research in practice

National Children's Bureau

# Workforce perspectives on harmful sexual behaviour

## Findings from the Local Authorities Research Consortium 7

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# Executive summary

Harmful sexual behaviour (HSB) can be defined as "Sexual behaviours expressed by children and young people under the age of 18 years old that are developmentally inappropriate, may be harmful towards self or others and/ or be abusive towards another child, young person or adult." (Hackett, Holmes and Branigan, 2016)

In the context of increasing awareness of harmful sexual behaviour as an issue affecting many children across England, the Local Authorities Research Consortium (LARC) set out to investigate the understanding and needs of the children's workforce in this field. This report sets out the results of a survey of over 500 professionals working across a range of agencies in the six participating local authority areas.

*Whilst some of the workforce rated their knowledge and skills in this area highly, this varied according to the particular tasks involved. Overall there appears to be more work needed to ensure all professionals have the knowledge, skills and confidence to most effectively support children and young people with harmful sexual behaviour*

In spite of a lack of a statutory definition, most practitioners and carers felt that they knew what HSB was. However **this level of awareness could be further raised to improve early identification of children in need of support.**

Many practitioners and carers felt that they did not necessarily have the knowledge and skills for working directly with children displaying HSB. Notably, this included significant proportions of those who *had* worked with several of such children over the previous year. Practitioners had a fairly high degree of confidence in their knowledge and skills for assessing and identifying children with HSB. However, only nine per cent of practitioners and carers *strongly* agreed that they were confident in identifying children with HSB. Not all of the relevant parts of the children's workforce reported being confident in relation to key aspects of this complex and varied work; fewer than half of managers and leaders felt confident leading multi-agency partnerships or designing and commissioning services.

*Meeting the often complex needs of children displaying HSB can be challenging for all parts of the workforce*

Most respondents said that they had seen at least some increase in the numbers of children with HSB in the previous two years. Their responses regarding the needs and vulnerabilities of these children corroborated existing evidence that children with HSB often face other challenges. These can include experience of neglect and abuse and additional needs relating to learning and communication (Hackett, 2014).

Respondents reported experiencing a number challenges in working with children displaying HSB. These included the development of positive trusting relationships with the children concerned and balancing the needs and safety of the child, their peers and staff working with them. Work with children with HSB had a notable emotional impact on many of those carrying it out. Negative feelings such as anxiety, worry and upset were experienced even by those reporting higher levels of knowledge, skills and experience.

*Access to some important forms of support and guidance is inconsistent across the workforce*

Most practitioners and carers felt they were able to access a range of support and guidance that impacted positively on their work in this area. Many, however, felt that they would benefit from additional development support, particularly training, team meetings focused on the topic, team-based learning, formal peer-learning and being able to refer to / consult with a specialist. Access to these forms of support were associated with higher levels of confidence in working with children with HSB, but access to them appeared to be inconsistent. Use of them varied both by agency and local area.

The majority of those who had received training on issues around HSB felt it had impacted positively on their work. However, on average, only 35 per cent of practitioners and carers had accessed

such training in the previous three years, with this figure being even lower for those working in health and education. This suggests that there is a need for local areas to consider increasing **training and other skills development opportunities for those working with or caring for children displaying HSB.**

Responses demonstrated that **supervision, peer support and advice from senior colleagues all play a vital role in building the skills and knowledge of the workforce**. Supervision was seen as playing an important part in helping practitioners and carers to manage the emotional impact of the work and was associated with increased confidence. Supervision was more commonly accessed than peer support and team-based learning, but there was inconsistent access to all of these methods of support. It may therefore be beneficial for local agencies to **share their supervision practice and strategies in order to strengthen support across the multi-agency partnership** for those working directly with children displaying HSB. **Peer support and team-based learning could usefully be further embedded so that practitioners across areas and agencies can benefit.**

*There are signs of some strong partnership working, but there is scope for specialist HSB services to work more closely with other agencies*

A perceived lack of specialist services and placements for children displaying HSB was felt to be one of the key challenges in working in this area. A minority of respondents were aware of a specialist service in their area, with 24 per cent of those saying that specialist service thresholds were set too high. This perspective *may* be related to the fact that many professionals identify gaps in their knowledge, skills and confidence and so do not always feel equipped to undertake direct work themselves. Only a minority of these specialist services were reported to provide support to practitioners working with children displaying HSB. This gap formed part of a mixed picture in terms of partnership working. Encouragingly, most managers and leaders felt supported by wider partners in the work with children displaying HSB. Information sharing, consistent management of HSB and different approaches to early intervention were all highlighted as challenges, however. With these issues in mind, it is **important that knowledge and skills held by a specialist HSB service are shared across the wider workforce in order to build capacity and confidence.** This should underpin wider improvements in workforce development, enabling practitioners to learn from local specialist services rather than only referring children to these services (though the latter remains an essential part of any local response).

*Many of the potential enablers to increasing workforce knowledge skills and confidence are relatively low cost and go beyond traditional training*

Reflecting on the support that practitioners said they could benefit from, and how levels of confidence are associated with accessing these, it is notable that **there are many options besides external training**. Other methods such as team-based learning; reflective group and one-to-one supervision; structured peer-learning activities; shadowing; protected time for self-directed study and access to managers' expertise were all cited as being helpful. Thinking creatively about how such activities can contribute to the development of the workforce may prove to be more cost-effective than relying only on traditional training.

# Introduction

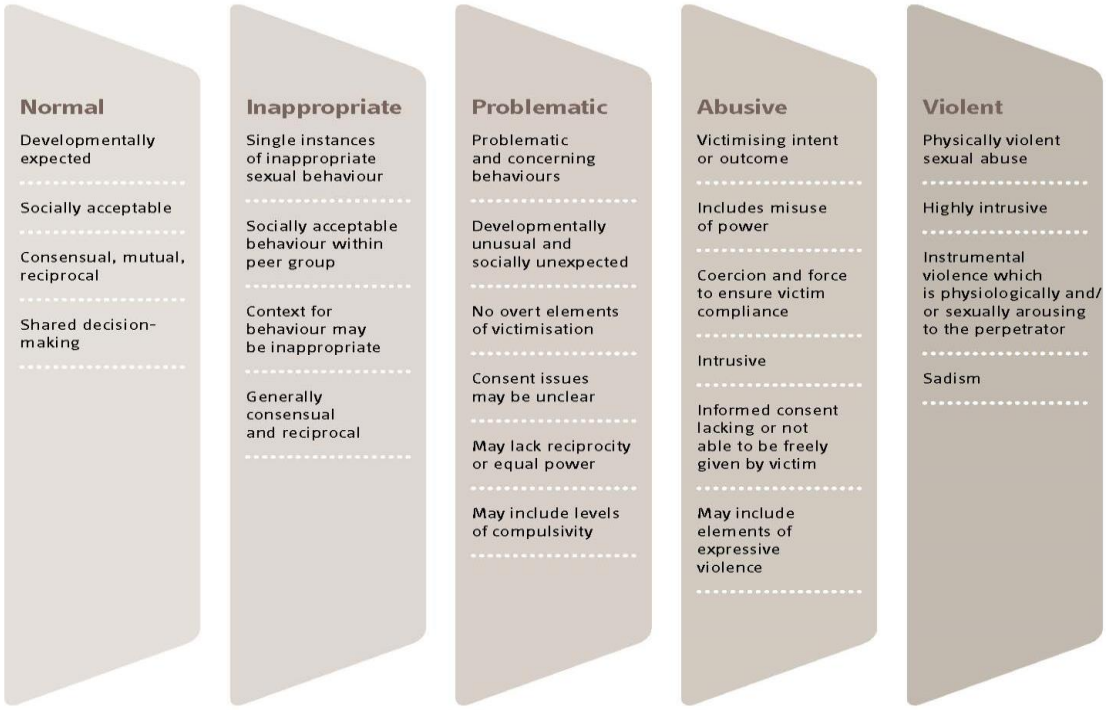
## What is harmful sexual behaviour?

This research has been designed using the following definition of harmful sexual behaviour (HSB):

> "Sexual behaviours expressed by children and young people under the age of 18 years old that are developmentally inappropriate, may be harmful towards self or others and/ or be abusive towards another child, young person or adult."
> *(Hackett, Holmes and Branigan, 2016)*

It must be stressed that this term encompasses a wide range of behaviour that may or may not be abusive. Hackett's (2010) continuum of children and young people's sexual behaviours helpfully illustrates the range of behaviours under consideration and their interaction with other sexual behaviours. In this continuum, problematic, abusive and violent sexual behaviours may all be considered harmful (see Figure 1).

**Figure 1: Continuum of children and young people's sexual behaviours (Hackett, 2010)**




## A contested and challenging area of practice

The UK has seen a steady increase in awareness of young people coming to the attention of professionals because of their sexual behaviours (Hackett, 2016). It is thought that between a third and two thirds of contact sexual abuse reported by children and young people is perpetrated by other children and young people under the age of 18 (Hackett, 2014; Radford *et al*, 2011). Less is known about the prevalence of HSB that is 'problematic' but not abusive.

Looking across the country, some common challenges and shortfalls have been identified in provision for children and young people displaying HSB. In particular:

- Evidence on the use of models designed for adult sex offenders to treat children and young people who may not have been convicted and are often themselves particularly vulnerable (Hackett *et al*, 2012; Harris *et al*, 2015).
- Indications that there is a lack of early identification and intervention to address and manage problematic behaviours before more serious incidents occur (Criminal Justice Joint Inspection, 2013).
- Weaknesses in the consistency and effectiveness of interventions across local authority areas (Smith *at al*, 2014; Criminal Justice Joint Inspection, 2013).

This all suggests that this is an area where practice can be improved. However, it is important to recognise that services looking to take this forward face a number of challenges:

- Stigma and shame may lead to under-reporting and the hidden nature of abuse makes recognition difficult.
- Harmful Sexual Behaviour can be understood to overlap with child sexual exploitation (CSE) (where CSE is peer-perpetrated) and with intra-familial child sexual abuse (e.g. sibling abuse). This can present challenges in terms of service response and local strategy.
- Many children and young people who display HSB may also be victims of it at the hands of others and/or may be vulnerable for other reasons (see chapter one). These dual identities can be particularly conceptually challenging given the emotive nature of this issue and increased public awareness of particular types of HSB such as child sexual exploitation.
- The needs of children and young people displaying HSB has received relatively little attention with the policy arena. There is currently no national strategy or overarching service delivery framework. Furthermore, it is not currently addressed in the main guidance for local agencies on safeguarding and child protection, *Working Together to Safeguard Children* (HM Government, 2015); although it is acknowledged in *Working Together* that children may commit acts of sexual abuse, there is no acknowledgment of the continuum of children's sexual behaviour (NICE, 2016). Services working with children and young people have therefore arguably had to identify their own way of supporting these children and young people using their own wider resources.
- Despite progress, there remains a dearth of evidence from the UK to inform practice that covers the full range of HSB and the needs and experiences of those who display it.
- The services that identify and support children and young people displaying HSB, as part of the wider public sector, face challenges in meeting demand for their services with limited and sometimes shrinking funds. Such a situation limits opportunities for investment in new services and leaves the existing workforces with limited time to engage in development and training.

# Focus of this research

Participating local authorities identified that workforce needs and confidence was a key area of interest. This research therefore pays particular attention to the confidence, knowledge, skills and development opportunities of those working with children at various levels of local services.

In an important step forward for this field of work, the National Institute for Health and Care Excellence (NICE 2016) recently published its *Guideline on harmful sexual behaviour among children and young people*. Based on consideration of available evidence this NICE guideline sets out recommendations across the range of work with children and young people with HSB, including:

- multi-agency approach and universal services;
- early help assessment;
- risk assessment for children and young people referred to harmful sexual behaviour services;
- engaging with families and carers before an intervention begins;
- developing and managing a care plan for children and young people displaying harmful sexual behaviour;
- developing interventions for children and young people displaying harmful sexual behaviour;
- supporting a return to the community for 'accommodated' children and young people.

By focusing on workforce needs, LARC presented an opportunity to test the extent to which practitioners and managers are able to adopt the NICE recommendations, and the topics explored by the LARC study reflect to some extent the pathway set out in the guideline. For example, the LARC national survey asked respondents about their confidence in various stages such as identification, care planning and working with parents. In recognition of the multi-agency response recommended by the guideline, the sample and analysis sought to ensure that all key stakeholders were represented. This includes not just children's social care and specialist mental health services to which children displaying HSB may be referred, but also all those who may be professionally involved in identifying HSB and working with and caring for children who display HSB.

# About LARC 7

LARC, the Local Authorities Research Consortium, was founded by Research in Practice and the National Foundation for Educational Research (NFER) to support local authorities to develop sector-led collaborative research projects. For this round of LARC, the National Children's Bureau (NCB) carried out the role previously carried out by NFER.

LARC supports local authorities to undertake research in order to inform improvements to services for children, young people and families. This is the report of the seventh research project undertaken by LARC. The research topic and design was developed by Research in Practice, NCB and the six local authorities participating in LARC 7. The participating local authority areas were made up of:

- Two non-metropolitan counties.
- Two Metropolitan Borough Councils from the Midlands and North of England.
- Two London Boroughs.

As well as participating in this national project, each participating local authority has been supported by NCB and Research in Practice to carry out their own local research into a related topic. More information on local research is provided in chapter 6.

This research is not intended to assess or comment upon the performance of individual local authority areas In relation to HSB. Rather, the project and this report seeks to share learning about challenges that many areas will likely be facing, and to do so openly and honestly. Participating local authority areas are not named in this report.

# Methodology

This report is based on the results of an online survey completed by practitioners, carers, managers and commissioners, spanning the multi-agency partnership across the six participating local authority areas of LARC 7. The survey was distributed by local authority participants through local channels.

Separate questions were asked of two key groups:

- Practitioners working directly with children and young people and foster carers (shortened to 'practitioners and carers' or 'practitioners' in discussion of results throughout this report).
- Team, service and strategic managers and commissioners (referred to collectively as managers and leaders).

Both groups were asked about their respective knowledge, skills, confidence and support they had received to develop these, in relation to their role in supporting children and young people displaying HSB. Managers and leaders were also asked for their assessment of their staff's knowledge, skills and development opportunities. Most questions used pre-coded response lists (ie. were multiple choice), leading to the mainly quantitative analysis that follows in the body of this report.

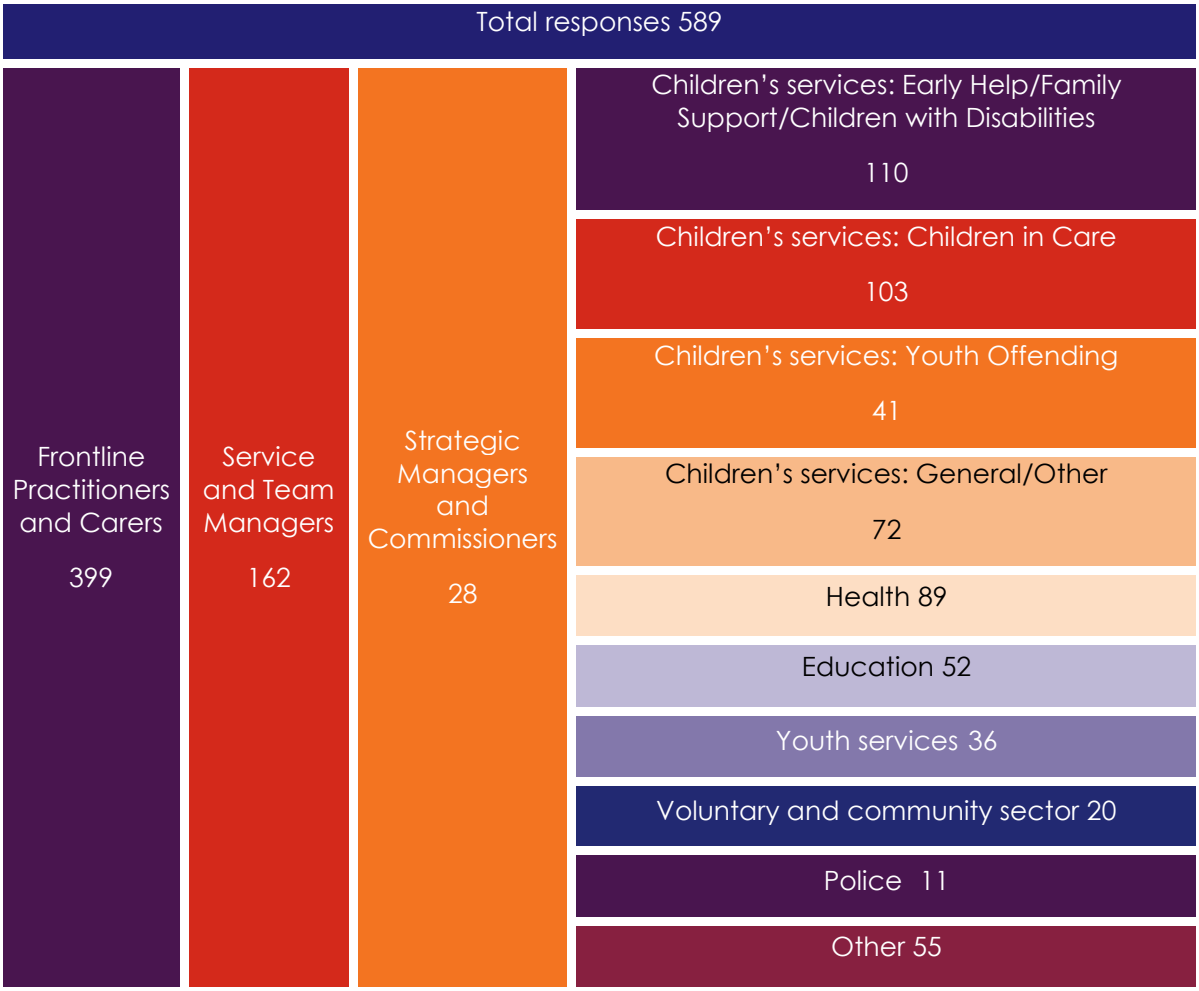
To ensure parity of respondents' underpinning interpretation, the concept of Harmful Sexual Behaviour was explained at the beginning of the survey. The information provided included the Hackett, Holmes and Branigan (2015) definition and Hackett's (2010) continuum of children and young people's sexual behaviours (See 'What is harmful sexual behaviour', above).

See Appendix 2 for the survey that was issued to respondents.

# Respondents

The number of responses from different types of respondent are summarised in Figure 2**.** Some of the categories relating to which agency respondents worked for have been created by combining several categories included in the relevant survey question. In quantitative analysis of results, the categories 'police', 'youth services' and 'voluntary sector' have been included in the 'other' category as well as those who did not feel any of the provided categories described where they worked. See Appendix 1 for a full description.

**Figure 2: Roles of survey respondents**




# Reading this report

In reading the findings of this research, it is important to bear in mind the methods used, and the constraints they bring in interpreting the results.

The six participating local authorities all volunteered to take part and, were therefore all self-selecting, though they did reflect a range of authority types and geographies. Furthermore, the respondents to the local surveys were also, to some extent, self-selecting. Finally, participating local authorities each adopted their own approach to securing responses from a wide range of participants which is not recorded here.

This kind of approach tells us something about the individuals who participated in the survey in those local areas taking part in the research but they cannot be said to be statistically representative of the wider population of professionals working with children with HSB. From a strict random-probability sampling approach (or even quota sampling approach), the methods used here **do not** allow us to extrapolate or to infer about wider populations, either about all the relevant staff in the participating local areas, or about LA practice or other agency practices in general across the country. The recommendations included in this report are therefore based on our assumption that issues arising in the participating LAs also arise in other similar authorities across England. These recommendations will be most relevant for those areas that recognise similar issues to those identified in this report; they are not necessarily applicable to all areas.

Finally, when reading this report, it is important to remember that the **results are based on the self-reported perceptions of the individuals who responded**. The accuracy of those perceptions – for

example, about the existence of local protocols or services, the prevalence of HSB in an area, or about the sufficiency of different professionals' knowledge and skills, was not separately verified as part of this research.

In this report, when we refer to 'children' this means children and young people aged under 18. If any finding specifically relates to younger children or older 'young people' this is specified.

## Structure of this report

This report is structured as follows:

**Chapter 1: The needs of children with harmful sexual behaviour** sets out what the survey found about the children displaying HSB with whom professionals and services were working, including other factors that may be affecting these children. It explores some of the related challenges in this area of work identified by professionals.

**Chapter 2: Systems and services for children displaying HSB** looks at what services for children were available locally, approaches to assessing and working with children displaying HSB and the coordination of multi-agency work.

**Chapter 3: Confidence, knowledge and skills for the workforce** sets out what respondents said about their own awareness of HSB and about their confidence, knowledge and skills in working with children displaying HSB.

**Chapter 4: Supporting the workforce** sets out findings in relation to how the workforce were trained, supported and guided in their work with children displaying HSB.

**Chapter 5: Priorities for policy and practice development** discusses the implications of the findings, and suggests four priority areas for improvement and how these might be taken forward by local agencies.

**Chapter 6: Further research** sets out further areas for research being taken forward by the participants of LARC 7.

# 1 The needs of children displaying harmful sexual behaviour

## Key findings

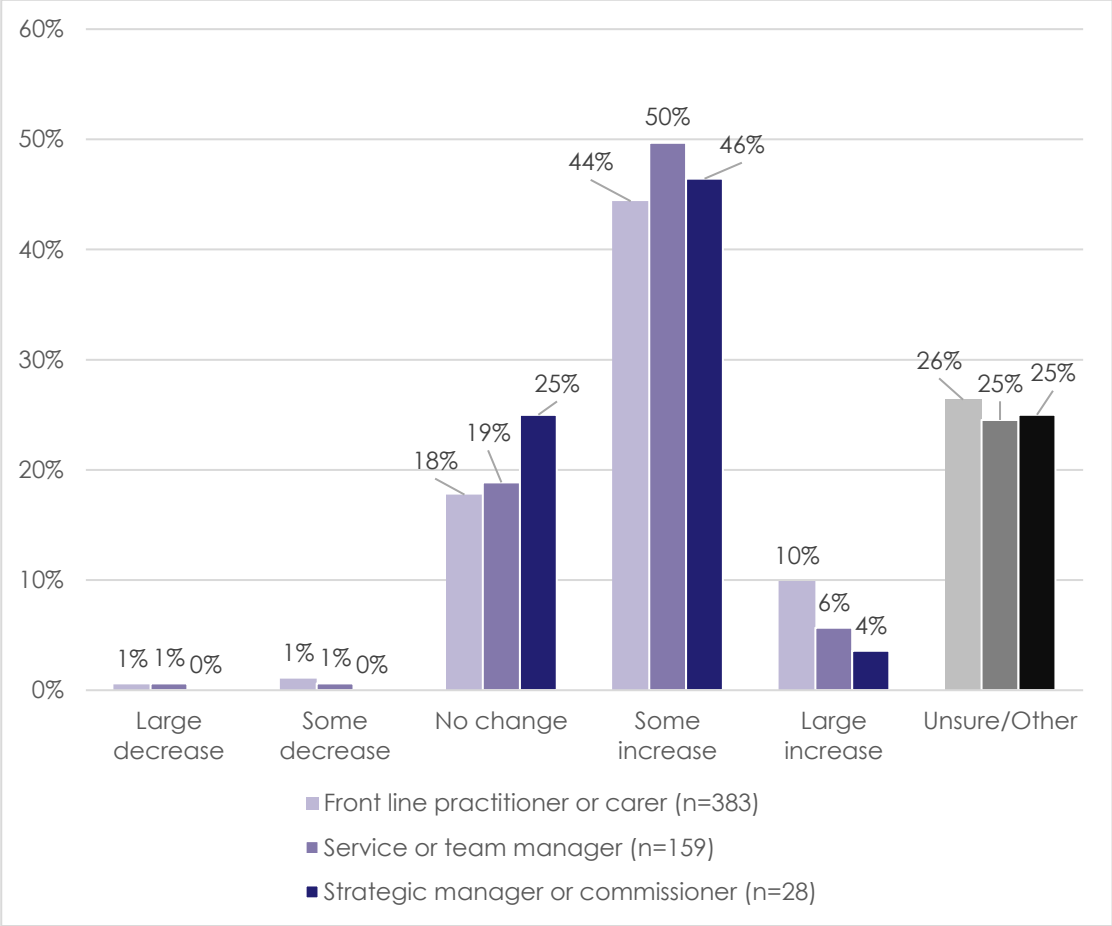
- Professionals from a wide range of agencies had experienced working with, or a caring for, children with HSB.
- The workforce commonly considered children displaying HSB to also be victims of sexual and other types of abuse and maltreatment.
- There was a range of other challenges and/or additional needs which children displaying HSB may be receiving support for, such as special educational needs, or being a child in care.
- A combination of the nature of HSB and the other issues affecting these children presented challenges around:
    - building trusting and constructive relationships between professionals and children; and
    - balancing the needs of children with HSB and the needs of those around them.

## 1.1 Experience of working with children displaying HSB

Over half (56%) of the practitioners and carers who responded to the survey said that they had worked with between one and five children or young people displaying HSB in the previous year. Over a quarter (27%) said that they had worked with more than five children displaying HSB. A minority of practitioners and carers (1%), and of managers and leaders (11%), said that they or their agency had worked with over fifty such children or young people during this time. This reflects their role and organisational focus.

Figure 3, overleaf, shows that at least half of respondents *thought* that there had been some increase in the number of children displaying HSBs over the last two years. Strategic managers and commissioners were more inclined than other groups to say there had been no increase, practitioners and carers were more inclined than managers to report that there had been a large increase.

**Figure 3: Perceived change in the number of children displaying HSBs in the last two years**




Base: see legend

It is hard to ascertain the prevalence of HSB. Research by Barnardo's (2017) found that over 9,000 *recorded* child sex offences were perpetrated by children aged between 10 and 17 in 2016. This does not include any HSB displayed by a child under the age of 10 (the age of criminal responsibility) or by any child or young person above that age in instances where the behaviour was not deemed an offence. It is thought that between a third and two thirds of contact sexual abuse reported by children is perpetrated by other children under the age of 18 (Hackett, 2014; Radford *et al*, 2011). Again, this would not take account of instances where HSB does not involve abuse.

This research does not attempt to calculate any estimate of prevalence of all HSB from the results of the LARC survey, rather to explore professionals' perspectives on the scale of the issue. It is important to note that perceived increases in children displaying HSB could be a result of increased awareness of the issue amongst professionals and society at large. The results do underline the point however, that HSB should not be seen as something that happens in rare instances, but increasingly something that all agencies working with children need to know how to identify and respond to.

## 1.2 Interaction of HSB with other vulnerabilities or disadvantage

Research suggests that children displaying HSB are likely to be experiencing other vulnerabilities and negative experiences. In particular, it has been suggested that significant proportions of those displaying HSB have themselves been victims of abuse. An evidence scope published by Research in Practice (Hackett, 2016) found that:

- Estimates of children with HSB who have also been subject to sexual abuse range from 26 per cent to 84 per cent.
- Estimates of children with HSB who have also been subject to physical abuse range from 21 per cent to 81 per cent.
- Estimates of children with HSB who have also been subject to emotional abuse range from 10 per cent to 50 per cent.
- Estimates of children with HSB who have also been subject to neglect range from 12 per cent to 48 per cent.

This interaction between HSB and other factors is reflected in the results of this workforce survey. Respondents were asked what to estimate the proportion of the children with HSB they had worked with were also affected by other specific factors. Looking at the experiences of those who had worked with more than five children displaying HSB over the past year:

- 23 per cent (*base: n*=189) said they believed most or a lot of these cases involved a child who had experienced sexual abuse by others.
- 37 per cent (*base: n*=183) said they believed most or a lot of these cases involved a child who had experienced other types of abuse by others.
- 43 per cent (*base: n*=183) said they believed most or a lot of these cases involved a child who had experienced neglect.

As set out in Table 1, children displaying HSB were also reported to face high incidences of other challenges. These included domestic violence, exclusion from education and difficulties with social skills. Fewer respondents, but still a significant proportion, thought that the children displaying HSB that they worked with were also affected by social isolation, poverty or offending.

**Table 1: Factors affecting children displaying HSB as perceived by respondents who worked with six or more children displaying HSB in the last year**

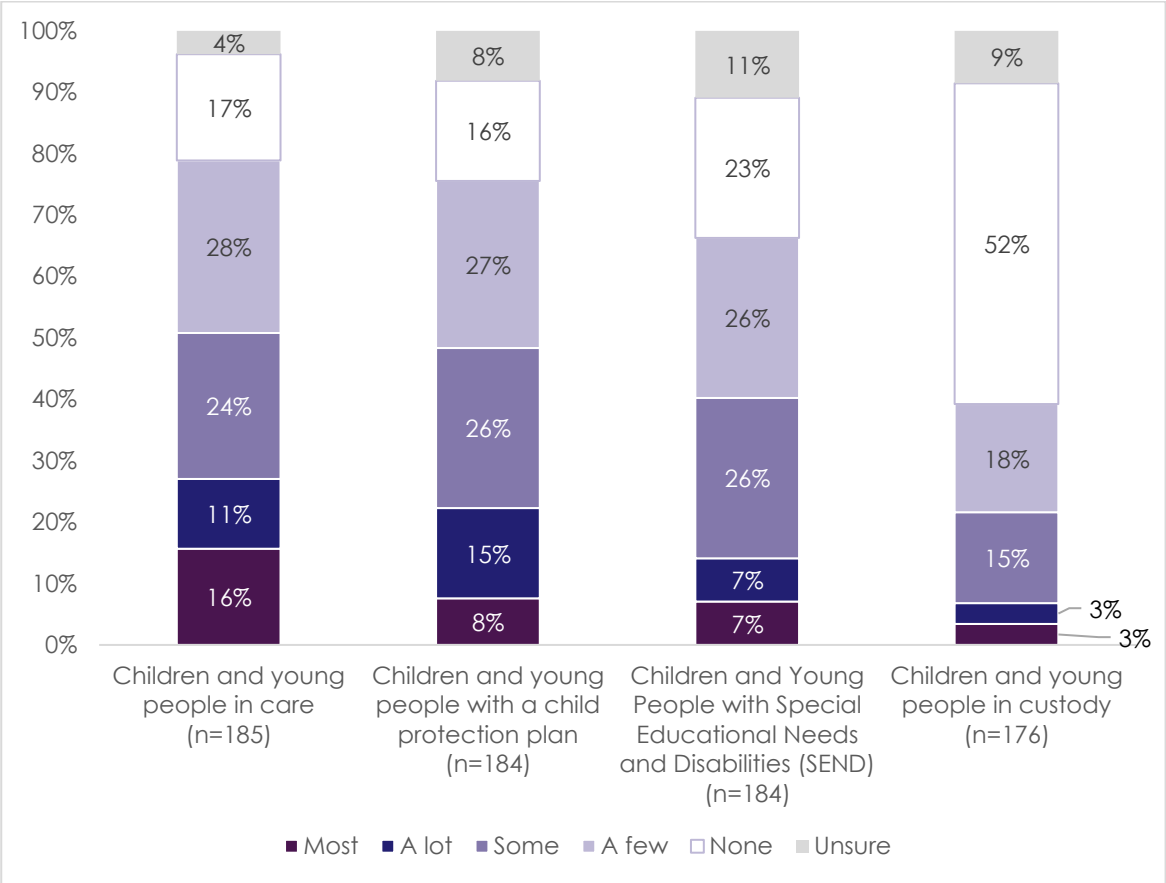
| | Base[1] | **Respondents who worked with six or more children displaying HSB in the last year reporting 'most' or 'a lot' were also affected by these factors** |
|---|---|---|
| Neglect | (*n*=185) | 43% |
| Difficulties with social skills | (*n*=185) | 43% |
| Abuse from others (non-sexual) | (*n*=183) | 37% |
| Mental Health Problems | (*n*=186) | 36% |
| Domestic violence | (*n*=184) | 33% |
| Exclusion from education | (*n*=183) | 33% |
| Social isolation | (*n*=184) | 30% |
| Poverty | (*n*=178) | 26% |
| Sexual abuse from others | (*n*=189) | 23% |
| Offending | (*n*=182) | 19% |

Children displaying HSB may have significant contact with services either because of the HSB itself or as a result of other needs and challenges such as those set out in in Table 1. Figure 4 sets out estimated proportions of children displaying HSB with whom respondents had worked that were also in particular categories receiving statutory intervention. Many of these children were reported as being in care or the subject of a child protection plan.

Again, these questions were not intended to establish local needs data, but to explore what professionals and carers *perceived* to the be the needs and characteristics of the children they support.

[1] The base for this question varies as respondents could choose to just answer in relation to just some of the listed factors. An 'unsure' option was provided in all cases and is included in the base.

**Figure 4: Estimated proportions of children displaying HSB with whom respondents had worked who were also receiving statutory intervention**




Base: see column labels

# 1.3 Key challenges

The survey asked an open question about what challenges people experienced in working with children displaying HSB. Many responses pointed to things felt to be lacking in the local provision for children with HSB, which is discussed in Chapter 2. Responses to this question also described, however, some inherent challenges in working with this particular group of children.

## 1.3.1 Balancing needs, safety and risk

Respondents highlighted that it could be difficult to balance the needs and safety of everyone who is affected, or potentially affected, by HSB. For example, there was awareness of the need to ensure that the child displaying HSB was not denied an education and other life opportunities in the pursuit of managing risk. The word 'unpredictability' was commonly used in respondents' comment, highlighting a concern that it is hard to judge the risk a child or young person poses to others at a particular time or place.

> "Schools find this behaviour difficult to understand and manage in a group setting. Exclusion from school or isolation from others may be an outcome"
> *Strategic manager, services for children in care*

Respondents also expressed concern about deciding to what extent a child or young person's confidentiality should be protected when making judgements about information-sharing. Another

concern raised by several respondents was the need to keep staff, who were working with the child, safe. Some referred to the need to undertake risk assessments to carefully consider who was working with the child. One manager from a service that employed volunteers explained that they would usually struggle to find a volunteer to work with children displaying HSB.

### 1.3.2 Engaging with children

Engaging with children and ensuring that they understand the support being offered is to *help them* to address something that is affecting them negatively was seen as a challenge. Tackling this successfully is dependent on surmounting two particular obstacles:

*Building trust with a child or young person who is understandably reluctant to discuss their behaviours with an adult:* Some respondents suggested that this could be difficult if they had little time to spend with each individual who needed their support. High caseloads were identified by respondents as a key barrier to developing these relationships.

The influence of other people in the child's life may also obstruct the formation of trusting relationships. It was suggested by some respondents that parents may impede this engagement because they feel they are being judged, are experiencing shame and/or they are afraid of other risks – possibly even maltreatment - being discovered. This touches on another challenge which was identified by many respondents, that of working with parents who do not understand or who deny that there is a problem, and so may impede or undermine engagement with professionals. Others may block engagement too; it was felt that in cases of sexual exploitation, pressure may have been put on the child not to discuss their 'relationship', or their loyalty may have been 'bought' with gifts.

*Helping the child or young person to understand that the behaviour is problematic/harmful:* It was suggested that children displaying HSB may think what they are doing is 'normal' because they believe that everyone in their peer group does it.

> "They are reluctant to talk about it, even with family members and especially with people they don't know. For many children they don't have an understanding of it being harmful behaviour."
> *Children's services practitioner*

The importance of children understanding the impact of their actions (on themselves and others) was repeatedly highlighted. Several respondents described how children abusing others may not take responsibility for their actions, sometimes because they blame the 'victim'. Several other respondents acknowledged that children with HSB are often vulnerable themselves because of a background of abuse or particular needs such as learning disabilities and autism. One health practitioner suggested that it was not always clear which of these challenges may be affecting the children concerned. When asked to identify three challenges in working with children with HSB they asserted:

> "1. There is usually a background of likely abuse, 2. this background is strongly denied by the parent, who 3. insists the child is autistic."
> *Health practitioner*

This research does not attempt to verify or counter these assertions, though it should be noted that the wider literature indicates children with HSB should not be assumed to have experienced sexual abuse (Hackett, 2016). Instead this project explores professionals' perspectives on the issue, with a view to understanding the development needs of the workforce.

# 2 Systems and services for addressing harmful sexual behaviour

## Key findings

- Many professionals used specific tools developed by a third party to help them assess the needs of children displaying HSB.
- Respondents identified a lack of specialist services and placements to refer children displaying HSB as one of the key challenges in working in this area. Around a third (34%) of respondents were aware of specialist service in their area, with 24 per cent of those saying that specialist service thresholds were set too high.
- Specialist services tended to provide specialist assessment and direct support to children. Residential placements and provision of support to practitioners working with children displaying HSB appear to be less common.
- Some agencies and services had a policy or strategy on children displaying HSB. These were less common in education, health and early help/family support/disabled children's services than, for example, services for children in care and youth offending services.
- Whilst there were some signs of strong partnership working, challenges also exist. Most managers and leaders felt supported by wider partners in the work on children displaying HSB, however, only a minority of all respondents were aware of multi-agency policies (38%), strategies (32%), and referral pathways(38%) in their area.

## 2.1 Approaches and tools for identifying, assessing or supporting children displaying HSB

Respondents were asked to specify any particular tools and/or approaches used in their area for identifying, assessing or supporting children who display HSB. The purpose of this was to build a broad picture of the approaches being taken to assess and address HSB in children. This research does not explore the strength of evidence underpinning these tools (for more on this, see NICE 2016), but rather professionals' awareness and access to tools.

A number of specific tools were identified for working with children who may be beginning to display HSB. Some of those tools mentioned by multiple respondents are described in Figure 5. Several respondents made reference to their areas' or services' standard procedures for addressing safeguarding concerns, such as child protection conferences or initial assessments by children's services. Similarly, some referred to the standard needs assessments carried out by youth offending teams and mental health services. It is not clear from such responses whether these procedures include specific consideration of HSB or they are simply the default response to any concerns about a child or young person's welfare. Having said this, one aspect of AIM (see Figure 5) is indeed the integration of consideration of HSB into mainstream assessments by children's services. Many respondents also referred to a child sexual exploitation screening tool or assessment framework.

In terms of broader practice approaches, several respondents described the efforts they made to building trusting relationships and effective open communication in order to better understand the needs and behaviours of children with HSB.

**Figure 5: Tools for assessing and supporting children displaying HSB noted by respondents**

**AIM– Assessment, Intervention, Moving on**: A suite of tools for assessment and intervention with children who display sexually harmful behaviour first developed by children's services, youth offending teams and partners in Greater Manchester. A key aim is to enable existing services to identify and respond to children displaying HSB, avoiding over-reliance on discrete, specialist services. The suite includes the popular AIM and AIM2 models for assessment of children displaying HSB.
http://aimproject.org.uk/

**Sexual Behaviours Traffic Light Tool**: A tool initially developed in Australia, but adapted for used in the UK by the charity Brook, which uses a traffic light system to categorise the sexual behaviours of young people.
https://www.brook.org.uk/our-work/category/sexual-behaviours-traffic-light-tool

**Protective Behaviours**: A safety awareness and life skills programme which aims to help children and adults to recognise any situation where they feel worried or unsafe, such as feeling stressed, bullied or threatened. It is be used as an abuse prevention strategy, as well as promoting good citizenship, and is employed by a wide range of professionals and agencies.
https://www.safety-net.org.uk/protective-behaviours/what-is-protective-behaviours/

**Spotting the Signs:** A proforma developed by Brook and the British Association of Sexual Health and HIV to help health professionals across identify young people attending sexual health services who may be at risk of or experiencing sexual exploitation.
https://www.brook.org.uk/our-work/spotting-the-signs-cse-national-proforma

## 2.2 Specialist services

34 per cent of respondents (n=586) said that they were aware of a specialist service for children displaying HSB in their area[2], whilst a further 24 per cent said that they were unsure. Respondents described a range of services including those provided by the voluntary and community sector (principally NSPCC and Barnardo's), child and adolescent mental health services (including specialist services for HSB or consultants within these services), youth services, secure children's homes and early help/family support.

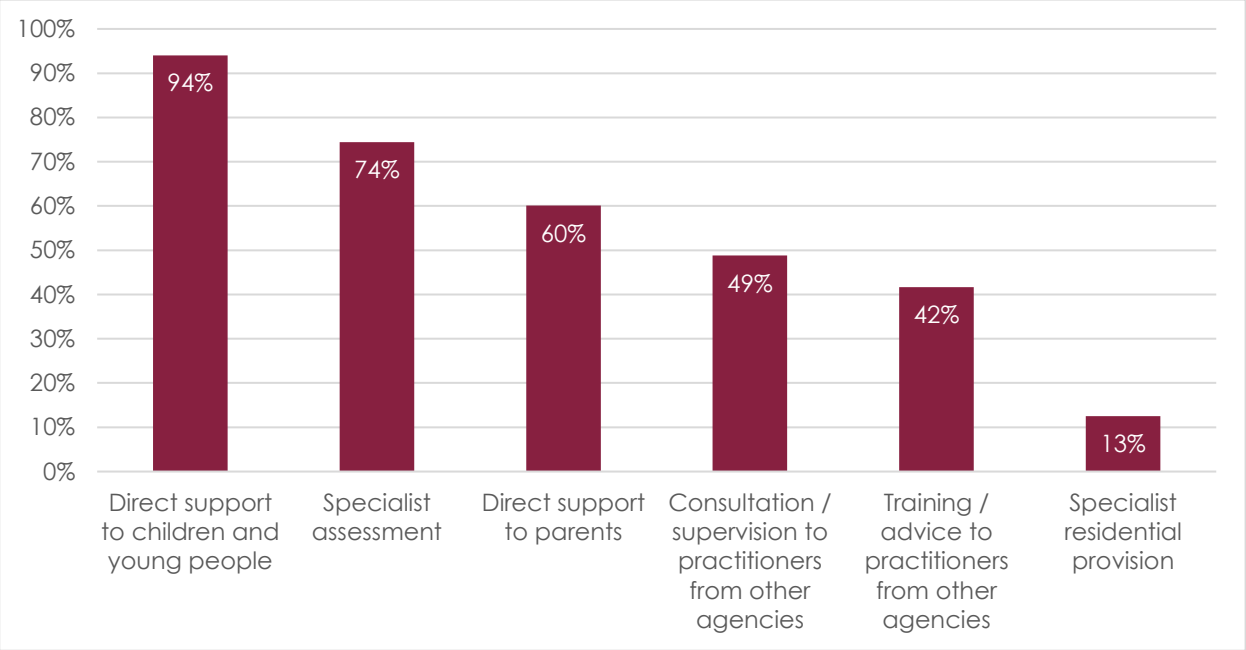
A perceived lack of available treatment and therapeutic services was highlighted by many respondents answering an open question about challenges in working with children with HSB. Several also suggested that it was hard to find placements for children in care displaying HSB. When asked specifically about the threshold for their local specialist services, 24 per cent of respondents (n=236) thought that it was set too high, compared to 42 per cent who thought it was set about right and four per cent who thought it was too low.

The percentages of respondents who said their local service fulfilled particular functions are set out in Figure 6. Of those who answered questions about what these specialist service provides (base: n=168), 94 per cent said that their local specialist service provided direct support to children and 47 per cent said that it provided specialist assessment. Fewer than half said that it provided either consultation/supervision (49%) or training/advice (42%) to practitioners from other agencies. Where

[2] This figure excludes 36 respondents who said that they were aware of a service, but in their description of this, named only a service known to be aimed at victims of child sexual exploitation.

the local service provided these functions, practitioners generally reported higher levels of confidence in working with children with HSB.

**Figure 6: Proportion of respondents reporting that their local specialist service fulfils particular functions**




Base: n=168

## 2.3 Strategies and plans of individual agencies

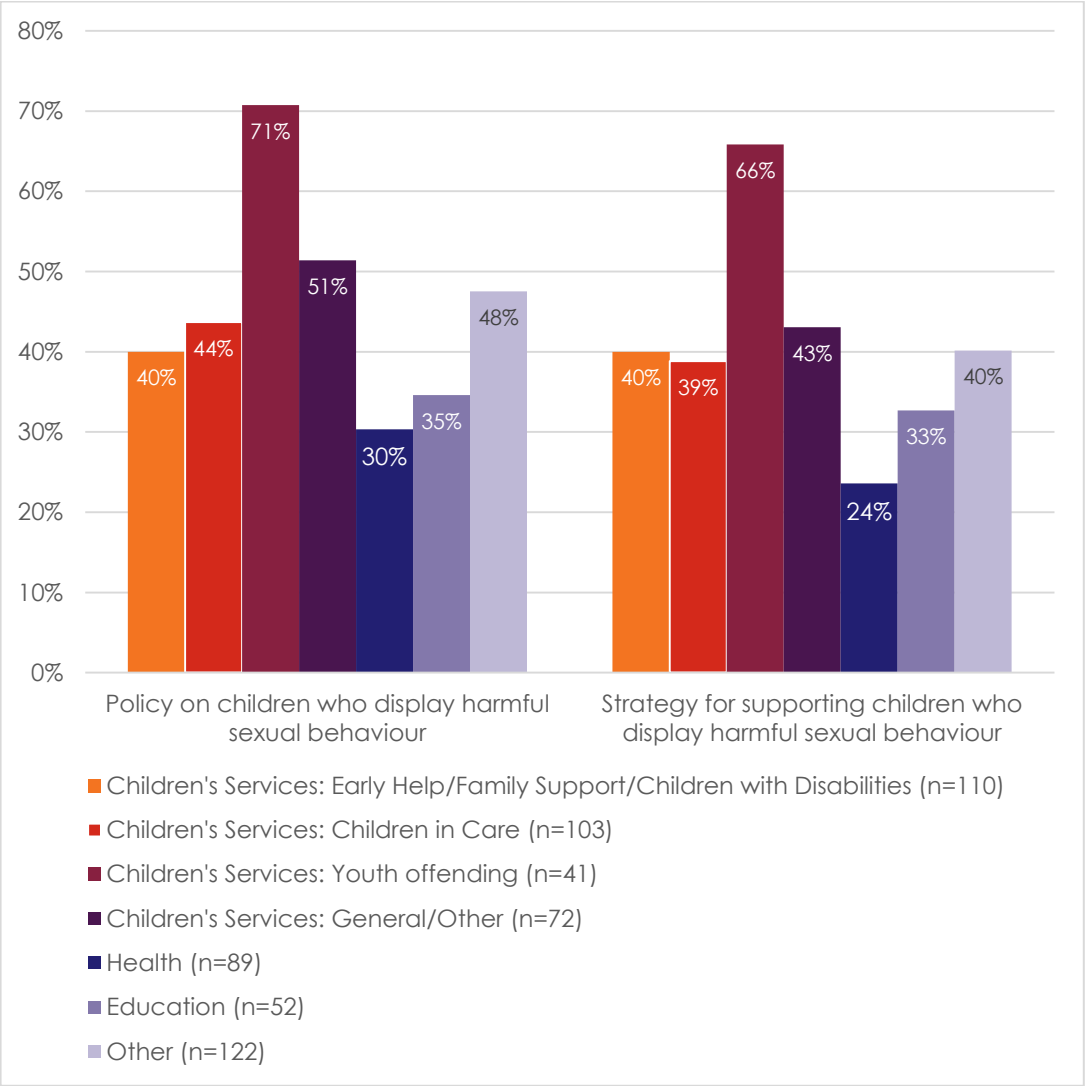
Respondents were asked if their agency had a policy on children who display HSB or a strategy for supporting them. Variations in responses to this question could also reflect varying awareness of policies and strategies; responses did not necessarily indicate whether these policies and strategies existed in particular areas or organisations.

Whilst 71 per cent of those working in youth offending said that their organisation had a policy on children who display harmful sexual behaviour, this figure was much lower for those working in health (30%) and education (35%). Responses regarding strategies for supporting children with HSB showed a similar pattern. The full results to this question are set out in Figure 7.[3]

It is important to bear in mind that the perceived need for a policy or strategy may depend on the role that the agency or service in question plays in the pathway of support for children displaying HSB. A health service, for example, may have a discrete role to provide specialist treatment for child displaying HSB, which only those directly involved might need to understand. A setting where a child is present on a day to day basis, such as residential care or a school, may need to implement a multifaceted response and therefore may be more likely to benefit from a policy document setting out agreed procedures.

[3] The base for these calculations is the total number of respondents who reported working for the specified agencies.

**Figure 7: Proportion of respondents from different agencies and services reporting their organisation having a policy and/or strategy regarding HSB**




Base: see legend

## 2.4 Partnership Working

Whilst there were many positive responses about interagency working relationships, this was also identified by many as a challenging aspect of working with children with HSB. Specific concerns included in consistent information sharing about individual children and a lack of shared understanding of what HSB is and what support should be provided.

> "Other agency support is lacking in regard to getting support for these young people at an early stage."
> Youth Offending Practitioner

> "Lack of consistency in management of sexual harmful behaviour, including inconsistent communications from agencies or professionals."
> Mental health practitioner

> "The sharing of information from other professionals is hard to gather and therefore difficult to have the whole picture about a child."
> Practitioner in Early Help

All respondents were asked about the infrastructure available to support multi-agency working with children displaying HSB. 38 per cent (base: n=590) said that their area had a multi-agency policy, 32 per cent a multi-agency strategy and 38 per cent a multi-agency[4] referral pathway. It must be stressed that these results reflect the *awareness* respondents had regarding such policies and strategies, rather than the *existence* or otherwise in the six local areas taking part in LARC 7. In two of the six areas[5] taking part in LARC 7 over 40 per cent said that they had a multi-agency policy, in one area[6] over 40 per cent said that they had a multi-agency strategy and in three areas[7] over 40 per cent said they had a multi-agency referral pathway.

Encouragingly, there was also evidence of strong relationships supporting multi-agency partnership working. 44 per cent of managers and leaders (base: n=191) said that they felt supported by the wider partnership in the field of children displaying HSB, compared to just 17 per cent who disagreed (none strongly disagreed).

[4] See Footnote 3
[5] bases: n=103, n=72
[6] base: n=103
[7] bases: n=103, n=72, n=56

# 3 Confidence, knowledge and skills of the workforce

## Key findings

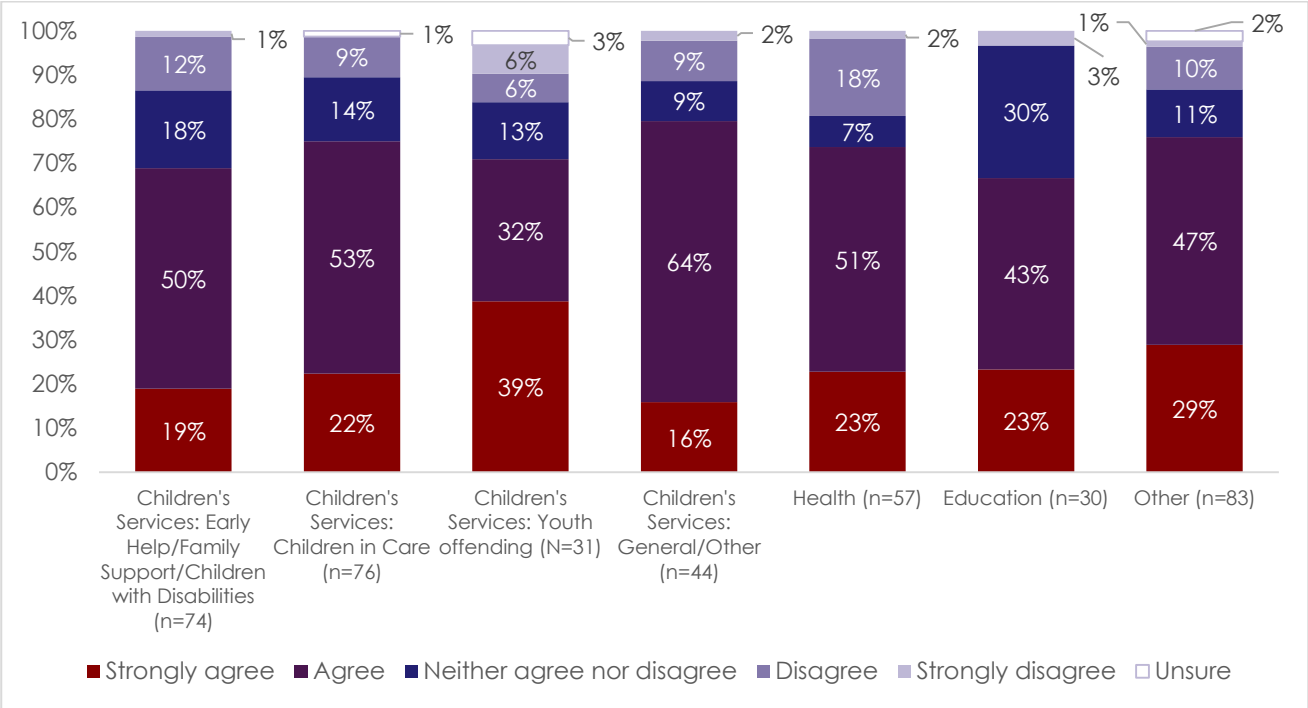
- Most practitioners and carers felt that they knew what HSB is. However, a significant minority did not.
- Many practitioners and carers felt they did not have the knowledge and skills for working directly with children displaying HSB. Notably, this included significant proportions of those who had worked with several of such children over the last year.
- Practitioners had more confidence in their knowledge and skills for assessing and identifying children with HSB and their ability to manage the emotional impact of working in this field.
- Responses suggested that there were many very skilled and knowledgeable professionals working in this field. However, not all of the relevant parts of the children's workforce reported high levels of confidence, particularly in their ability to:
    - Identify children displaying HSB;
    - Work directly (delivering interventions) with children displaying HSB;
    - Lead partnerships; and
    - Commission and design services.
- The work had a notable emotional impact on those carrying it out. Negative feelings such as anxiety, worry and being upset were experienced even by those reporting higher levels knowledge, skills and experience.

## 3.1 Awareness and understanding of HSB

### 3.1.1 Self-reported understanding

Understanding what HSB is enables professionals to identify and therefore better support children displaying HSB. Figure 8, below, sets out responses by respondents' agency/service area.

**Figure 8: Proportion of respondents from different agencies and services reporting confidence in knowing what HSB is**




Base: see column labels

The majority of respondents (73%, base: n=396) agreed or strongly agreed that they fully understood what HSB is. This figure was 66 per cent (base: n=30) for education providers and 69 per cent (base: n=74) for those working in early help, family support and services for disabled children. Those working in youth offending were most likely to strongly agree (39%, base: n=31) followed by those working in other services (such as youth services, policy and charities (29%, base: n=81). Further research would be needed to determine if this pattern is reflected across the country, as the base numbers for the categories discussed (particularly youth offending (base: n=44)) are low. When interpreting these results it should also be noted that responses to other questions (see sections 2.1 and 4.2, for example) suggest that several respondents may have confused HSB with child sexual exploitation. This is potentially not an uncommon confusion as some instances of HSB could indeed constitute CSE and vice versa.

## 3.1.2 Identification of children with HSB

When commenting on challenges relating to identifying HSB several respondents suggested that the boundary between harmful and acceptable sexual behaviour is difficult to judge and open to subjective interpretation. For example, some experimentation is part of normal development, particularly in adolescence. This may reflect the fact that whilst there are definitions of child sexual abuse and child sexual exploitation in statutory guidance (HM Government 2015) there is not currently a statutory definition for HSB.

> "Context and definition of 'harmful' can be open to personal interpretation."
> *Children's services manager*

Some respondents suggested that disagreement between different professionals and agencies was a barrier to providing timely support to children with HSB.

> "Identifying the threshold for sexually harmful behaviour amongst professionals. Disagreements to the levels of the behaviour leads to delays in investigations and actions taken to reduce sexually harmful behaviour."
> *Practitioner working in early help/family support*

## 3.2 Confidence of the workforce

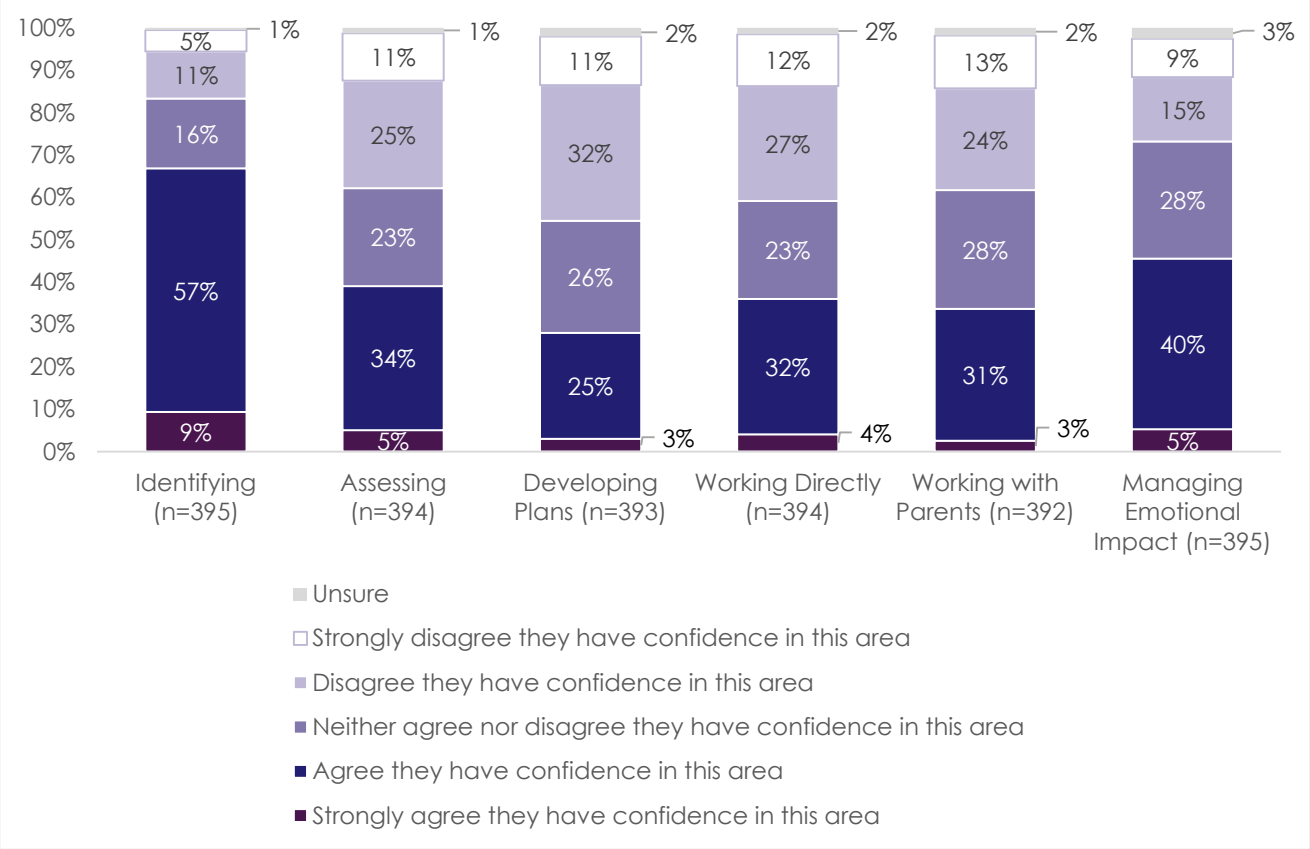
Ensuring children displaying HSB are identified and supported involves a number of professionals successfully carrying out a wide range of tasks. Respondents were asked a number of questions about how confident they felt in carrying out these tasks. It is important to note that the results discussed below (including those relating to knowledge and skills) offer no objective insight into individuals' capability to carry out their roles, but reflects how professionals from various agencies *feel* about these aspects of the work.

Respondents were asked about their **confidence** in relation to:

- **Identifying** harmful sexual behaviour in children and young people they work with/care for.
- **Assessing** children displaying HSB.
- **Developing plans** for children displaying HSB.
- **Working directly** (delivering interventions) **with children** displaying HSB displaying harmful sexual behaviour).
- **Working directly with parents** of children displaying HSB.
- Effectively **managing the emotional impact** of working with/caring for children displaying HSB.

Some parts of the support pathway for children with HSB, such as identifying that a particular child may be exhibiting HSB, will potentially involve all professionals that come into contact with children. Other more targeted work to address the identified behaviour may involve a select group of specialists. Reflecting this, Figure 9 shows that a higher proportion of frontline practitioners and carers reported confidence in identifying children displaying HSB than in developing plans for or working directly with children displaying HSB.

**Figure 9: Self-reported confidence of practitioners and carers in carrying out particular areas of work with children displaying HSB**




Base: see column labels

The majority (66%, base: n= 395) of frontline practitioners and carers agreed or strongly agreed that they were confident in *identifying* children displaying HSB. However, just 9 per cent strongly agreed. This relatively low proportion of respondents strongly agreeing was reported across the individual agencies and service areas considered by the analysis.

Looking at the total of respondents who *agreed* or *strongly agreed* they had confidence in a particular area of work **the area with the lowest confidence appears to be developing plans** for children with HSB. 28 per cent agreed or strongly agreed they were confident in this area of work compared to between 34 per cent and 66 per cent for other areas of work. There was also **relatively low confidence reported relating to working directly *children* with HSB,** with 36 per cent of respondents *agreeing* or *strongly agreeing* they had confidence this area of work. The same was true of confidence relating to **direct work with *parents***, with 34 per cent of respondents *agreeing* or *strongly agreeing* they were confident

Low levels of confidence in carrying out direct work with children and their parents may reflect some of the challenges in engaging with children discussed in 1.3.2, above. For example, if it is difficult to establish a trusting relationship with a child or young person, it may also be challenging to ensure that the child or young person engages in interventions to address their HSB. It may also reflect a potentially greater emotional impact of direct work, meaning the ability of practitioners and carers to manage this impact is a key driver of their confidence. Low levels of confidence in developing plans for children with HSB may reflect another challenge highlighted in 1.3.2 – that of professionals finding it difficult to balance the interests of a child displaying HSB with the safety of children and professionals around them.

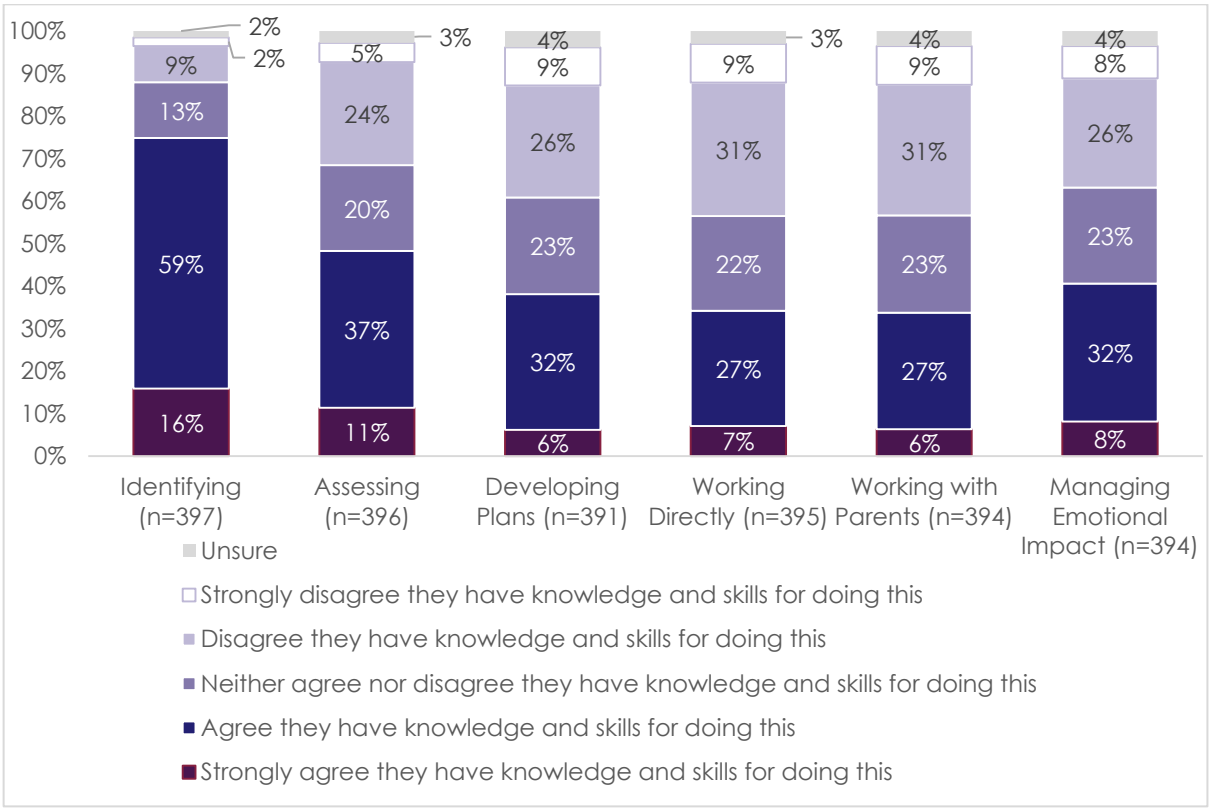
Managers and leaders reported varying degrees of confidence in fulfilling their roles in relation to children displaying HSB. **Leading multi-agency partnerships and designing and commissioning services appear to be often challenging areas of work**, with fewer than half agreeing or strongly

agreeing they were confident in carrying out these elements of the work. **There appeared to be more confidence in developing strategies, supporting high quality practice and supporting staff to manage the emotional impact of the work**. However, even for each of these areas, around fifteen per cent of managers and leaders disagreed or strongly disagreed that they were confident. All of these areas of work are, of course, critical to ensuring children displaying HSB get the support they need. Managers play a vital role in this; supporting leaders and managers is therefore a critical part of the workforce development agenda.

## 3.3 Knowledge and skills

The survey asked whether practitioners and carers felt they had the requisite **knowledge and skills** for the same areas of work as describe above (3.2). This distinction is important as some professionals may be skilled and well-trained but do not feel confident, due to other factors. The results are set out in Figure 10.

**Figure 10: Self-reported knowledge and skills of practitioners and carers in carrying out particular areas of work with children displaying HSB**



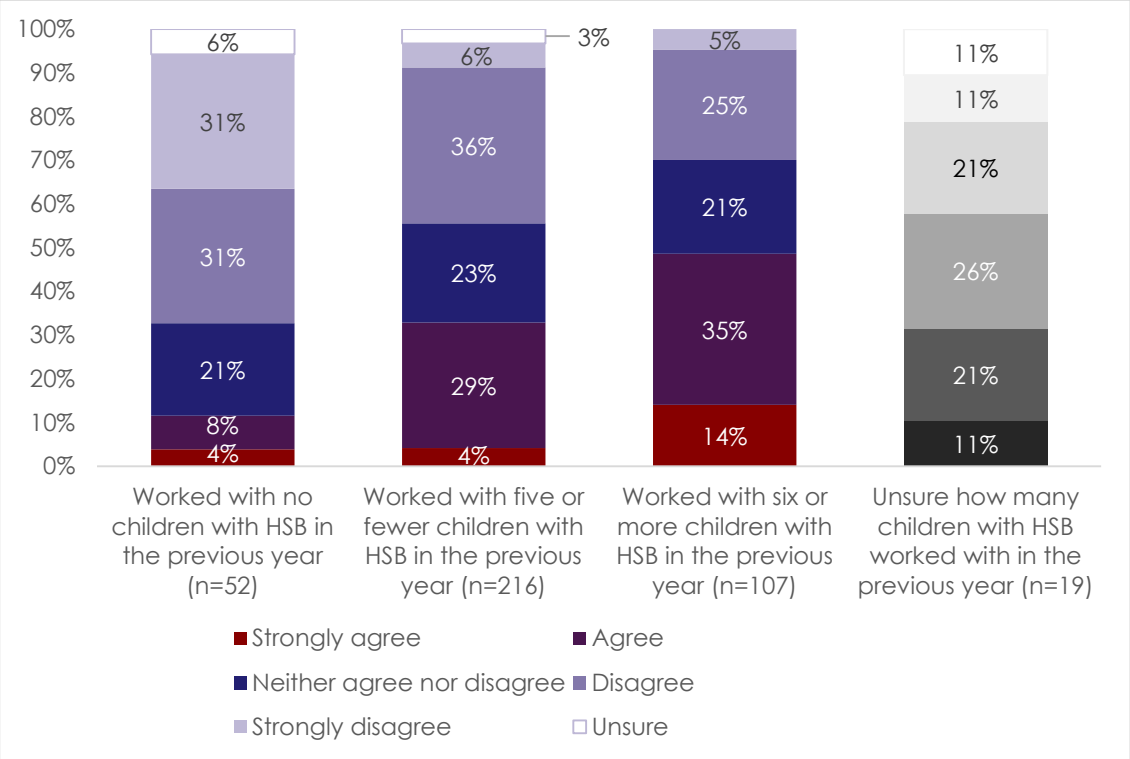

Base: see column labels

34 per cent agreed or strongly agreed that they had the knowledge and skills to work directly with children, with similar results relating to working directly with parents (33%). Respondents were more positive about their knowledge and skills for **identifying** (75 per cent agreed or strongly agreed) and **assessing** children with HSB (48%). These results relating to self-reported knowledge and skills are broadly similar to those relating to confidence.

Figure 11 details respondents' self-assessment of knowledge and skills in **working directly** with children with HSB, split according to the number of children they had worked with in the previous year. Those who had worked with six or more children generally gave more positive responses than those who had worked with five or fewer or were unsure of how many children they had worked with. Those who reported not having worked with any children displaying HSB accounted for just 13

per cent of respondents, but accounted for 46 per cent (base: n=35) of those who 'strongly disagreed' that they had the knowledge and skills for direct work. This pattern was reflected across all areas of work with children displaying HSB. It might be expected that those practitioners working more frequently with children with HSB are provided with more support and training to develop their knowledge and skills in this area. Nonetheless, only around half (49 per cent) of those who had worked with six or more children displaying HSB agreed or strongly agreed that they had the knowledge and skills to work directly with these children.

**Figure 11: Respondents' assessment of their own knowledge and skills for working directly with children displaying HSB - by number of children displaying HSB respondent reported having worked with over the previous year**

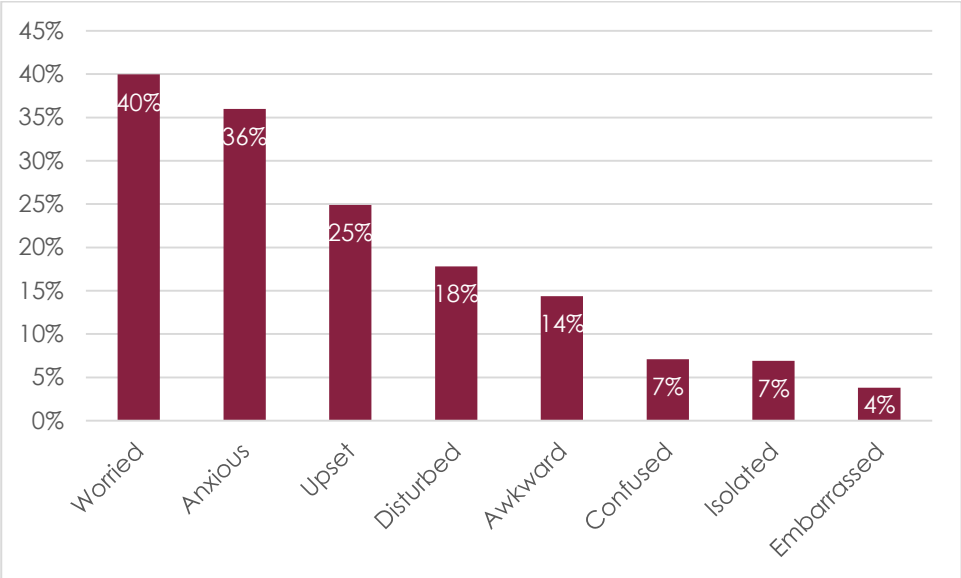



Base: see column labels

## 3.4 Emotional impact of working with children displaying HSB

Taking into account the nature of HSB and work in this field, it is important to note the potential impact of this work. Those that work closely with these children to help them address their behaviours demonstrate notable resilience in the face of significant challenges. Although there are many rewarding aspects to this work, and a high level of commitment was evident, several responses also pointed to the emotional impact of working with children displaying HSB. Figure 12 shows the proportion of respondents who reported experiencing one or more negative feelings when thinking about their experience of, or the prospect of, working with children displaying HSB. Results of the survey demonstrates that there can be emotional challenges related to working in this area: 40 per cent of respondents (*base: n*=578) said they felt 'upset', for example, whilst 36 per cent said they felt 'anxious' and 25 per cent said they felt 'worried'.

**Figure 12: Negative feelings experienced by respondents in relation to working with children displaying HSB**




Base: n=578 (more than one option could be selected)

Interestingly, there was little difference between those who worked with one to five children displaying HSB over the past year (71%, base: n=257) and those who worked with over five (68%, base: n=194) in terms of experiencing one or more of these feelings. Furthermore, there only appears to be a weak association between greater self-reported knowledge and skills and experiencing at least one of these feelings.[8] This suggests that **no matter how experienced the professional is, they can still experience difficult emotional impact** related to their work with children displaying HSB.

[8] 75 per cent of those who disagreed or strongly disagreed that they had knowledge and skills for working directly with children displaying HSB reported experiencing at least one of these feelings. 70 per cent of those who agreed or strongly agreed that they had knowledge and skills for working directly with children displaying HSB reported experiencing at least one of these feelings

# 4 Supporting the workforce

## Key findings

- Most practitioners and carers felt they were able to access some form of support and guidance that impacted positively on their work in this area. Many however, felt they would benefit from additional development support, particularly training, team meetings and team-based learning and being able to access the support of a specialist.
- Supervision, peer support and advice from senior colleagues played a critical role in building the skills and knowledge of the workforce. Supervision also played an important part in helping practitioners and carers to manage the emotional impact of the work.
- Training was not the only form of learning and development activity felt to be valuable, but did have an important role to play. The majority of those who had received training on issues around HSB felt it had impacted positively on their work. However, only 35 per cent of practitioners and carers had accessed such training, with this figure being even lower for those working in health and education.
- Responses to the survey underpinned the value of all these forms of support; they also suggested use of them may vary significantly between services and local authority areas.

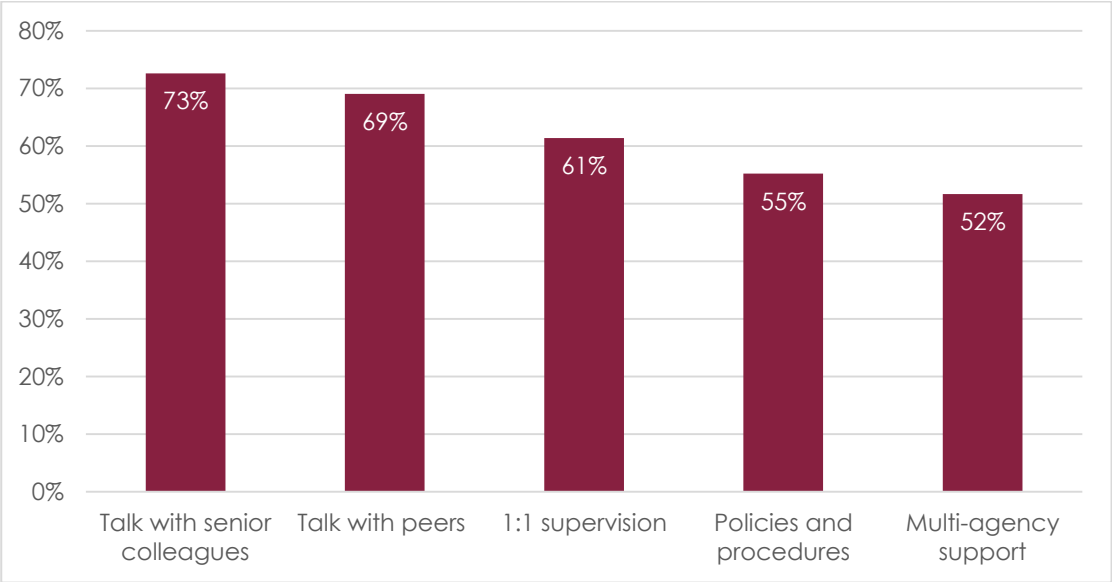
## 4.1 Support and Guidance

Most respondents felt that available support and guidance had to some extent improved how they and their staff worked with children displaying HSB. Specifically:

- 29 per cent (base: n=567) said that it improved their **confidence** working with children displaying HSB 'a lot' (and 34 per cent said it did this 'somewhat').
- 36 per cent (base: n=565) said that it improved their **awareness/knowledge** of the signs of HSB 'a lot' (and 29 per cent said it did this 'somewhat').
- 35 per cent (base: n=564) said that it improved **knowledge of the impacts** of HSB 'a lot' (and 28 per cent said it did this 'somewhat').
- 29 per cent (base: n=562) said that it Influenced the **specific methods or skills** used when working with children displaying HSB 'a lot (and 28 per cent said it did this somewhat).

Respondents were asked which of a range of 13 methods of support and guidance they or their staff used in their roles. The five methods most commonly used by practitioners and carers are set out in Figure 13.

**Figure 13: Five most commonly reported forms of support and guidance amongst practitioners and carers**

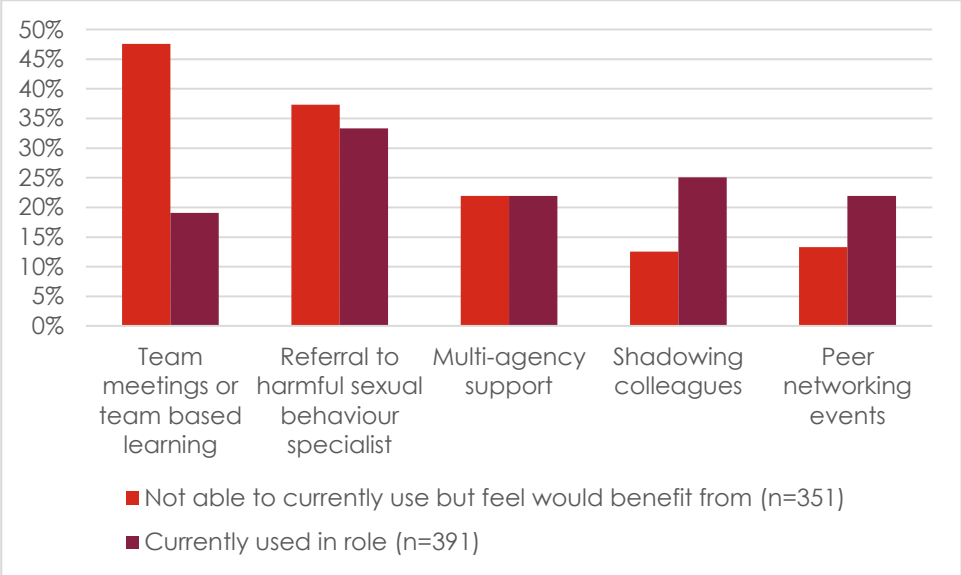



Base: *n*=391 (more than one option could be selected)

The three methods of support most commonly used by practitioners and carers were talking with senior colleagues (73%), talking with peers (69%) and one-to-one supervision (61%). The survey also asked about the extent to which supervision enabled staff to address the emotional impact discussed in Chapter 2. Practitioners and carers were asked to what extent they were able to use supervision to explore and address emotional impact and negative feelings. The important role that supervision plays in equipping the workforce is clear from the findings: Well over half (61%, base: n= 304) said that they were able to do so all or most of the time. 80 per cent of managers and leaders (base: n=193) agreed or strongly agreed that they felt confident in supporting staff that they supervise to address such feelings. **Those accessing one-to-one supervision were more likely than those not accessing it to say that their overall package of support and guidance improved their confidence** in working with children with HSB (see Table 2, overleaf).

Practitioners and carers were also asked which methods of support they were currently *unable* to access but felt they would benefit from. The five top answers are shown in Figure 14 alongside the proportion of respondents who said that they used this form of support. This illustrates the additional forms of support and guidance most desired by practitioners and carers are already being made available to some, which highlights the opportunity for sharing best practice between agencies and areas in relation to workforce development.

**Figure 14: Five forms of support and guidance practitioners and carers most feel they would benefit from but are currently unable to use; and proportion of practitioners and carers who are currently using these methods**




Base: see legend (more than one option could be selected)

48 per cent (*base: n*=351) said that they were unable to access team meetings or team based learning but if they could this would benefit them as a form of support and guidance, whilst 19 per cent said (*base: n*=391) that they were currently accessing this. Practitioners and carers also wanted opportunities to shadow colleagues and network with their peers at events. Taken alongside the fact that talking with peers was the second most commonly used form of support and guidance (See Figure 13), this may suggest that practitioners and carers want to access the benefits of peer support in a more structured and formalised way. Reflecting the perceived unavailability of specialist services highlighted in Chapter 2, 37 per cent said that they would benefit from being able to refer to a specialist but were currently unable to.

Survey results suggest that these forms of support and guidance that practitioners and carers want access to may indeed provide a benefit in terms of confidence in working with children with HSB. As reported above, a total of 63 per cent of practitioners and carers said that the package of support and guidance they used improved their confidence in working with children with HSB 'a lot' or 'somewhat'. This improvement in confidence was greater among respondents who reported using any of the specific support or guidance measures shown in Table 2, overleaf. For example, 70 per cent of respondents whose support and guidance package included 1:1 supervision said their support and guidance package improved their confidence in working with children with HSB; among those whose support and guidance package did *not* include 1:1 supervision, the proportion of respondents saying the package improved their confidence in working with children displaying HSB was lower, at 53 per cent.

**Table 2: Practitioners' and carers' views on their overall package of support and guidance based on whether this included use particular forms of support and guidance**

| **Type of support and guidance** | *1:1 supervision* | *Team meetings or team based learning* | *Referral to harmful sexual behaviour specialist* | *Multi-agency support* | *Shadowing colleagues* |
|---|---|---|---|---|---|
| Proportion of those whose package of support and guidance **included this form of support or guidance** who said this package improved their confidence in working with children with HSB 'a lot' or 'somewhat' | **70%** | **72%** | **72%** | **70%** | **67%** |
| | base: n=238 | base: n=183 | base: n=145 | base: n=200 | base: n=49 |
| Proportion of those whose package of support and guidance **did *not* include this form of support or guidance** who said this package improved their confidence in working with children with HSB 'a lot' or 'somewhat' | **53%** | **56%** | **59%** | **57%** | **63%** |
| | base: n=123 | base: n=178 | base: n=216 | base: n=161 | base: n=312 |

As discussed in Chapter 2, specialist services may fulfil a range of functions, but only a minority of respondents thought that, in their area, this included support for the wider workforce (as opposed to delivering direct support to children and young people). Confidence appears slightly higher in practitioners and carers who said that their local specialist service provided training, advice, consultation, and/or supervision to practitioners from other agencies. **The proportion of those agreeing or strongly agreeing that they were confident in assessing children's needs, developing plans or direct work was over ten percentage points higher when the local specialist service was said to provide consultation and supervision to practitioners** from other agencies than when it did not (see Table 3, below).

**Table 3: Self-reported confidence of practitioners and carers in carrying out particular areas of work based on support provided by the local specialist service**

Proportions who agree or strongly agree they are confident in these areas of work with children with HSB

| | Identifying | | Assessing | | Developing Plans | | Working Directly | | Working Directly with Parents | | Managing the Emotional Impact | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Base | | Base | | Base | | Base | | Base | | Base | |
| ***Does** provide training / advice to practitioners from other agencies* | n=82 | **76%** | n=81 | **46%** | n=81 | **42%** | n=81 | **42%** | n=80 | **43%** | n=82 | **55%** |
| ***Does not** provide training / advice to practitioners from other agencies* | n=85 | **72%** | n=85 | **47%** | n=84 | **30%** | n=84 | **41%** | n=85 | **34%** | n=85 | **48%** |
| | | | | | | | | | | | | |
| ***Does** provide consultation / supervision to practitioners from other agencies* | n=70 | **77%** | n=69 | **52%** | n=68 | **43%** | n=69 | **48%** | n=69 | **42%** | n=70 | **54%** |
| ***Does not** provide consultation / supervision to practitioners from other agencies* | n=97 | **71%** | n=97 | **42%** | n=97 | **31%** | n=97 | **37%** | n=96 | **35%** | n=97 | **49%** |

A desire for more and/or different types of training was a key concern amongst those who commented on the support and guidance available to them.

> "More training is required"
> *Manager in family safeguarding services*

> "I want more specific training"
> *Youth offending practitioner*

> "Whole service training from specialists would benefit large organisations."
> *Disabled children's services practitioner*

The proportion of practitioners using some of the methods of support and guidance discussed above are set out in Table 4 based on local area, and in Table 3 based on service/agency. There was notable variation both between agencies and between the different local authority areas taking part in the research. Access to one-to-one supervision (as a means of developing skills / knowledge in relation to HSB) ranged from 29 per cent of practitioners working in education to 78 per cent working with children in care or in general children's services. Similarly, use of one-to-one supervision in this way ranged from 46 per cent in one local authority area to 78 per cent in another. Use of team meetings and team based learning ranged from 41 per cent of practitioners in general children's services to 63 per cent of practitioners working with children in care and from 46 per cent in one local authority area to 59 per cent in another.

It is important to note that the makeup of respondents from different local authority areas varied in terms of the types of practitioners which responded and that the base for some of the categories described are particularly small (e.g. n=22 for Local authority 4 and n=28 respondents working in education). This means that, in order for firm conclusions to be drawn about the significance and causes of these variations, further research would need to be undertaken.

**Table 4: Use of selected methods of support and guidance by practitioners from each participating local authority area**

| | **Local authority area 1** (*base: n*=28) | **Local authority area 2** (*base: n*=51) | **Local authority area 3** (*base: n*=148) | **Local authority area 4** (*base: n*=22) | **Local authority area 5** (*base: n*=49) | **Local authority area 6** (*base: n*=59) |
|---|---|---|---|---|---|---|
| *Shadowing colleagues* | 18% | 33% | 10% | 5% | 12% | 8% |
| *Peer networking events* | 11% | 24% | 12% | 14% | 14% | 15% |
| *1:1 supervision* | 46% | 78% | 73% | 73% | 57% | 53% |
| *Team meetings or team based learning* | 50% | 55% | 53% | 59% | 47% | 46% |
| *Referral to harmful sexual behaviour specialist* | 46% | 45% | 32% | 50% | 59% | 34% |

**Table 5: Use of selected methods of support and guidance by practitioners from each agency/service**

| | **Children in Care** (*base: n*=68) | **Early Help/ Family Support/ Children with Disabilities** (*base: n*=65) | **Children's Services: General/ Other** (*base: n*=41) | **Youth offending** (*base: n*=29) | **Education** (*base: n*=28) | **Health** (*base: n*=51) | **Other** (*base: n*=79) |
|---|---|---|---|---|---|---|---|
| *Shadowing colleagues* | 12% | 9% | 10% | 34% | 7% | 18% | 13% |
| *Peer networking events* | 13% | 17% | 7% | 17% | 21% | 14% | 14% |
| *1:1 supervision* | 78% | 68% | 78% | 76% | 29% | 57% | 66% |
| *Team meetings or team based learning* | 63% | 48% | 41% | 52% | 43% | 51% | 53% |
| *Referral to harmful sexual behaviour specialist* | 44% | 43% | 37% | 62% | 46% | 27% | 35% |

## 4.2 Specific training on working with children with HSB

35 per cent of practitioners and carers (*base: n*=398) said that they had received training in working with children who display HSB since 2014. Some respondents described training about a specific aspect of working with children displaying HSB, for example training in using the AIM assessment tool (see Chapter 2) or in addressing HSB in children aged under 12. Some described training that was not dedicated training to HSB. Descriptions given in these cases suggested that the training had focused on related issues such as child sexual exploitation, female genital mutilation and gangs, or referred to more general child safeguarding issues.

Those working in youth offending were more likely to have received training (57%, *base: n*=30) than those working in other agencies. Those working health (25%, *base: n*=57) and education (27%, *base: n*=30) were less likely to have received training.

The majority of those who received training felt it had at least somewhat improved how they worked with children displaying HSB. Specifically:

- 49 per cent (*base: n*=567) said that it improved their confidence working with children displaying HSB a lot (and 45 per cent said it did this somewhat).
- 62 per cent (*base: n*=565) said that it improved their awareness/knowledge of the signs of HSB (and 32 per cent said it did this somewhat).
- 57 per cent (*base: n*=564) said that it improved knowledge of the impacts of HSB a lot and 36 per cent said it did this somewhat).
- 45 per cent (*base: n*=562) said that it Influenced the specific methods or skills used when working with children displaying HSB a lot (and 37 per cent said it did this somewhat).

# 5 Priorities for policy and practice development

Reflecting on the key findings from the research, four key priorities emerge. These are set out below, with rationale and recommendations for how local authority leaders, their staff and those working for partner agencies could take them forward. In formulating these recommendations we have tried to focus on **the most cost efficient and practical solutions**. This should mean these are viable even despite significant resource constraints facing public services in the current economic climate.

## 1. Embed peer support and team-based learning, addressing disparity across areas and agencies

Given the emotional impact of this line of work and the other challenges set out in Chapter 1, it is important that as well as developing their knowledge in this area, practitioners have opportunities to support each other and build each other's confidence. Some agencies and areas already do this, indicating that greater consistency is achievable simply by sharing best practice. Practitioners and carers value the support and input of their peers and colleagues into their professional development in this area, but are in need of more formalised opportunities to access this.

*What would this entail?*

- Mapping locally how services and teams are engaging with HSB, in order to identify pockets of particular expertise: this would enable collaboration and coordination across geographic and service boundaries for peer learning opportunities about HSB, reducing reliance on external providers.
- Setting up case clinics and/or 'surgeries' within or between agencies: these provide opportunities for practitioners to come together with a clear focus on practice and problem-solving. This might involve collectively undertaking an assessment, or debating a case. Reading groups or study groups provide another low-cost method for enabling peer support and reflection.
- Encouraging innovation in training: commissioners of training could request that providers design learning resources that can be used in team-based learning and provide support to implement these, rather than only commissioning traditional training packages.

## 2. Strengthen support through reflective supervision for those working directly with children displaying HSB

All of those who work directly with children displaying HSB should be able to access supervision to support them in their role. One-to-one supervision is useful for many practitioners in addressing the emotional impact of work with children displaying HSB. However, a significant minority are missing out on this important form of support and development.

*What would this entail?*

- Sharing practice across agencies on effective supervision: supervision arrangements will vary by agency and role but it is important that all of those working in this area have access to some kind of one-to-one support which enables them to reflect on and process the emotional impact of the work. As agencies work together to develop their policies and strategies on HSB, they should also share practice on effective supervision, to minimise variability.

- Exploring options for group supervision: finding time for adequate one-to-one supervision may be challenging in busy teams. Group supervision can be valuable in supporting reflection and knowledge exchange, and offers a more structured means of enabling professionals to get together than broader networking events.
- Specialist supervision: specialist services providing direct support to children with HSB may also be ideally placed to provide supervision to non-specialist practitioners. Commissioners may want to consider how capacity-building and workforce development could be incorporated into the work of specialist agencies. This will require careful planning to avoid increasing pressure on capacity in a way that reduces the support available to children.

## 3. Training and skills development for those working with or caring for children displaying HSB

Those working with or caring for children should be offered broader learning support as well as specific training to help them in their role. This should help improve the knowledge, skills and confidence of amongst professionals. In turn, this is vital for ensuring the most vulnerable children displaying HSB can receive care that is holistic, taking into account all of their needs. Work to develop the knowledge, skills and confidence of those working with children in care may help to address concerns raised about the lack of available placements for those displaying HSB.

*What would this entail?*

- Specific training about working with children with HSB: effective training can help professionals and carers to navigate the complexities of this work. Training should be designed to encourage strengths-based approaches, and support increased understanding of the vulnerabilities that can accompany HSB.
- Enabling non-specialist professionals to access specialists able to advise on any queries, provide coaching and consultancy: whilst requiring investment, this consultancy model may yield cost benefits if increasing professionals' capabilities results in less call on specialist provision and more children being supported safely in the community.
- Specialist services offering learning opportunities: specialist services, including voluntary and community sector agencies, could offer enhanced learning opportunities to those with less established knowledge, skills and confidence. It is important not to assume that learning means traditional training. These learning opportunities might include:
    - bite-size briefings
    - work shadowing opportunities
    - practice observation and feedback
    - facilitation of peer-learning opportunities
- Developing a broader offer from specialist provision: commissioners should explore with specialist providers how to augment the package of support offered beyond their direct interventions with children; this should ideally include providing responsive support and advice to parents, carers and those working in universal and early help services.

## 4. Improve awareness of harmful sexual behaviour

All settings and services, particularly those with which children have most contact, need to have awareness and understanding of HSB. Despite the lack of statutory definition, the vast majority of respondents suggested that they had at least some understanding of what HSB was. This is testament to local services' and practitioners' determination to understand and address the needs of vulnerable children, regardless of how they may be categorised. However, there were signs in

the responses to the survey that there may still be room for improvement in this area. Improving awareness will support identification and earlier support, increasing the likelihood of positive outcomes and potentially reducing the need for more specialist interventions further down the line. As training was reported to being more effective in raising awareness than as a means of developing particular skills, it is an appropriate response to this challenge.

*What would this entail?*

- Reviewing existing HSB awareness-raising activity: is it effective? Inclusive? Are the messages about HSB up-to-date? Non-stigmatising? Child-centred?
- Ensuring practitioners receive training appropriate to their role: practitioners - in particular safeguarding leads and those working in education, health and early help - should receive training in what constitutes HSB and how to identify it. This could usefully be delivered by specialist services working locally, in order to strengthen interagency learning and promote professional dialogue. It should support understanding of the spectrum of sexual behaviours, including the boundary between those that are problematic and those that are harmful, what can be addressed through early help in mainstream settings and what requires specialist intervention.
- Ensuring carers are equipped with knowledge on HSB: information regarding HSB should be included in core training for foster carers and others caring for children. This will need to be accessible and non-stigmatising.
- Incorporating the topic of HSB in other relevant training opportunities: practitioners may have little time for additional training, and may be accessing only that which is deemed core / mandatory to their role. Those responsible in agencies and across the partnership for ensuring core training, such as safeguarding training, should assure themselves that HSB has been reflected in these other, broader, topics.
- Managers and leaders using their reach and influence: managers and senior leaders are often a highly respected source of support and advice; colleagues in these roles can do much to raise awareness of HSB simply by discussing it frequently and publicly.

# 6 Further research

This research has provided insight into the needs and experiences of those working with children displaying HSB. Further investigation would be helpful to explore the variation in – and impact of - peer support and team-based learning. Secondly, it would be helpful to examine whether support for the wider workforce around HSB could, over time, reduce demand for specialist intervention and provision. A future survey with a larger sample could provide opportunities for more robust and more detailed analysis of these areas and how they affect different groups within the children's workforce.

Local authorities participating In LARC 7 have also identified their own priorities for further investigation which they are taking forward locally using various methodologies. These include:

- Using focus groups with practitioners and managers to understand how the local multi-agency pathway for identifying and addressing HSB is operating in practice;
- Talking to children in local schools about their attitudes to sexual behaviour and what would help them make their own, informed decisions and access support should the need arise;
- Carrying out an online survey exploring practitioners' confidence and in skills in working with children whose HSB involves the use of technology and social media;
- Using focus groups to explore workforce understanding of the needs of siblings displaying HSB.

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# Appendix 1: Categories of respondent

Respondents (total: 589) were asked which of 18 agencies (including 'other') they worked for. To aid analysis, respondents were categorised by 7 groups of agencies as set out below.

| | |
|---|---|
| **Children's services: Early Help/Family Support/Children with Disabilities 110** | Children's Services: Early Help/Family Support (89)<br>Children's Services: Children with Disabilities (21) |
| **Children's services: Children in Care 103** | Children's Services: Corporate Parenting/Children in Care (56)<br>Children's Services: Fostering (28)<br>Independent reviewing officers and IRO managers (11)<br>Children's Services: Residential Care (8) |
| **Children's services: Youth Offending 41** | Children's services: Youth Offending (41) |
| **Children's services: General/Other 72** | Children's Services: General (e.g. strategic manager or commissioner covering more than one areas of children's services) (72) |
| **Education 52** | Education provider (school, further education setting etc) (52) |
| **Health 89** | Clinical commissioning group (4)<br>General or physical health service (27)<br>Mental health service (28)<br>Public health (Including sexual health services and school nursing) (30) |
| **Other 122** | Police (11)<br>Youth services (36)<br>Voluntary and community sector (20)<br>Other (55)<br>Examples of what respondents specified under this:<br>• Local authority<br>• Children's services: Safeguarding<br>• Housing<br>• Children's Centre<br>• Education welfare/psychology |

# Appendix 2: Survey

## A: questions for all respondents

### Harmful Sexual Behaviour

This survey is part of a research project set up with a range of local authorities, and supported by Research in Practice and the National Children's Bureau. This survey is for completion by those working with children and young people in the Hampshire local authority area.

Completing this survey is entirely **voluntary** and you are free to exit the survey at any time. We would be grateful if you could answer as many questions as you feel able to. If you make a mistake, or want to change your answer, you can click the back button. It is fine if you do not know the answers to some questions, please just answer as accurately as you can. Once you have finished please remember to click the **SUBMIT** button at the end of the survey.

If you have any questions about the survey or any problems completing it, please contact [redacted]

The closing date for the survey is **31st December 2016**.

## What do we mean by 'harmful sexual behaviour'?

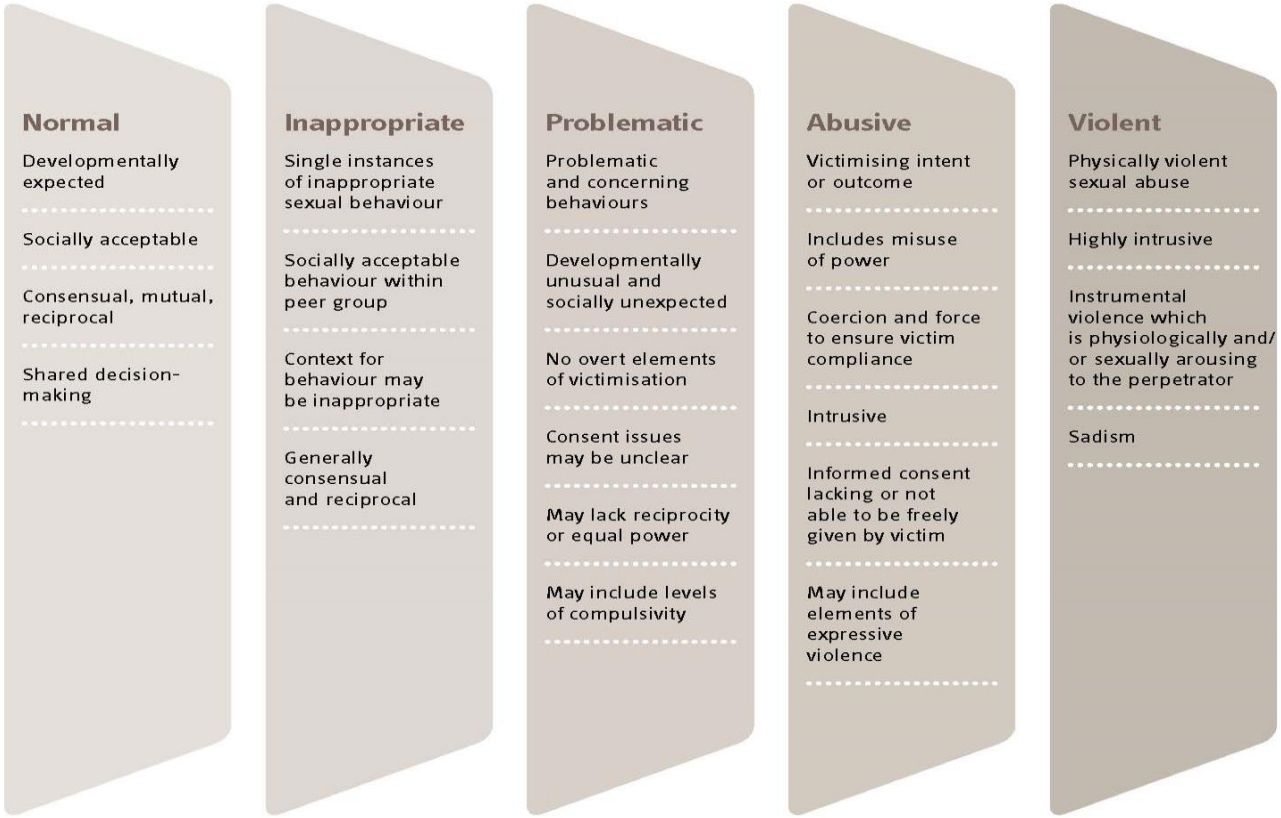
Thank you for showing an interest in this research on working with children and young people with harmful sexual behaviours.

Harmful sexual behaviour can be defined as follows:

*Sexual behaviours expressed by children and young people under the age of 18 years old that are developmentally inappropriate, may be harmful towards self or others and/ or be abusive towards another child, young person or adult*. (Hackett, Holmes and Branigan, 2016).

Note that Harmful Sexual Behaviour can be understood to overlap with child sexual exploitation (CSE) (where CSE is peer-perpetrated) and with intrafamilial child sexual abuse (e.g. sibling abuse).

The image below sets out Hackett's continuum of sexual behaviours, on which harmful sexual behaviours may fall anywhere on the middle and right.




The purpose of this survey is to find more information about the workforce's knowledge, skills, and confidence around harmful sexual behaviour, and perceived barriers and enablers to increasing workforce capabilities around harmful sexual behaviours. Findings are **anonymous** and will be shared, as one report, across the sector to inform improved practice and services.

## Background

If you're happy to complete this survey, please click **next** to start.

Which agency do you work for? Please tick one answer.

- ❑ Children's Services: General (e.g. strategic manager or commissioner covering more than one of the areas below)
- ❑ Children's Services: Corporate Parenting/Children in Care
- ❑ Children's Services: Fostering
- ❑ Children's Services: Residential Care
- ❑ Children's Services: Children with Disabilities
- ❑ Children's Services: Early Help/Family Support
- ❑ Children's Services: Independent reviewing officers and IRO managers
- ❑ Children's Services: Youth offending
- ❑ Clinical commissioning group
- ❑ General or physical health service
- ❑ Mental health service
- ❑ Public health (Including sexual health services and school nursing)
- ❑ Education provider (school, further education setting etc)
- ❑ Youth services
- ❑ Police
- ❑ Secure justice setting
- ❑ Voluntary and community sector
- ❑ Other

Please specify

---

Do you sit on the Local Safeguarding Children's Board (LSCB) or one of its subgroups?

- ❑ Yes
- ❑ No

Which of the following best describes your professional role? Please tick one answer.

- ❑ Strategic manager or commissioner
- ❑ Service or team manager
- ❑ Front line practitioner or carer

Which age groups do you work with? Please tick all that apply.

- ❑ 0 - 5 years
- ❑ 6 - 10 years
- ❑ 11 - 14 years
- ❑ 15 - 18 years
- ❑ Over 18 years

## Local area/organisation strategies

Are you aware of a specialist service for children and young people with harmful sexual behaviour in your area?

- ❑ Yes
- ❑ No
- ❑ Unsure

Please name the service or provide a very brief description

_____

_____

Please tell us about the support they provide (please tick all that apply)

- ❑ Direct support to children and young people
- ❑ Direct support to parents
- ❑ Specialist assessment
- ❑ Specialist residential provision
- ❑ Consultation / supervision to practitioners from other agencies
- ❑ Training / advice to practitioners from other agencies
- ❑ Other

Please specify:

_____

Which of the following best describes your opinion on the threshold for accessing the service?

- ❑ It is set too high
- ❑ It is set about right
- ❑ It is set too low
- ❑ Unsure
- ❑ Other

Please specify

_____

Does **your agency** have either of the following?

- ❑ Policy on children who display harmful sexual behaviour
- ❑ Strategy for supporting children who display harmful sexual behaviour

Does your **local area** have any of the following regarding harmful sexual begaviour in children?

- ❑ Multi-agency policy
- ❑ Multi-agency strategy
- ❑ Multi-agency referal pathway

## Additional Comments

Is there anything else you would like to tell us about your experiences of working with children and young people who display harmful sexual behaviours?

_____

_____

_____

# B: Questions for frontline practitioners and carers

## Scale of Harmful Sexual Behaviour (HSB)

To your knowledge, **approximately** how many children and young people have you worked or cared for within the **last three months** with harmful sexual behaviours? Please tick one answer.

- ❑ None
- ❑ 1- 5
- ❑ 6 - 10
- ❑ 11 - 20
- ❑ 21 - 30
- ❑ 31 - 40
- ❑ 41 - 50
- ❑ More than 50
- ❑ Unsure

To your knowledge, **approximately** how many children and young people have you worked with or cared for in the **last year** with harmful sexual behaviours? Please tick one answer.

- ❑ None
- ❑ 1 - 5
- ❑ 6 - 10
- ❑ 11 - 20
- ❑ 21 - 30
- ❑ 31 - 40
- ❑ 41 - 50
- ❑ More than 50
- ❑ Unsure

Have you seen a change in the number of children and young people with harmful sexual behaviours in the **last two years** (since 2014) from the perspective of your team / service? Please tick one.

- ❑ Large increase

- ❑ Some increase
- ❑ No change
- ❑ Some decrease
- ❑ Large decrease
- ❑ Unsure
- ❑ Not applicable - I am a carer or otherwise work with a small number of children and young people each year
- ❑ Other

Please specify, e.g. increase in under 13 year olds with harmful sexual behaviour

_____

_____

## Your experience of working with children and young people with harmful sexual behaviour

**Approximately** what proportion of the harmful sexual behaviour cases you work with are with children and young people from the following groups? Please tick one answer in each row. (If you have worked with/cared for just one child or young person with harmful sexual behaviour, tick 'most' for any groups that they were from.)

| | None | A few | Some | A lot | Most | Unsure |
|---|---|---|---|---|---|---|
| Children and young people from BME groups | ❑ | ❑ | ❑ | ❑ | ❑ | ❑ |
| Girls and young women | ❑ | ❑ | ❑ | ❑ | ❑ | ❑ |
| Boys and young men | ❑ | ❑ | ❑ | ❑ | ❑ | ❑ |
| LGBT children and young people | ❑ | ❑ | ❑ | ❑ | ❑ | ❑ |
| Children and young people with mental health problems | ❑ | ❑ | ❑ | ❑ | ❑ | ❑ |

| | | | | | | |
|---|---|---|---|---|---|---|
| Children and young people in custody | ❑ | ❑ | ❑ | ❑ | ❑ | ❑ |
| Children and young people in care | ❑ | ❑ | ❑ | ❑ | ❑ | ❑ |
| Children and young people with a child protection plan | ❑ | ❑ | ❑ | ❑ | ❑ | ❑ |
| Children and Young People with Special Educational Needs and Disabilities (SEND) | ❑ | ❑ | ❑ | ❑ | ❑ | ❑ |

Provide more detail on type of SEND here (optional)

_____

_____

| | | | | | | |
|---|---|---|---|---|---|---|
| Other<br>Please specify: | ❑ | ❑ | ❑ | ❑ | ❑ | ❑ |

_____

_____

**Approximately** how many of the young people with harmful sexual behaviours you work with are affected by the following factors? Please tick one in each row. (If you have worked with/cared for just one child or young person with harmful sexual behaviour, tick 'most' for any issues that they were affected by)

| | None | A few | Some | A lot | Most | Unsure |
|---|---|---|---|---|---|---|
| Abuse from others (non-sexual) | ❑ | ❑ | ❑ | ❑ | ❑ | ❑ |
| Sexual abuse from others | ❑ | ❑ | ❑ | ❑ | ❑ | ❑ |
| Neglect | ❑ | ❑ | ❑ | ❑ | ❑ | ❑ |
| Offending | ❑ | ❑ | ❑ | ❑ | ❑ | ❑ |

| | | | | | | |
|---|---|---|---|---|---|---|
| Social isolation | ❑ | ❑ | ❑ | ❑ | ❑ | ❑ |
| Difficulties with social skills | ❑ | ❑ | ❑ | ❑ | ❑ | ❑ |
| Poverty | ❑ | ❑ | ❑ | ❑ | ❑ | ❑ |
| Domestic violence | ❑ | ❑ | ❑ | ❑ | ❑ | ❑ |
| Exclusion from education | ❑ | ❑ | ❑ | ❑ | ❑ | ❑ |
| Other<br>Please specify: | ❑ | ❑ | ❑ | ❑ | ❑ | ❑ |

_____

_____

Please specify any particular **tools and/or approaches** for identifying, assessing or supporting children and young people who display harmful sexual behaviour

_____

_____

_____

_____

Please tell us about up to three **challenges** of working with children and young people with harmful sexual behaviour

_____

_____

_____

_____

## Knowledge, skills and training to work with harmful sexual behaviours

The next few questions ask you about your knowledge, skills and confidence in working with harmful sexual behaviours, as well as how this work makes you feel.

We would like to remind you that the answers you give to all of the questions in this survey are confidential, it is not a 'test', and that there are no 'right' or 'wrong' answers.

You may find it useful to refamilarise yourself with our contextual information about harmful sexual behaviour, which is repeated below.

***What do we mean by 'harmful sexual behaviour'?***

Harmful sexual behaviour can be defined as follows:

*Sexual behaviours expressed by children and young people under the age of 18 years old that are developmentally inappropriate, may be harmful towards self or others and/ or be abusive towards another child, young person or adult*. (Hackett, Holmes and Branigan, 2016).

Note that Harmful Sexual Behaviour can be understood to overlap with child sexual exploitation (CSE) (where CSE is peer-perpetrated) and with intrafamilial child sexual abuse (e.g. sibling abuse).

The image below sets out Hackett's continuum of sexual behaviours, on which harmful sexual behaviours may fall anywhere on the middle and right.

How far do you agree or disagree with the following statements about your **knowledge and skills** regarding children and young people with harmful sexual behaviours? Please tick one answer on each row.

| | Strongly disagree | Disagree | Neither agree nor disagree | Agree | Strongly agree | Unsure |
|---|---|---|---|---|---|---|
| I fully **understand** what harmful sexual behaviour in children and young people is | ❑ | ❑ | ❑ | ❑ | ❑ | ❑ |
| I have knowledge/ skills for **identifying** harmful sexual behaviour in children and young people I work with/care for | ❑ | ❑ | ❑ | ❑ | ❑ | ❑ |
| I have knowledge/skills for **assessing** children and young people displaying harmful sexual behaviour | ❑ | ❑ | ❑ | ❑ | ❑ | ❑ |
| I have knowledge/ skills about **developing plans** for children and young people displaying harmful sexual behaviour | ❑ | ❑ | ❑ | ❑ | ❑ | ❑ |
| I have knowledge/ skills for **working directly (delivering interventions)** with children and young people displaying harmful sexual behaviour | ❑ | ❑ | ❑ | ❑ | ❑ | ❑ |
| I have knowledge/ skills for working directly with parents of children and young people displaying harmful sexual behaviour | ❑ | ❑ | ❑ | ❑ | ❑ | ❑ |
| I have knowledge/skills to use to **effectively manage the emotional impact** of working with/caring for children and young people displaying harmful sexual behaviour | ❑ | ❑ | ❑ | ❑ | ❑ | ❑ |

We understand that this work, as well as being rewarding, can also cause negative feelings amongst professionals and carers. Thinking about experience you may have working with or caring for children displaying harmful sexual behaviour, or the prospect of having to address these issues, how does it make you feel? Please tick all that apply:

- ❑ Anxious
- ❑ Awkward
- ❑ Embarrassed
- ❑ Isolated
- ❑ Confused
- ❑ Disturbed
- ❑ Upset
- ❑ Worried
- ❑ Anxious
- ❑ None of the above
- ❑ Other

Please specify

_____

_____

To what extent are you able to explore and address these feelings in your supervision?

- ❑ Not at all
- ❑ Hardly at all
- ❑ Some of the time
- ❑ Most of the time
- ❑ All the time

How far do you agree or disagree with the following statements about your **confidence** regarding children and young people with harmful sexual behaviours? Please tick one answer on each row.

| | Strongly agree | Agree | Neither agree nor disagree | Disagree | Strongly disagree | Don't know |
|---|---|---|---|---|---|---|
| I feel confident in **identifying** harmful sexual behaviour in children and young people I work with/care for | ❑ | ❑ | ❑ | ❑ | ❑ | ❑ |

| | | | | | | |
|---|---|---|---|---|---|---|
| I feel confident about **assessing** children and young people displaying harmful sexual behaviour | ❑ | ❑ | ❑ | ❑ | ❑ | ❑ |
| I feel confident about **developing plans** for children and young people displaying harmful sexual behaviour | ❑ | ❑ | ❑ | ❑ | ❑ | ❑ |
| I feel confident about **working directly (delivering interventions**) with children and young people displaying harmful sexual behaviour | ❑ | ❑ | ❑ | ❑ | ❑ | ❑ |
| I feel confident about working directly with **parents** of children and young people displaying harmful sexual behaviour | ❑ | ❑ | ❑ | ❑ | ❑ | ❑ |
| I feel confident that I can **effectively manage the emotional impact** of working with/caring for children and young people displaying harmful sexual behaviour | ❑ | ❑ | ❑ | ❑ | ❑ | ❑ |

Have you received training in working with children and young people who display harmful sexual behaviour since 2014? Please tick one.

- ❑ Yes
- ❑ No
- ❑ Unsure / Can't remember

If yesPlease provide a brief description of the training (including whether it related to any specific groups of children and young people and how long ago you participated in this training and how often).

_____
_____
_____
_____

Is training in working with children and young people who display harmful sexual behaviour available to people undertaking your role locally?

- ❑ Yes
- ❑ No
- ❑ Unsure

Did the training impact on you in any of the following ways? Please tick all that apply.

| | Not at all | Not a lot | Somewhat | A lot | Don't know / Can't remember |
|---|---|---|---|---|---|
| Improved my **confidence** working with/caring for children and young people with harmful sexual behaviour | ❑ | ❑ | ❑ | ❑ | ❑ |
| Improved my **awareness/knowledge** of the signs of harmful sexual behaviour | ❑ | ❑ | ❑ | ❑ | ❑ |
| Improved my **knowledge** of the impacts of harmful sexual behaviour | ❑ | ❑ | ❑ | ❑ | ❑ |
| Influenced the **specific methods or skills** I use when working with/caring for children and young people with harmful sexual behaviour | ❑ | ❑ | ❑ | ❑ | ❑ |
| Other<br>Please specify | ❑ | ❑ | ❑ | ❑ | ❑ |

_____
_____

Which of the following methods of support and guidance do you use in your role working with or caring for children and young people with harmful sexual behaviour? Please tick all that apply.

- ❑ Talk with peers
- ❑ Talk with senior colleagues
- ❑ Written guidance from senior colleagues
- ❑ Shadowing colleagues
- ❑ Self-directed study / reading
- ❑ Peer networking events
- ❑ 1:1 supervision
- ❑ Team meetings or team based learning
- ❑ Policies and procedures
- ❑ Sector-specific media
- ❑ Group supervision
- ❑ Multi-agency support
- ❑ Referral to harmful sexual behaviour specialist
- ❑ None of the above
- ❑ Other

Please specify:

_____

_____

How do the methods of support and guidance you outlined impact upon your work/care you provide? Please tick one in each row.

| | Not at all | Not a lot | Somewhat | A little | A lot | Don't know |
|---|---|---|---|---|---|---|
| Improved my **confidence** working with children and young people with harmful sexual behaviour | ❑ | ❑ | ❑ | ❑ | ❑ | ❑ |
| Improved my **awareness/knowledge** of the signs of harmful sexual behaviour | ❑ | ❑ | ❑ | ❑ | ❑ | ❑ |
| Improved my **knowledge of the impacts** of harmful sexual behaviour | ❑ | ❑ | ❑ | ❑ | ❑ | ❑ |

| | | | | | | |
|---|---|---|---|---|---|---|
| Influenced the **specific methods or skills** I use when working with children and young people with harmful sexual behaviour | ❑ | ❑ | ❑ | ❑ | ❑ | ❑ |

Do you have any specific comments about the methods outlined above?

_____

_____

Which of the following methods of support and guidance are you not able to currently use but feel you would benefit from? Please tick all that apply.

- ❑ Talk with peers
- ❑ Talk with senior colleagues
- ❑ Written guidance from senior colleagues
- ❑ Shadowing colleagues
- ❑ Self-directed study / reading
- ❑ Peer networking events
- ❑ 1:1 supervision
- ❑ Team meetings or team based learning
- ❑ Policies and procedures
- ❑ Sector-specific media
- ❑ Group supervision
- ❑ Multi-agency support
- ❑ Referral to harmful sexual behaviour specialist
- ❑ None of the above
- ❑ Other

Please specify

_____

_____

# C: Questions for team and service managers, and strategic managers and commissioners

## Scale of Harmful Sexual Behaviour (HSB)

To your knowledge, **approximately** how many children and young people has your agency worked with in the **last three months** with harmful sexual behaviours? Please tick one answer.

- ❑ None
- ❑ 1- 5
- ❑ 6 - 10
- ❑ 11 - 20
- ❑ 21 - 30
- ❑ 31 - 40
- ❑ 41 - 50
- ❑ More than 50
- ❑ Unsure

To your knowledge, **approximately** how many children and young people has your agency worked with in the **last year** with harmful sexual behaviours? Please tick one answer.

- ❑ None
- ❑ 1 - 5
- ❑ 6 - 10
- ❑ 11 - 20
- ❑ 21 - 30
- ❑ 31 - 40
- ❑ 41 - 50
- ❑ More than 50
- ❑ Unsure

Have you seen a change in the number of children and young people with harmful sexual behaviours in the **last two years** (since 2014) from the perspective of your team / service? Please tick one.

- ❑ Large increase
- ❑ Some increase

- ❑ No change
- ❑ Some decrease
- ❑ Large decrease
- ❑ Unsure
- ❑ Other

Please specify, e.g. increase in under 13 year olds with harmful sexual behaviour

_____

_____

## Your agency's experience of working with children and young people with harmful sexual behaviour

**Approximately** what proportion of the harmful sexual behaviour cases your agency work with are with children and young people from the following groups? Please tick one answer in each row.

| | None | A few | Some | A lot | Most | Unsure |
|---|---|---|---|---|---|---|
| Children and young people from BME groups | ❑ | ❑ | ❑ | ❑ | ❑ | ❑ |
| Children and young people with learning disabilities | ❑ | ❑ | ❑ | ❑ | ❑ | ❑ |
| Children and young people with mental health problems | ❑ | ❑ | ❑ | ❑ | ❑ | ❑ |
| Girls and young women | ❑ | ❑ | ❑ | ❑ | ❑ | ❑ |
| Boys and young men | ❑ | ❑ | ❑ | ❑ | ❑ | ❑ |
| LGBT children and young people | ❑ | ❑ | ❑ | ❑ | ❑ | ❑ |
| Children and young people in custody | ❑ | ❑ | ❑ | ❑ | ❑ | ❑ |
| Children and young people in care | ❑ | ❑ | ❑ | ❑ | ❑ | ❑ |

| | | | | | | |
|---|---|---|---|---|---|---|
| Children and young people with a child protection plan | ❑ | ❑ | ❑ | ❑ | ❑ | ❑ |
| Children and Young People with Special Educational Needs and Disabilities (SEND) | ❑ | ❑ | ❑ | ❑ | ❑ | ❑ |

Please provide more detail on type of SEND here (optional)

_____

_____

| | | | | | | |
|---|---|---|---|---|---|---|
| Other<br>Please specify: | ❑ | ❑ | ❑ | ❑ | ❑ | ❑ |

_____

_____

**Approximately** how many of the young people with harmful sexual behaviours your agency work with are affected by the following factors? Please select one answer in each row.

| | None | A few | Some | A lot | Most | Unsure |
|---|---|---|---|---|---|---|
| Abuse from others (non-sexual) | ❑ | ❑ | ❑ | ❑ | ❑ | ❑ |
| Sexual abuse from others | ❑ | ❑ | ❑ | ❑ | ❑ | ❑ |
| Neglect | ❑ | ❑ | ❑ | ❑ | ❑ | ❑ |
| Offending | ❑ | ❑ | ❑ | ❑ | ❑ | ❑ |
| Social isolation | ❑ | ❑ | ❑ | ❑ | ❑ | ❑ |
| Difficulties with social skills | ❑ | ❑ | ❑ | ❑ | ❑ | ❑ |
| Poverty | ❑ | ❑ | ❑ | ❑ | ❑ | ❑ |
| Domestic violence | ❑ | ❑ | ❑ | ❑ | ❑ | ❑ |
| Exclusion from education | ❑ | ❑ | ❑ | ❑ | ❑ | ❑ |

| | | | | | | |
|---|---|---|---|---|---|---|
| Other | ❑ | ❑ | ❑ | ❑ | ❑ | ❑ |

Please specify:

_____

_____

Please specify any particular **tools and/or approaches** for identifying, assessing or supporting children and young people who display harmful sexual behaviour.

_____

_____

_____

_____

Please tell us about up to three **challenges** your staff experience in working with children and young people with harmful sexual behaviour.

_____

_____

_____

_____

## Knowledge, skills and training to work with harmful sexual behaviours

### *What do we mean by 'harmful sexual behaviour'?*

Harmful sexual behaviour can be defined as follows:

*Sexual behaviours expressed by children and young people under the age of 18 years old that are developmentally inappropriate, may be harmful towards self or others and/ or be abusive towards another child, young person or adult*. (Hackett, Holmes and Branigan, 2016).

Note that Harmful Sexual Behaviour can be understood to overlap with child sexual exploitation (CSE) (where CSE is peer-perpetrated) and with intrafamilial child sexual abuse (e.g. sibling abuse).

The image below sets out Hackett's continuum of sexual behaviours, on which harmful sexual behaviours may fall anywhere on the middle and right.

In general, how far do you agree or disagree with the following statements about your **knowledge and skills** regarding children and young people with harmful sexual behaviours? Please tick one answer on each row.

| | Strongly disagree | Disagree | Neither agree nor disagree | Agree | Strongly agree | Unsure |
|---|---|---|---|---|---|---|
| **Developing strategies** for harmful sexual behaviour | ❑ | ❑ | ❑ | ❑ | ❑ | ❑ |
| Leading **multi-agency partnerships** relating to harmful sexual behaviour | ❑ | ❑ | ❑ | ❑ | ❑ | ❑ |
| **Designing services** for harmful sexual behaviour | ❑ | ❑ | ❑ | ❑ | ❑ | ❑ |

| | | | | | | |
|---|---|---|---|---|---|---|
| **Commissioning services** for harmful sexual behaviour | ❑ | ❑ | ❑ | ❑ | ❑ | ❑ |
| **Supporting high quality practice** for harmful sexual behaviour | ❑ | ❑ | ❑ | ❑ | ❑ | ❑ |
| **Supporting practitioners** to manage the emotional impact of harmful sexual behaviour | ❑ | ❑ | ❑ | ❑ | ❑ | ❑ |

How far do you agree or disagree with the following statements about your **confidence** regarding children and young people with harmful sexual behaviours? Please tick one answer on each row.

| | Strongly agree | Agree | Neither agree nor disagree | Disagree | Strongly disagree | Don't know |
|---|---|---|---|---|---|---|
| **Developing strategies** for harmful sexual behaviour | ❑ | ❑ | ❑ | ❑ | ❑ | ❑ |
| **Leading multi-agency** partnerships relating to harmful sexual behaviour | ❑ | ❑ | ❑ | ❑ | ❑ | ❑ |
| **Designing services** for harmful sexual behaviour | ❑ | ❑ | ❑ | ❑ | ❑ | ❑ |
| **Commissioning services** for harmful sexual behaviour | ❑ | ❑ | ❑ | ❑ | ❑ | ❑ |
| **Supporting high quality practice** for harmful sexual behaviour | ❑ | ❑ | ❑ | ❑ | ❑ | ❑ |
| **Supporting practitioners** to manage the emotional impact of harmful sexual behaviour | ❑ | ❑ | ❑ | ❑ | ❑ | ❑ |

How far do you agree with the following statements about your **confidence** as a manager regarding children and young people with harmful sexual behaviours? Please tick one answer on each below

| Strongly agree | Agree | Neither agree nor disagree | Disagree | Niether agree nor disagree | Don't know |
|---|---|---|---|---|---|

| | | | | | | |
|---|---|---|---|---|---|---|
| I feel **confident** in supporting staff that I supervise to address any negative feelings they may have as a result of working with children displaying harmful sexual behaviour | ❑ | ❑ | ❑ | ❑ | ❑ | ❑ |
| I feel I can **exercise ownership and leadership** in the field of harmful sexual behaviour | ❑ | ❑ | ❑ | ❑ | ❑ | ❑ |
| I am **confident** my staff have the requisite knowledge and skills to work effectively in this field | ❑ | ❑ | ❑ | ❑ | ❑ | ❑ |
| I am **supported** by the wider local partnership in working in this field | ❑ | ❑ | ❑ | ❑ | ❑ | ❑ |

We understand that this work, as well as being rewarding, can also cause negative feelings amongst professionals. Thinking about experience you may have working with children displaying harmful sexual behaviour, or the prospect of having to address these issues, how does it make you feel? Please tick all that apply:

- ❑ Anxious
- ❑ Awkward
- ❑ Embarrassed
- ❑ Isolated
- ❑ Confused
- ❑ Disturbed
- ❑ Upset
- ❑ Worried
- ❑ None of the above
- ❑ Other

Please specify

_____

_____

Have your staff received training in working with children and young people who display harmful sexual behaviour, since 2014? Please tick one.

- ❑ Yes

- ❑ No
- ❑ Unsure / Can't remember

If yesPlease provide a brief description of the type of training your staff have received (including whether it related to any specific groups of children and young people and how often).

_____
_____
_____
_____

Do you think the training impacts your staff in any of the following ways? Please tick all that appy.

| | Not at all | Not a lot | Somewhat | A lot | Don't know / Can't remember |
|---|---|---|---|---|---|
| Improved **confidence** working with children and young people with harmful sexual behaviour | ❑ | ❑ | ❑ | ❑ | ❑ |
| Improved **awareness/knowledge** of the signs of harmful sexual behaviour | ❑ | ❑ | ❑ | ❑ | ❑ |
| Improved my **knowledge** of the **impacts** of harmful sexual behaviour | ❑ | ❑ | ❑ | ❑ | ❑ |
| Influenced the **specific methods or skills** used when working with children and young people with harmful sexual behaviour | ❑ | ❑ | ❑ | ❑ | ❑ |
| Other<br>Please specify: | ❑ | ❑ | ❑ | ❑ | ❑ |

_____
_____

Which of the following methods of support and guidance does your agency use in working with children and young people with harmful sexual behaviour? Please tick all that apply.

- ❑ Talk with peers
- ❑ Talk with senior colleagues

- ❑ Written guidance from senior colleagues
- ❑ Shadowing colleagues
- ❑ Self-directed study / reading
- ❑ Peer networking events
- ❑ 1:1 supervision
- ❑ Team meetings or team based learning
- ❑ Policies and procedures
- ❑ Sector-specific media
- ❑ Group supervision
- ❑ Multi-agency support
- ❑ Referral to harmful sexual behaviour specialist
- ❑ None of the above
- ❑ Other

Please specify:

_____

_____

How do the methods of support and guidance you outlined impact upon how your staff work? Please tick one answer in each row.

| | Not at all | Not a lot | Somewhat | A little | A lot | Don't know |
|---|---|---|---|---|---|---|
| Improved **confidence** working with children and young people with harmful sexual behaviour | ❑ | ❑ | ❑ | ❑ | ❑ | ❑ |
| Improved **awareness/knowledge** of the signs of harmful sexual behaviour | ❑ | ❑ | ❑ | ❑ | ❑ | ❑ |
| Improved **knowledge** of the impacts of harmful sexual behaviour | ❑ | ❑ | ❑ | ❑ | ❑ | ❑ |
| Influenced the **specific methods or skills** used when working with children and young people with harmful sexual behaviour | ❑ | ❑ | ❑ | ❑ | ❑ | ❑ |

Do you have any specific comments about the methods listed above?

_____

_____

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