommendation 1.3.4 for examples of resources.)
- Children's social services have access to policies and procedures for training staff to deal with concerns about a child or young person's sexualised behaviour.

1.1.6 The multi-agency team should agree which service is responsible when children and young people are referred for assessment. Consider one of the following for the lead role:

- child health services such as child and adolescent mental health services (CAMHS)
- children's social services
- voluntary sector organisations such as Barnardos or the NSPCC.

1.1.7 Consider a range of care pathways based on the 5 core domains identified in the NSPCC harmful sexual behaviour framework.

1.1.8 The designated lead practitioner responsible for coordinating the care plan (see recommendation 1.3.2) should request a review of the care plan via the multi-agency, multidisciplinary team meeting if:

- the child or young person's needs are not being met **or**
- the referral and assessment procedure is unnecessarily delayed.

Information sharing

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

1.1.10 Ensure the designated lead practitioner responsible for coordinating the care plan can access information on the child or young person's family situation and factors that may affect parenting capacity and attachment (see recommendation 1.4.2). Do this as part of the assessment process (See NICE's guideline on children's attachment and recommendations on sexualised behaviour in NICE's guideline on when to suspect child maltreatment.)

1.1.11 Ensure information is collected and shared in a sensitive and professional manner, as set out in the Caldicott Guardian information standards.

1.1.12 If there is a need to share information with other agencies and carers to inform risk management, do this in consultation with the multidisciplinary team.

1.2 Named safeguarding leads in universal services

1.2.1 Immediately inform your organisation's named safeguarding lead when a child or young person displays sexualised behaviour that is not appropriate for their age or developmental stage (for tools see recommendation 1.3.4). Possible signs of problems include:

- using sexualised language such as adult slang to talk about sex
- sexualised behaviour such as sexting or sharing and sending sexual images using mobile or online technology
- viewing pornography that is inappropriate for age and developmental status[1].

1.2.2 Immediately inform your organisation's named safeguarding lead when a child or young person displays sexualised behaviour that is always inappropriate, regardless of age, such as public masturbation.

1.2.3 Named safeguarding leads should use locally agreed resources to assess concerns about the sexual behaviour of a child or young person. See recommendation 1.3.4.

1.2.4 Named safeguarding leads concerned about a child or young person's sexual behaviour should contact their local children's social services to discuss their concerns and determine whether a referral is appropriate.

1.3 Early help assessment

1.3.1 Children's social services should refer children and young people who display inappropriate sexualised behaviour for an early help assessment, in line with local thresholds and referral procedures (see recommendation 1.1.5). Focus on the child or young person as an individual and not on the presenting behaviour.

1.3.2 At point of referral, early help professionals should identify a designated lead practitioner in the multi-agency, multidisciplinary team (see recommendation 1.1.6) who will:

- act as a single point of contact for the child or family
- coordinate early help and subsequent assessments and develop the care plan to avoid unnecessary or repetitious assessments that may be stigmatising
- coordinate delivery of the agreed actions
- involve children, young people and their families and carers in the design and delivery of early help services, as appropriate
- reduce overlap and inconsistency in services provided.

1.3.3 Early help professionals should be familiar with the child or young person's health and social care record and have access to neonatal and early health information, if necessary. This includes information on developmental delays or a diagnosis of autism spectrum condition, for example.

1.3.4 Use a locally agreed tool as part of the early help assessment that accounts for the severity of the behaviour, to avoid unnecessary and potentially stigmatising referrals. Examples of tools include:

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

1.3.5 Take account of the child or young person's age, developmental status and gender and, if relevant, any neurodevelopmental or learning disabilities.

1.3.6 Recognise that inappropriate sexualised behaviour is often an expression of a range of problems or underlying vulnerabilities.

1.3.7 Use the early help assessment to identify whether the child or young person has unmet needs that can be met by universal services. See Ofsted's Early help: whose responsibility? and Department for Education's Working together to safeguard children. Also:

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

1.3.8 Ensure services support children and young people of all ages. See the principles of care recommendations from NICE's guideline on children's attachment and the principles and values in NICE's guideline on looked-after children and young people.

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

- For children and young people who may have experienced trauma, see the sections on specific recognition issues for children (section 1.3.4) and treatment for children (section 1.9.5) in NICE's guideline on post-traumatic stress disorder.

1.3.9 If harmful sexual behaviour is displayed, refer to harmful sexual behaviour services, child protection services and the criminal justice system, if necessary.

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

1.4.1 Children's social care services and NHS England should identify services employing staff with the skills to undertake a specialist assessment of risk for children and young people displaying harmful sexual behaviour. This may include:

- child health services such as CAMHS
- children's social services
- voluntary sector organisations such as the NSPCC or Barnardos
- organisations within the criminal justice system such as youth offender teams and youth justice boards.

1.4.2 Professionals responsible for specialist harmful sexual behaviour assessments should access any additional information they need. This includes incident reports of any behaviour that is causing concern. Get this information from the child or young person's:

- social care history
- educational records
- health records
- youth offending and youth justice records
- police records.

1.4.3 Consider the child or young person's developmental age, neurodevelopmental disabilities, learning disabilities and gender as part of the assessment. Do this in collaboration with other specialist services, if relevant.

1.4.4 Professionals responsible for assessing risk should use risk assessment tools suitable for the child or young person's developmental age and gender. For example, when assessing:

- Pre-adolescent children or those aged under 12, consider psychometric measures and questionnaires such as the Child Behaviour Checklist and the Child Sexual Behaviour Inventory[3].
- Children under 12 who have not been charged with a sexual offence, consider the relevant elements of AIM plus clinical judgement.
- Children aged 10 to 12 who have been charged with an offence, consider the relevant elements of AIM plus clinical judgement.
- Adolescent boys, consider tools such as J-SOAP-II, ERASOR or AIM2, plus clinical judgement.

1.5 Engaging with families and carers before an intervention begins

1.5.1 Consider family or social factors that may contribute to the child or young person's harmful sexual behaviour, particularly if there is evidence of abuse within the family. See NICE's guideline on child maltreatment.

1.5.2 Think about the impact a child or young person's harmful sexual behaviour may have on all family members.

1.5.3 If the person at the receiving end of the harmful sexual behaviour is another child within the family, provide support for the family or a referral as needed[4].

1.5.4 Consider the following before providing an intervention:

- Meeting families and carers to discuss any concerns they may have, including any potential barriers to attendance.
- Providing families and carers with information about the intervention and including them, when appropriate.

- Adopting a flexible approach to accommodate the child or young person's social activities.

1.6 Developing and managing a care plan for children and young people displaying harmful sexual behaviour

General principles

1.6.1 Recognise that children and young people with learning and neurodevelopmental disabilities have specific needs. Consider providing short and more frequent sessions for them. Work with specialists in these areas to provide the intervention.

1.6.2 Help children and young people develop a strong sense of personal identity that does not include harmful sexual behaviour. This includes helping them to maintain their cultural and religious beliefs.

Developing and managing a care plan

1.6.3 Develop a care plan using an established risk assessment model, such as J-SOAP-II, ERASOR, AIM assessment for under-12s, or AIM2, and a recognised treatment model such as the Good Lives Model, AIM or AIM2. The plan should:

- recognise the needs and strengths of the child or young person and the risks they may pose
- support them, their families and carers
- include clearly defined therapeutic goals
- include a safety plan that is agreed with the child or young person, their parents or carers and support network.

1.6.4 Ensure the care plan:

- Encourages and supports children and young people to participate in a range of peer, school and community activities to help build a sense of belonging.
- Includes supervised social activities that promote self-esteem, develop resilience and encourage socially appropriate behaviour.

1.6.5 Ensure the care plan is reviewed by the multidisciplinary team, and with the child or young person and their parent or carers at 3–6 monthly intervals, or if there is a significant change in circumstances.

1.7 Developing interventions for children and young people displaying harmful sexual behaviour

1.7.1 Structure interventions, but make them flexible enough to meet changing needs and the developmental status and age of the child or young person. Include regular progress reviews by practitioners delivering the intervention.

1.7.2 Base interventions on:

- A comprehensive assessment of the child or young person's family and social context. This includes: their placement (for example, home, foster care, residential care, secure children's home or other custodial settings).
- Developmental stage, gender, learning ability, culture and religion.
- Factors that may have contributed to the harmful sexual behaviour, such as their background, past care or any trauma they may have experienced.
- The harmful sexual behaviour itself.

1.7.3 Consider including the following elements:

- safety planning to reduce the risk they pose to others and themselves
- engagement and working that takes account of their denial of the behaviour
- sex and relationships education including consent, boundaries and social and moral considerations
- empathy development
- how to make good choices to keep themselves and others safe sexually
- emotional and self-regulation
- life story work
- understanding of their harmful sexual behaviour

- victimisation
- peer and social relationships
- community reintegration for those who have spent time in residential or secure units
- support to make future plans.

1.7.4 Use recognised treatment resources or guided interventions such as:

- AIM assessment and intervention model for boys and girls. This includes components for:
  - children aged under 12 who have not committed a criminal offence, and
  - children aged 10 to 12 who have committed an offence (10 is the age of criminal responsibility in England).
- AIM2 assessment and intervention model for boys aged 12 to 18 within or outside the criminal justice system. This also has a component aimed at girls in the same age group and for those with learning disabilities. But note: the 'level of supervision' scale for young females (12 to 18 years) is likely to misrepresent the level of risk. A degree of caution is also advised when using it to predict sexual reoffending in young people with learning disabilities.
- Barnardo's Cymru Taith project for girls – assessment and treatment workbook.
- The California Evidence-Based Clearinghouse for Child Welfare Children with problematic sexual behaviour cognitive-behavioural treatment program: preschool program and school-age program.
- Good Lives Model, a strengths-based programme.
- NSPCC manualised treatment programme Change for good[5] aimed at boys aged 12 to 18 in residential care.
- NSPCC harmful sexual behaviour programme Turn the page, a guided intervention that follows certain key principles for boys and girls aged 5 to 18 and those with learning disabilities. This is suitable as a community-based approach.

1.7.5 Use therapeutic approaches such as:

- cognitive behavioural therapy

- multisystemic therapy for problematic sexual behaviour
- psychotherapeutic approaches
- strengths-based approaches
- systemic therapy (a type of family therapy).

1.7.6 Consider 1 or more of the following modes of delivery:

- individual therapy
- group therapy
- family therapy.

1.7.7 Deliver interventions in community and family settings, if it has been assessed as safe to do so.

1.7.8 Work alongside care staff when delivering interventions in residential, secure or custodial settings. Ensure the care plan includes safety planning to reduce the risk the child or young person may pose to others in the same environment.

1.7.9 Consider including family members when delivering interventions in residential, secure or custodial settings. Do this only if it is safe and has been agreed as part of the care plan (see recommendation 1.6.4).

Children and young people not living with their birth parents

1.7.10 Ensure links with their family of origin or community are maintained if it is in the best interests of the child or young person. Maintain links with birth parents if safe and appropriate.

Children and young people who have been abused by a family member

1.7.11 If it is in the best interests of the child or young person, consider family reconciliation, re-integration and restorative approaches, if it is safe and appropriate.

Looked after children and young people

1.7.12 Ensure the intervention supports carers. This includes giving them advice on how to respond to the risks presented by children and young people in their care.

Working with parents and carers

1.7.13 Encourage caring relationships between the child or young person and their family and carer, if it is safe to do so. Recognise that looked after children and young people may have problems arising from insecure attachment, making the relationship with their carer very challenging (see NICE's guideline on children's attachment).

1.7.14 Help carers create a sense of belonging and trust to ensure the child or young person feels safe, valued and protected.

1.7.15 Consider including the following elements in the programme:

- how to work with parents and carers in denial about their child's harmful sexual behaviour
- support to come to terms with harmful sexual behaviour and its impact
- how to understand harmful sexual behaviour risk indicators
- maintaining safety plans, including ongoing supervision
- addressing the parent-child relationship, if needed
- communications and problem solving
- behaviour management.

See NICE's guidelines on:

- challenging behaviour and learning disabilities, sections 1.5 to 1.11
- autism in under 19s: support and management, recommendations 1.4.1 to 1.4.13 and section 1.5

- violence and aggression: short-term management in mental health, health and community settings.

1.8 Supporting a return to the community for 'accommodated' children and young people

1.8.1 Provide ongoing support when children and young people in residential homes, secure children homes or young offenders' institutions move back into the community or return to the family home. This includes continuity of care for those who need this type of support.

Terms used in this guideline

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

Children

In this guideline, 'children' refers to anyone under 10.

Harmful sexual behaviour

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

Risk assessment tool

In this guideline, this term is used for tools that estimate the risk of sexual re-offending or the level of supervision needed, and help users decide what action to take. It includes tools such as J-SOAP-II and ERASOR, which are North American tools designed to assess the risk of sexual reoffending. The AIM assessment model was developed in the UK and considers the level of management and supervision needed for people displaying harmful sexual behaviour.

Young people

In this guideline, 'young people' refers to those aged 10 to 18. It includes those on remand and those serving community or custodial sentences. The guideline also includes people aged up to 25

who display harmful sexual behaviour and have special educational needs or a disability. This age extension is in light of the Children and Families Act 2014.

[1] See Brook Organisation information on pornography and the law.

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

[3] Achenbach T (1991) Manual for the Child Behaviour Checklist/4–18 and 1991 Profile. Burlington: University of Vermont.
Friedrich W (1997) Child Sexual Behaviour Inventory: professional manual. Odessa, Florida; Psychological Assessment Procedures.

[4] This will be dealt with in NICE's child abuse and neglect guideline, expected to be published in September 2017.

[5] McCrory E, Walker-Rhymes P (2011) A treatment manual for adolescents displaying harmful sexual behaviour: change for good. London: Jessica Kingsley.

Putting this guideline into practice

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

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

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

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

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

4. **Develop an action plan** with the steps needed to put the guideline into practice. Recognise that it may take several years. Include milestones and the business case, which will set out additional costs, savings and possible areas for disinvestment. A small project group should develop the action plan. The group should include the guideline champion, a senior organisational sponsor, staff involved in the associated services (including those who would form part of the multidisciplinary team), finance and information professionals.

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

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

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

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

Context

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

Data indicate that children and young people with learning disabilities are over-represented among those in the criminal justice system (Examining multi-agency responses to children and young people who sexually offend; The needs and effective treatment of young people who sexually abuse: current evidence Department of Health). However, few studies have been done with children and young people with learning disabilities.

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

Evidence suggests that sexualised behaviours in children and young people can be an expression of other problems or underlying vulnerabilities. It also suggests that early help assessments, without involving specialist harmful sexual behaviour services, can help. But there is little evidence of effectiveness on interventions addressing harmful sexual behaviour.

This guideline covers children and young people under 18 who display harmful sexual behaviour. It includes those on remand and those serving community or custodial sentences. It also includes people up to the age of 25 who have special educational needs or a disability, as set out the Children and Families Act 2014. This guideline does not deal with the consequences of sexual abuse. NICE's guideline on child abuse and neglect will be published in September 2017.

More information

You can also see this guideline in the NICE pathway on harmful sexual behaviour among children and young people.

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

See also the evidence reviews and information about how the guideline was developed, including details of the committee.

The committee's discussion

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

Background

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

Using the term 'harmful sexual behaviour' avoids labelling young children as sexual offenders, but it does not reflect the diversity of children and young people who engage in sexualised behaviours.

It is critical to differentiate between sexually abusive behaviour and behaviours that are detrimental to the child or young person's development. Sexually abusive behaviours are coercive and involve forcing others to comply with an action. This can include oral, anal and vaginal penetration. Whereas behaviours that affect individual development could include, for example, compulsive masturbation or addiction to online pornography. Such behaviours may result in stigmatisation and victimisation, as well as making others feel uncomfortable.

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

The focus of this guideline is on children and young people who are sole perpetrators of harmful sexual activities, directed either towards themselves or other individuals. It does not focus on activities such as child sexual exploitation and peer-on-peer or gang-related sexual violence.

The Department for Education's Working together to safeguard children definition of sexual abuse (which covers physical, emotional and sexual abuse, and neglect) acknowledges that children can commit acts of sexual abuse. But it does not acknowledge that children and young people's sexual behaviour is on a continuum. The NSPCC's definition of harmful sexual behaviour acknowledges that children and young people's sexual behaviour is on a continuum. It defines harmful sexual behaviour as acts that are inappropriate for age or stage of development and are important factors when assessing and intervening with this group.

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

The committee agreed with evidence from expert paper 1, and members' own experience, that many children and young people's display of harmful sexual behaviour will naturally come to an end as they mature. But members also agreed that concerns about a child or young person's sexualised behaviour should always be followed up and assessed.

Little is known about the number of prepubescent children who continue with harmful sexual activities as they get older. What is known is that only a small number go on to commit more serious sexual offences. In addition, the committee recognised the need to distinguish between chronological and developmental age when deciding how to assess and then intervene with this group.

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

In addition, the committee recognised the need to distinguish between these groups in the context of the criminal justice system in England, where 10 is the age of criminal responsibility. The committee also noted that the Children Act 1989 defines a child as someone who has not reached 18 and that young people enter the adult criminal justice system at age 18.

The committee noted that young people with ongoing or long-term health or social care needs may need to move into adult services at age 18 or 25, if they have special educational needs or disabilities. It agreed that these transitions need to be managed as part of the harmful sexual behaviour assessment and intervention process.

The committee discussed the fact that pornography is now more readily available thanks to new technology, but no evidence was found in the systematic search of the literature. Expert testimony confirmed a significant gap in the literature on how pornography influences sexual behaviour [EP11]. So the committee agreed to make a research recommendation on this.

See also gaps in the evidence numbers 10–12.

Section 1.1 Multi-agency approach

Multi-agency, multidisciplinary team

The discussion below explains how we made recommendations 1.1.1–1.1.3.

Current practice

The committee acknowledged a number of statutory arrangements are relevant for children and young people displaying harmful sexual behaviour. This includes:

- Section 10 of The Children Act 2004. This makes local authorities responsible for promoting interagency cooperation to improve the welfare of children in need.
- Ofsted's Early help: whose responsibility? and the Department for Education's Working together to safeguard children give local safeguarding children boards statutory responsibilities for children in need of protection and those with highly complex needs. Safeguarding boards are also responsible for developing thresholds for action.

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

The committee discussed the role of children and adolescent mental health services (CAMHS) in this area. Members noted that, in their experience, referral thresholds to CAMHS vary and that not all CAMHS services would take referrals for children and young people displaying harmful sexual behaviour.

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

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

Evidence for effectiveness

From the committee's experience, interagency assessments would be a suitable route for developing multi-agency approaches. These could use, for example, the Common Assessment

Framework (see 'Working together to safeguard children'), the local children safeguarding board and the Department for Communities and Local Government's Troubled Families Programme.

There was no evidence of effectiveness on the multi-agency approach but the committee agreed with the conclusions from 8 qualitative studies (3 high quality, 3 moderate quality and 2 low quality). These stated that early assessment should be 'joined up' with any subsequent therapeutic interventions, to ensure continuity between assessment and intervention [ES2.11, ES2.12].

Based on their own experiences, members also agreed that a lack of effective interagency working is often a key factor in serious case reviews (see New learning from serious case reviews: a 2-year report for 2009–2011 Department for Education).

Evidence for cost effectiveness

The committee agreed that failures in interagency working could have a serious 'knock on' effect and lead to a limited response to referrals. This may also have implications for cost effectiveness: failure to provide services may leave the behaviour unchecked and eventual entry into the criminal justice system. The latter would be expensive and is also likely to result in harm to others.

Additional factors taken into account

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

Practitioners working with children and young people with complex needs, such as autism spectrum condition or conduct disorder, need access to specialists working in harmful sexual behaviour services. It would not be possible to agree interagency care plans without a multidisciplinary team of professionals who meet regularly to agree and evaluate outcomes.

The committee agreed that the practice of closing a social work file on a child or young person once they have been referred to harmful sexual behaviour services is not helpful. Members described how, in some instances, referrals to harmful sexual behaviour services were declined because specialist services do not have the resources to deal with the child or young person's additional needs. They agreed there was a need for greater recognition that a range of agencies is usually needed to provide support.

Trade-off between benefits and harms

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

Resource impact and implementation issues

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

The committee agreed that failure to provide local expertise using a coordinated, multi-agency approach will mean children and young people displaying more serious behaviour are likely to receive ad hoc assessments and interventions. Sometimes this might result in out-of-area placements that could prove expensive. It could also lead to delays in providing a more effective intervention in the child or young person's locality and at an earlier stage.

Multi-agency, multidisciplinary working

The discussion below explains how we made recommendations 1.1.4–1.1.8.

Current practice

Committee members discussed their experience of working across agencies and disciplines within the harmful sexual behaviour service sector. Their experiences were generally positive, but they knew that there was room for improvement in many locations.

Evidence for effectiveness and cost effectiveness

There was no empirical evidence of effectiveness or cost effectiveness.

The committee agreed that children and young people who display harmful sexual behaviour are likely to have complex needs that can only be met by numerous health and social care agencies working together. Members agreed that a well-established multi-agency response is likely to lead to multiple cost savings to society. This includes:

- savings from otherwise lost educational and employment opportunities during the child or young person's life

- savings from preventing harm to others.

The committee agreed that local safeguarding children boards should implement NICE recommendations in this area and should identify lead agencies to commission and develop harmful sexual behaviour services.

The committee noted that various services are needed to respond to this group of children and young people, and that a statutory response is not always necessary. It agreed that the safeguarding needs of children and young people referred for an early help assessment should be a priority, with the results used to determine whether a statutory or criminal justice response is needed. (For victims of sexual abuse see Reporting and acting on child abuse and neglect, Home Office and Department for Education.) It recommended that a variety of referral and care pathways should be in place.

The committee heard testimony on the NSPCC harmful sexual behaviour framework [EP12]. It aims to improve local interagency working and coordination while recognising the resource constraints that local areas face. Members agreed that local authorities should offer a range of care pathways based on the 5 core domains of the framework to create a consistent approach across services.

Currently there is no national strategy or overarching service delivery framework for harmful sexual behaviour. The NSPCC framework was developed by a wide range of partners and is being tested in a number of local authority areas.

The committee agreed that, in line with 'Working together to safeguard children', local safeguarding children boards should set thresholds for when to refer a child or young person for early help assessment or specialist harmful sexual behaviour services.

The committee saw local safeguarding children boards as a potential vehicle for ensuring a coordinated approach to meeting the needs of this group. This would have the benefit of making use of existing services to improve multiagency working.

The committee recommended that local safeguarding children boards should ensure local policies and procedures are in place to train staff in children's social services to deal with concerns about a child or young person's sexualised behaviour. Concerns may be raised by professionals working in universal services or members of the public.

Local safeguarding children boards should recommend resources for professionals working in universal services to consult when there are concerns over a child or young person's sexualised behaviour.

Resource impact and implementation issues

The committee agreed that these recommendations are informed by government guidance and form the basis of current health and social care practice. It also agreed that a brief consultation (or triage meeting) over the phone or face-to-face with a concerned parent or teacher and a specialist practitioner could sometimes be enough.

Information sharing

The discussion below explains how we made recommendations 1.1.9–1.1.12.

Current practice

The committee agreed that information sharing between agencies remains a contentious issue. Members also agreed that fears about sharing information should not stand in the way of the need to promote the welfare and protect the safety of children. (See Information sharing: advice for practitioners providing safeguarding services to children, young people, parents and carers.)

Evidence for effectiveness

The committee recognised that the recommendations were not based on evidence of effectiveness but reflected the committee's experience of serious case reviews (see New learning from serious case reviews: a 2-year report for 2009–2011 Department for Education). The issues are also highlighted in the Department for Education's report 'Working together to safeguard children.' Seven qualitative studies reported there is reluctance among practitioners to share assessments (2 high quality, 4 moderate, 1 low) [ES2.13].

The committee also discussed the need for clear, effective protocols that are regularly evaluated. In particular, these protocols should highlight the adverse consequences of not sharing information – a point repeatedly made in serious case reviews, including cases of violent or sexual assault and rape.

Evidence for cost effectiveness

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

Additional factors taken into account

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

Resource impact and implementation issues

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

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

In addition, information sharing using a locally agreed approach does not have a significant resource impact because it uses established pathways and protocols, as set out in 'Working together to safeguard children'.

Section 1.2 Named safeguarding leads in universal services

The discussion below explains how we made recommendations 1.2.1–1.2.4.

Current practice

Any professional working in universal services who is concerned about the sexualised behaviour of a child or young person has a responsibility to notify their organisation's named safeguarding professional. Named safeguarding leads should discuss their concerns with children's social services so a decision can be made about whether referral for an early help assessment is needed (see Early help: whose responsibility? Ofsted).

The committee noted, however, that members were aware of instances where such behaviour had been ignored and children had been harmed.

Evidence of effectiveness

No evidence of effectiveness was identified for this section. The recommendations are linked to the Department for Education's guidance 'Working together to safeguard children'. This requires professionals in universal services and those providing services to adults working with children to

identify emerging problems and share this with other professionals involved in early identification and assessment of harmful sexual behaviour. It requires them to discuss concerns and referrals through agreed routes so appropriate referrals are made, to reduce risk of stigmatisation.

The committee agreed that professionals working in universal services should use locally agreed resources to identify if a child or young person's behaviour is a cause for concern [ES2.1].

Section 1.3 Early help assessment

The discussion below explains how we made recommendations 1.3.1–1.3.10.

See also gaps in the evidence number 2.

Current practice

The principles of early help assessment are discussed in the Department for Education's guidance 'Working together to safeguard children' (see current practice in the 'Multi-agency, multidisciplinary team' section of the committee discussion). This type of assessment is key to identifying and addressing needs not being met by universal services. For example, it can identify the need for:

- targeted services
- specialist harmful sexual behaviour assessment
- referral to the child protection team
- referral to the criminal justice system.

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

In their experience, members said that early help professionals and professionals not trained to work with people displaying harmful sexual behaviour need more information and resources to identify such behaviour. That is because referrals to children's services are based on a generic practice model and not one that specialises in harmful sexual behaviour.

Evidence for effectiveness

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

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

The committee agreed that it should be made clear which agencies are responsible for children and young people who do not fall under the remit of child protection, or who do not need harmful sexual behaviour services but do have unmet needs.

The committee agreed that a locally agreed identification tool should be used as part of the early help assessment for a child or young person displaying sexualised behaviour that is a cause for concern [ES2.1, ES2.13].

The committee based these recommendations on government guidance on early help (see 'Working together to safeguard children'). It also included expert testimony that recognised the need for early help to prevent escalation [EP12 and EP13].

There is no evidence on how effective tools are at identifying harmful sexual behaviour, but the committee agreed that a tool should be used as part of the early help assessment. This will help to identify harmful sexual behaviour and improve decision making. The aim would be to screen for age and developmentally inappropriate sexualised behaviour and language to decide whether to refer on to specialist harmful sexual behaviour services.

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

Evidence for cost effectiveness

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

Additional factors taken into account

The committee considered that such assessments could prevent the escalation of sexualised behaviour. This, in turn, could prevent the need for specialist harmful sexual behaviour services, a statutory assessment under The Children Act 1989 or involvement of the criminal justice system.

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

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

The committee also agreed that often, as children and young people mature, they stop displaying harmful sexual behaviour. However, their life chances may still be impaired (because of their previous behaviour or related factors). So they may need ongoing assessment and input, particularly in relation to educational and employment opportunities [EP1].

The committee acknowledged that those working with children and young people displaying inappropriate sexualised behaviour need a greater understanding of the benefits of an early help assessment. However, members also wanted to ensure that unnecessary assessments and referrals do not occur that may be stigmatising, so they included caution around this area in the recommendations.

Sexual behaviours exist on a continuum that ranges from normal and developmentally appropriate to highly abnormal and violent [EP1]. There is little evidence on interventions that address behaviours that fall short of thresholds needing a response from specialist harmful sexual behaviour services or the criminal justice system.

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

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

The committee agreed with expert paper 7. This recommends that when assessing children and young people displaying sexualised behaviour, practitioners should distinguish between children and young people in general and those with special educational needs and learning disabilities, or with autism. It noted that although the latter form a significant minority, there is a lack of tools for assessing their behaviour.

The committee agreed that using a tool to identify the sexual behaviour of children and young people would help make practitioners aware that this behaviour exists on a continuum. It would also help determine whether a referral to specialist services is necessary. Members recognised that if the tool is not designed for the subgroup being assessed, the results may not be accurate.

Resource impact and implementation issues

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

The committee believed that early identification and intervention would be cost effective by preventing escalation of the behaviour and avoiding involvement of the criminal justice system.

Section 1.4 Risk assessment for children and young people referred to harmful sexual behaviour services

The discussion below explains how we made recommendations 1.4.1–1.4.7.

See also gaps in the evidence number 2.

Current practice

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

When children and young people are charged by the Crown Prosecution Service for harmful sexual behaviour, the offence cannot be discussed with them while the case continues. But an assessment can still take place.

The committee discussed the AIM assessment model, which was originally developed for practitioners in the criminal justice system, but could be used in the community [EP8]. The committee was told that current practice is dominated by AIM2 designed primarily for boys and young men aged 12 to 18. The AIM model considers the level of management and supervision needed, together with the person's development and intervention needs. Members were also told that although the AIM assessment model has led to a more standardised approach, it is unclear how it might be applied outside the criminal justice system.

Members noted that the AIM model for under-12s is used to assess:

- children under 12
- children between 10 and 12 whose harmful sexual behaviour needs a criminal justice response (10 being the age of criminal responsibility in England).

Members noted that AIM2 is used mainly to assess males aged 12 to 18 and:

- Focuses on factors linked to the risk of harmful sexual behaviours.
- Brings together elements from the more general approach outlined in the Framework for the assessment of children in need and their families[6] (Department of Health) and the Youth Offending Asset assessment (Youth Justice Board for England and Wales) now AssetPlus.
- Takes into account clinical factors.

The committee also discussed whether AIM2 could be used with young females and young people with learning disabilities. Members agreed this should be on a more limited basis. The developers of AIM2 do not recommend using the 'level of supervision' scale for young females, as it is likely to misrepresent the level of risk. A degree of caution is also advised when using AIM2 to predict sexual reoffending in young people with learning disabilities. At this stage the committee agreed the evidence available was too limited to make recommendations in these areas. It noted that further research is needed on assessing risk in all children and young people (see research recommendation 5).

Evidence for effectiveness

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

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

The committee considered:

- J-SOAP-II (5 low to moderate quality studies on future sexual re-offending). The evidence was inconsistent: 3 predicted sexual re-offending, 2 did not [ES2.3].
- ERASOR (4 moderate to high quality studies). Three predicted sexual re-offending, 1 did not [ES2.5].
- Adapted AIM and AIM2 (2 moderate quality studies on future sexual re-offending). Both studies predicted that adolescents with and without learning disabilities who were previously known to sexually offend would reoffend [ES2.2].
- J-SORRAT-II (2 studies, 1 low and 1 moderate quality). One study found it was able to predict future sexual re-offending among adolescent males convicted of a sexual offence, the other found no effect [ES2.8].

The committee noted that although the evidence is contradictory for J-SOAP-II and ERASOR [ES2.3, ES2.4, ES2.5, ES2.6, ES2.7], the tools look promising for assessing young people's risk of sexual and non-sexual reoffending.

The committee agreed that although the evidence from adapted AIM and AIM2 studies is limited [ES2.2, EP8], they are promising tools and are relevant because they were developed in the UK. Only limited attempts have been made to test their predictive validity [ES2.2].

AIM2 is also now being used (with caution) for girls and for those with learning disabilities. So the committee recommended further research on AIM2.

So the committee was unable to make a strong recommendation for the use of AIM for under-12s or AIM2.

The committee agreed that the J-SORRATT-II was still undergoing research and was not used outside North America, so it could not currently recommend its use as a risk assessment tool [ES2.8].

There was no evidence that tools focusing on strengths (BERS-2) enhance the accuracy of ERASOR to predict sexual re-offending among adolescent young men who have committed a sexual offence [ES2.7].

The committee also considered evidence from 2 quantitative studies (moderate quality) on the SAVRY and YLS/CMI tools. It noted that SAVRY was unable to predict sexual or non-sexual reoffending for adolescent males convicted of a sexual offence [ES2.9]. The YLS/CMI tool did not predict sexual reoffending but did predict non-sexual violence, and any potential for non-sexual re-offending [ES2.10].

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

The committee discussed the literature on risk assessment tools to predict future sexual violence. Members agreed it is limited because the number of re-offenders recruited into research studies is too small for the research designs needed to validate tools. This means that most UK agencies are using largely under-tested models to underpin their assessments of risk and need. So further research is urgently needed (see research recommendation 5).

Evidence for cost effectiveness

There was no cost effectiveness evidence for this set of recommendations. The committee agreed that a good initial assessment is vital when making decisions about therapeutic interventions, treatment placements and care plans.

Additional factors taken into account

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

The quantitative evidence on sexual abuse was largely drawn from North America. It reported on small clinical populations of relatively high-risk young people referred for specialist treatment. The assessment models used were adapted from models used for male adults convicted of a sexual offence.

Assessing the risk of sexual re-offending among young people is particularly challenging because of the enormous changes they undergo at this age. The committee also noted a key finding from research that indicates that many young people who engage in offending behaviours stop them as they mature[7].

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

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

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

The committee agreed that risk assessment tools and models designed for adolescents convicted of a sexual offence should not be used with prepubescent children displaying harmful sexual behaviour.

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

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

Trade-off between benefits and harms

Benefits include the adoption of a consistent approach to assessment. In addition, using locally agreed tools allows practitioners from different agencies and professional backgrounds to share information.

However, potential harm could come from the fact that the assessment of the level of risk is not accurate. On the one hand, this could lead to an over-punitive or over-restrictive approach. On the other, it could sometimes mean the child or young person doesn't get the support they need to prevent further harmful sexual behaviour, so exposing them to risk – to themselves and others.

Resource impact and implementation issues

The committee noted that AIM for under-12s and AIM2 were developed for the UK, but have to be paid for and involve specialist training. In comparison, J-SOAP-II, and ERASOR are free and specialist training is not needed, so they would have less impact on training needs and resources. But their applicability in England is unknown.

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

In the absence of more consistent evidence, the committee agreed that it might be best if practitioners use AIM2, ERASOR, or J-SOAP-II for assessing risk. If time allows, the committee recognised that there may be benefits if the ERASOR and J-SOAP-II are used together to compare the use of these two models over time. In each case, the developers also recommend that practitioners use their own clinical judgement.

Only the most promising tools were included in the recommendations as examples of what was available. But the committee agreed that, given the uncertainty in the evidence base more research is needed (see research recommendation 5).

The committee also agreed by consensus that in their expert opinion children's social services and NHS England are best placed to identify who should undertake a risk assessment and these names were added to recommendation 1.4.1.

Section 1.5 Engaging with families and carers before an intervention begins

The discussion below explains how we made recommendations 1.5.1–1.5.4.

Current practice

Not all practitioners meet with families and carers before an intervention begins.

Evidence for effectiveness

There was no quantitative evidence of effectiveness on the role of practitioners. Six qualitative studies and 2 expert testimonies identified key features and approaches that practitioners could use to reduce barriers to services and improve communications between the practitioner and children, young people, parents and carers [EP9 and EP10].

The committee agreed that before an intervention begins, practitioners must consider whether the child or young person has been abused within the family or the victim is another family member. (See also NICE's guideline on when to suspect child maltreatment; NICE's guideline on child abuse and neglect is due for publication in September 2017.)

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

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

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

The committee agreed with 3 high quality qualitative studies and expert papers 9 and 10 that the therapist's relationship with the child or young person is vital if an intervention is to be effective

[ES1.21]. Members also agreed that, in their experience, interventions were only as good as the person providing them.

Evidence for cost effectiveness

There was no cost effectiveness evidence for this set of recommendations, but the committee agreed that encouraging practitioners to meet beforehand is likely to improve the outcome of the intervention. So they are likely to be cost effective and potentially cost saving.

Trade-off between benefits and harms

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

Resource impact and implementation issues

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

Section 1.6 Developing and managing a care plan for children and young people displaying harmful behaviour

The discussion below explains how we made recommendations 1.6.1–1.6.5.

Current practice

Practice may vary. But good practice involves using a care plan based on the results of the assessment of the child or young person's risks and needs.

Evidence of effectiveness

Based on members' own experience, the committee agreed that care planning should be based on the results of the needs and risk assessment and should include the use of recognised resources.

Resource impact and implementation issues

The committee believed that these recommendations would not result in increased costs but would probably improve outcomes [ES1.15].

Section 1.7 Developing interventions for children and young people displaying harmful sexual behaviour

The discussion below explains how we made recommendations 1.7.1–1.7.15.

See also gaps in the evidence (number 1).

Current practice

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

Evidence for effectiveness

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

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

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

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

Four papers reported on 3 studies of multisystemic therapy. Two randomised controlled trials and 1 controlled study (ranging from low to moderate quality) reported that multisystemic therapy significantly reduced the risk of adolescent sexual re-offending compared with CBT or usual care.

One controlled study (moderate quality) using adventure-based therapy (Legacy) for adolescent boys convicted of a sexual offence, reported no difference between the intervention and control group for re-offending rates for violent sexual offences.

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

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

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

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

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

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

The committee also considered evidence on 2 CBT programmes for young people displaying a range of harmful behaviours and personality disorders: SAFE-T (Sexual Abuse, Family Education and Treatment Programme) and Thought Change System. Both interventions included family members and carers. (The evidence comprised 2 low to moderate quality quantitative studies.)

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

The committee considered the evidence of effectiveness for multisystemic therapy compared with CBT-based usual care for adolescents convicted of sexual offences.

Two moderate quality quantitative studies found that significantly fewer people from the multisystemic therapy group had been re-arrested for sexual offences at follow-up than from the comparison group [ES2.9].

One moderate quality quantitative study found that multisystemic therapy for adolescents charged with sexual offences led to a reduction in deviant sexual interests when compared with CBT-based usual care [ES1.10]. Two moderate quality quantitative studies reported improvements in problem sexual behaviour, psychiatric symptoms, antisocial behaviour, family and peer relations and school performance among adolescents charged with sexual offences, compared with CBT-based usual care [ES1.11, ES1.12, ES1.13].

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

Research suggests, however, that multisystemic therapy may not be as effective with all subgroups of young people who display harmful sexual behaviour. For example, there is a strong link between antisocial peer groups and young people whose harmful sexual behaviour is often directed towards peers and accompanied by other non-sexual criminality. This group is different from those whose

harmful sexual behaviour targets younger, prepubescent children. The latter are less likely to have a social life or strong peer friendship groups.

The committee heard expert testimony on the ongoing trial of Multi-systemic therapy – problematic sexual behaviour in the UK and agreed that this may, in future, offer more conclusive results [EP14]. It noted that previous evaluations of the programme in the US were positive, and had been carried out by its designers.

The committee noted the results from 1 moderate quality study that evaluated an adventure-based programme (Legacy). This reported no difference for re-arrest rates for violent sex offences between groups but appears to be beneficial in reducing future risks of non-sexual reoffending [ES1.14].

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

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

The committee agreed that victim empathy is a contested component of harmful sexual behaviour interventions [ES1.18].

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

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

The committee agreed with 14 qualitative studies (11 low, 1 moderate, 2 high quality) that reported that communication skills, social skills training and anger management or 'emotional regulation' are important components of any intervention [ES1.19, ES1.27].

The committee noted the results from 3 qualitative studies (1 high, 1 moderate, 1 low) that showed that group interventions (for both the child and young person and their family and carer) can reduce their sense of isolation and provide valuable support. But members also noted that it may be problematic for those who find it difficult to talk in front of others [ES1.26]. In addition, they noted the difficulties involved in treating perpetrators of harmful sexual behaviour alongside their victims, as highlighted in 4 qualitative studies (2 moderate, 2 low) [ES1.25].

Evidence for cost effectiveness

The committee made the recommendations on cognitive behavioural therapy, multisystemic therapy and play therapy a priority for economic modelling. The model results showed a cost per QALY of under £20,000, but the committee questioned these estimates and thought that not all these therapies would in fact be cost effective. This is particularly true for children and young people who did not need a custodial sentence. That is because the studies that underpinned the modelling were from North America, where comparators are different.

Given that the multisystemic therapy trial in the UK has yet to report, the committee suggested that it would be prudent to continue with current approaches – but make them work better by following the recommendations outlined in this guideline. Getting better results at the same cost would automatically be cost effective.

If the current trial shows that more expensive methods are more effective than current methods, the approach advocated here (continuing with current practice) could be revised.

Additional factors taken into account

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

The qualitative studies identified programmes offering relapse prevention, anger management (emotional restraint), victim empathy, communication and social skills training. They also documented the emergence of family-level interventions and the role of the therapist as important components. The committee noted that mode of delivery (such as face-to-face or in groups) should be based on the needs and circumstances of the child or young person, as highlighted in the assessment and using clinical judgement.

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

The committee agreed that having to choose between cognitive behavioural therapy and multisystemic therapy is not realistic and that there are advantages to both (this includes the fact that effectiveness can depend on the family circumstances).

In the absence of clear evidence, the committee recommended continued use of these therapies. The evidence reported was based on small numbers of participants (and conducted by developers of the intervention in the case of multisystemic therapy). Members agreed that more research, with a low risk of bias and relevant to UK practice, is needed (see research recommendation 3).

Members acknowledged that multisystemic therapy is a more complex approach that needs the child or young person to be living in the family home or in a stable foster family situation (for at least 18 months in the case of multisystemic therapy Problematic Sexual Behaviour). As a significant proportion of children and young people displaying harmful sexual behaviour may not be living in a family situation this approach may not work. In that respect, cognitive behavioural therapy might be a more pragmatic solution but, the downside is that it needs more follow-up once the intervention has ended.

The committee did not put the list of interventions in order of priority, because the results of the child or young person's assessment should help practitioners decide what type of intervention to offer. Members agreed that what was needed was a 'toolbox' of approaches that could be tailored to individual needs. From their own experience, they agreed that comprehensive, multicomponent interventions that focus on the child or young person's family and background are more promising than those that focus solely on the abusive behaviour.

The committee also discussed looked after children and young people displaying harmful sexual behaviour and the need for foster carers to be adequately trained. It heard testimony from expert paper 10 that young people in the care system with harmful sexual behaviour often experience multiple placement moves. This, in turn, can affect the child's willingness to form attachments and makes therapeutic interventions more challenging.

Section 1.8 Supporting a return to the community for 'accommodated' children and young people

The discussion below explains how we made recommendation 1.8.1.

Current practice

The Glebe House model, a specialist children's home, is an example of residential practice in this area. It is based on a therapeutic community model for adolescent males with a known history of harmful sexual behaviours. The committee noted that the Glebe House model is not usual practice in this area, and that the types of interventions offered at Glebe House are very different from those offered by custodial services.

Young people in a young offender's institution serving a custodial sentence for a sexual offence do not always receive harmful sexual behaviour services. Local youth offending teams should provide this service but it can take months to arrange. That's because it may involve transferring the person to a young offender's institution that offers specialist services. It is not uncommon for a transfer from one custodial setting to another to take place a few months before the release date.

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

Youth Justice Board statistics for 2014/15 show that the average time, from the date of an offence being committed until completion of court proceedings, is 66 days. But for sexual offences this rises to 295 days – so many would not be eligible for support by the time they are sentenced. In addition, young people aged between 12 and 17 who receive a 12-month detention training order would not be eligible. That is because half the sentence will be spent in custody and the other half will be supervised by the youth offending team in the community.

However, the Wakefield harmful sexual behaviour model allows all young people displaying harmful sexual behaviour, whether or not it is part of the offence, to be referred. This is also regardless of the length of time they spend in custody and whether or not they receive a custodial or community sentence.

In this model, any agency involved with the young person can refer and self-referrals are also accepted. Everyone is offered a consultation plus a transition package, regardless of whether they are discharged into the community or transferred to adult prison.

Evidence for effectiveness

The committee noted that a small number of children and young people displaying harmful sexual behaviour may warrant placement in a specialist residential or secure setting. It drew on evidence

from expert paper 6 as an example of a specialist children's home that uses a therapeutic community model.

The committee agreed that, if possible, residential settings should draw on the values and approaches of a therapeutic model originally developed in the field of social psychiatry by Rapoport and Roscow[8]. This is based on 5 social psychology principles: attachment, containment, communication, involvement and agency.

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

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

Evidence reviews

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

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

Evidence statement (ES) ES1.1 indicates that the linked statement is numbered 1 in review 1. **ES2.1** indicates that the linked statement is numbered 1 in review 2. **EP1** indicates expert paper 1 'Definitions, epidemiology and natural history of HSB'. **EP2** indicates expert paper 2 'Developmental pathways towards sexually harmful behaviour and emerging personality disorder traits in childhood'. **EP3** indicates expert paper 3 'Harmful sexual behaviour of children'. **EP4** indicates expert paper 4 'Girls who display harmful sexual behaviour – developing assessment tools and intervention resources'. **EP5** indicates expert paper 5 'Glebe House'. **EP6** indicates expert paper 6 'Turn the page'. **EP7** indicates expert paper 7 'Harmful sexual behaviour – children and young people with learning difficulties who display harmful sexual behaviour'. **EP8** indicates expert paper 8 'AIM project'. **EP9** indicates expert paper 9 'Service user expert testimony'. **EP10** indicates expert paper 10 'Practitioner and advocate expert testimony'. **EP11** indicates expert paper 11 'Pornography and its impact on harmful sexual behaviour'. **EP12** indicates expert paper 12 'The development of an operational framework for children and young people who sexually harm'. **EP13**

indicates expert paper 13 'An overview of policy and practice'. **EP14** indicates expert paper 14 'MST PSB trial'.

If the committee considered other evidence, it is linked to the appropriate recommendation below.

Section 1.1: ES2.9; EP1, EP9, EP10

Section 1.2: ES2.1, ES2.13; EP1, EP7; Department for Education's 'Working together to safeguard children.'

Section 1.3: ES2.1; EP7, EP12

Section 1.4: ES1.6, ES1.28, ES2.2, ES2.3, ES2.4, ES2.5, ES2.6, ES2.7, ES2.8, ES2.10, ES2.14; EP3, EP4, EP7, EP8

Section 1.5: ES1.16, ES1.18, ES1.20, ES1.21, ES1.22, ES1.23, ES1.24; EP1, EP9, EP10

Section 1.6: ES1.6, ES1.17, ES1.28, ES2.2, ES2.3, ES2.4, ES2.5, ES2.6, ES2.7, ES2.11, ES2.13; EP3, EP4, EP8

Section 1.7: ES1.6, ES1.7, ES1.8, ES1.10, ES1.11, ES1.12, ES1.13, ES1.14, ES1.15, ES1.16, ES1.17, ES1.19, ES1.25, ES1.26, ES1.27, ES1.28; EP2, EP3, EP5, EP9, EP10, EP14

Section 1.8: ES1.6, ES1.15, ES1.28; EP5, EP9, EP10

Gaps in the evidence

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

1. A comparison of the effectiveness of therapeutic approaches such as cognitive behavioural therapy and multisystemic therapy for children and young people who display harmful sexual behaviour and their family and carers.

(Source ER1)

2. Evidence of effectiveness for recognised assessment and treatment models, such as the Good Lives Model and AIM2, for children and young people who display harmful sexual behaviour.

(Source ER1)

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

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

(Source ER2)

4. Evidence on interventions aimed at younger children (prepubescent or under 10) who display sexualised behaviour that is of concern.

(Source ER1)

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

(Source ER1)

6. Rates for continued problematic sexual behaviours following prepubescence.

(Source EP1)

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

(Source EP1)

8. Evidence of the impact that pornography and new technologies have on harmful sexual behaviour such as sexting, the posting of sexual images and grooming.

(Source EP11)

[6] This guidance was subsumed into 'Working together to safeguard children' and is no longer current.

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

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

Recommendations for research

The guideline committee has made the following recommendations for research.

1 Long-term outcomes for children and young people displaying harmful sexual behaviour

What are the long-term outcomes for children and young people displaying harmful sexual behaviour, when should practitioners intervene and what potentially modifiable factors have the most important impact?

Why this is important

Longitudinal evidence spanning the life-course of children and young people who display harmful sexual behaviour is needed to understand when to intervene. This is particularly true for children and young people whose sexual behaviour does not warrant an intervention from harmful sexual behaviour services or the criminal justice system.

There is a lack of evidence on thresholds for intervening, including evidence on modifiable risk and protective factors that prevent the behaviour escalating. We also need evidence on quality of life measures.

As a result we should be able to avoid mislabelling younger children as 'sexual offenders' and subjecting them to intrusive and stigmatising interventions.

2 Effective interventions for children and young people displaying harmful sexual behaviour

What interventions are effective with children and young people displaying harmful sexual behaviour?

Why this is important

Most of the evidence on interventions is inconclusive. It comes from small clinical populations of adolescent males convicted of sexual offences. More research is needed on the effectiveness of current interventions and to understand how to avoid children and young people who display sexualised behaviour being taken into the criminal justice system. This includes research on:

- prepubescent children
- young women
- children and young people with neurodevelopmental and learning disabilities
- minority ethnic and migrant communities
- looked after children (including those in non-family based settings).
- children and young people in the criminal justice system (community and custody).

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

Evidence of effective interventions could help target resources more effectively and ensure programmes are tailored to meet children and young people's differing needs.

3 Effective interventions for the families and carers of children and young people displaying harmful sexual behaviour

What type of therapeutic interventions are effective when working with the family and carers of children and young people who display harmful sexual behaviour?

Why this is important

Evidence on effective interventions for families and carers of children and young people who display harmful sexual behaviour is equivocal. Evidence of effectiveness for the 2 most common approaches – cognitive behavioural therapy and multisystemic therapy – and other therapies is very limited. Further research is needed to help practitioners tailor interventions according to need.

4 Early interventions to prevent problems escalating

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

Why this is important

There is a need for more evidence on what is effective in diverting children and young people away from further harmful sexual behaviour at the earliest stages of its development. Research is needed on missed opportunities to intervene and what the trajectory has been for those children and young people who were missed. Such evidence could help ensure children and young people receive timely support to prevent an escalation of the behaviour.

5 Assessment models for different groups of children and young people

How effective are the models currently used for assessing the needs of, and level of risk for, children and young people from different population groups who display harmful sexual behaviour?

Why this is important

Assessment is at the heart of effective intervention planning and risk management. Without good assessment models, levels of risk may be misclassified. To date, risk assessment tools have mainly been used on small clinical populations of adolescent males who have sexually offended and there is a need for assessment tools for other groups of children and young people. Assessment results are also a basis for needs assessment and decisions about therapeutic interventions, treatment placements and care plans.

For those in the criminal justice system, an assessment provides a clear guide to sentencing and multiagency management (for example, multi-agency public protection arrangements).

Lack of evidence on current assessment models means that we know little about:

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

6 Electronic media

How does the use of electronic media affect harmful sexual behaviour?

Why this is important

The reasons behind the growth in online grooming, the viewing of online pornography, and the making and distributing of sexual images is poorly understood. There have been few studies into the links between aggressive behaviour, sexual offending and the use of electronic media.

Longitudinal studies are needed to understand the impact electronic media has on sexual behaviour and on the general values, attitudes, beliefs and behaviour of children and young people. Research is also needed on its long-term impact on children and young people's social and psychological development. Such research could provide evidence on how best to assess, intervene and manage the risks associated with the use of electronic media in this area.

Glossary

Cognitive behavioural therapy

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

Cognitive restructuring therapy

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

Common Assessment Framework

Early help assessments, such as the Common Assessment Framework, identify what help the child and family need to prevent their needs escalating to a point where intervention would be needed via a statutory assessment under the Children Act 1989.

Conduct disorder

A serious behavioural problem that can last a long time and can affect a child or young person's ability to lead a normal life. Common signs and symptoms include:

- aggressive behaviour towards people or animals
- destructive behaviour towards other people's property
- lying and stealing
- playing truant from school.

For older children and adolescents, this can also include smoking, drinking alcohol, substance abuse and engaging in unprotected sexual activities.

Developmental age

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

Early help assessments

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

Guided interventions

Guided interventions offer practitioners a set of key principles on which to base interventions.

Multisystemic therapy

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

Neurodevelopmental disorders

Disorders that typically appear early in a child's development, often before they enter school. They are characterised by impairments in personal, social, academic, or occupational functioning. Examples are: learning disability, autism spectrum condition, speech and language disorders and ADHD (attention deficit hyperactivity disorder).

Prepubescent

A child who has not yet reached puberty.

Problematic sexual behaviour

Unusual and socially unexpected behaviour. It may not involve victimisation and consent issues may be unclear but it may make others uncomfortable or interfere with the child or young person's healthy psychosexual development.

Safeguarding

All organisations that work with or come into contact with children and young people should have safeguarding policies and procedures to ensure that they all, regardless of their age, gender, religion or ethnicity, can be protected from harm.

Satiation therapy

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

Sexually abusive

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

Strengths-based programmes

Strengths-based programmes are a collaboration between the person and the services supporting them. Programmes consider not only factors that are of concern but build on the person's capabilities and strengths.

Universal services

Universal services are those services provided to all children and young people such as schools, health visiting, GPs.

Youth criminal justice

The youth criminal justice system is for those aged 10 to 17 years: people aged 18 go through the adult criminal justice system.

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

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