18.
Children and young people exhibiting sexually harmful behaviour – what have we learned and what do we need to know to propose effective intervention?

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Introduction

Protecting children from sexual abuse and exploitation must be seen as imperative for all governments, regions and local communities if they are to create a society that nurtures, protects and cares for all its children. It is therefore important that child protection agencies work together with civil society to make protective adults aware of the dynamics behind this complex social problem. By educating the general population on this issue and introducing a “public health approach” to protecting children, society will be better equipped to protect them from all forms of sexual abuse and exploitation. This holistic form of safeguarding children should also incorporate appropriate assessment and therapeutic services for those who sexually harm children and for those individuals who are motivated to seek help before they sexually abuse a child.

Child protection professionals maintain that stereotypical views about people who sexually harm children still exist. There is still reluctance to move away from the “stranger danger” concept of child protection, which can distort research findings on the issue. Research has clearly shown that the vast majority of people who sexually abuse children know their victim. Over 80% of sexually abused children will have some form of relationship with their abuser. This person might be a member of the family or a known member of their
local community (Stop it Now UK and Ireland, 2003). Some people who sexually harm children hold responsible positions in society and are considered as being above all suspicion. To safeguard children from sexual abuse and exploitation, society needs to acknowledge that abusers are a heterogeneous group, a situation that needs to be reflected in comprehensive child protection policies. Florin and Jones (2001:18) write:

Child sexual exploitation and abuse is unlikely to be efficiently prevented unless the diversity of the people who sexually exploit children is fully taken into account. Both men and women, some children themselves, exploit children sexually in different ways, for many different reasons and in various contexts.

**Children and adolescents who sexually harm other children**

The fact that some children and adolescents sexually harm other children can be extremely difficult for many child care professionals and members of the public to comprehend. The emergence of what has been perceived of as a “new social problem” has been met with denial, confusion and a lack of appropriate intervention in most European countries. Yet we have become increasingly aware that children and young people under the age of 18 can sexually harm other children, with statistics stating that between 25% and 35% of sexually abusive acts are perpetrated by persons under 18 (Masson and Erooga, 2006). These figures have been quoted for many years by professionals working in this area, but appropriate service provision does not appear to have matched the growing awareness of the problem. Although assessment and treatment facilities for these children now exist in some countries, service provision based upon a coordinated national strategy and a cohesive governmental response has been extremely slow to develop (Hackett and Masson, 2004).

This chapter will give an overview of how the international community has responded to the challenge of working effectively with children and adolescents who have exhibited sexually harmful behaviour. It is essential that this group receive appropriate assessment
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and intervention to help them understand and to change. It is hoped that this chapter will also enable child care professionals to better recognise the need to address this phenomenon without labelling an individual child as a “sex offender”. “Sexually harmful behaviour” is the more appropriate term from the perspective of child’s rights and child protection.

**Historical perspectives**

To understand current practice in the field, it is helpful to look at how intervention has developed internationally within a historical and socio-political context. This is of particular relevance in relation to children and adolescents who have exhibited sexual harmful behaviour, as societal denial appears to have been difficult to overcome. Europe has been slow to acknowledge this phenomenon as a serious social problem, an attitude responsible for delays in offering effective assessment and treatment services to these children.

The United States was the first country to address this “new social problem”. Professionals there implemented assessment and treatment programmes for what were called “juvenile sex offenders”. This was later followed by work with younger children labelled as having “sexual behaviour problems”.

Adolescents responsible for committing “sexual offences” against other children was documented by the psychiatrist Dr Lewis Doshay, who worked with courts of justice and clinics in New York City during the 1920s and 1930s. In 1928 he began a six-year outcome study which followed 256 juveniles brought before the courts in various boroughs of New York in so-called “sexual delinquency cases” (Doshay, 1943). The study findings are interesting as they documented low levels of recidivism in relation to “sexual offending” by adolescents, but recorded high rates of other “non-sexual offending behaviour”. These findings have been replicated in recent outcome studies, which suggest that most adolescents convicted for sexually harming other children will not be re-convicted of further sexual offences as adults.
But it is important to consider the small subgroup that will go on to commit further sexual offences and it is these children that we should be targeting for long-term intervention. The Doshay report led to other studies in the United States just after the Second World War (Atcheson and Williams, 1954), but treatment programmes were not established on a significant national basis until the early 1980s, when there was a greater recognition of all forms of sexual abuse and exploitation.

The massive growth in treatment facilities in the United States has triggered criticism from professionals concerned that some adolescents are being unnecessarily admitted to residential treatment facilities. This is based on the premise that some adolescents are being forced to undergo treatment even though they might not benefit from it. It is important that therapeutic intervention be based upon a comprehensive assessment which reflects the risk posed by the child and also looks at the needs of the individual child or adolescent. Although risk assessment is important, therapeutic intervention should be implemented as a means of helping the young person move forward and not be used as a form of punishment or retribution.

**European developments**

The slow development of service provision in Europe as compared to that in North America can probably be attributed to the close cultural, social and historical ties between the United States, Canada and the United Kingdom. This may also explain why the latter appears to have been the first European country to begin working on the issue.

From a comparative socio-political perspective, research indicates that there is a correlation between social welfare models and recognising and reacting to complex social problems: countries which have adopted the Anglo-Saxon model tend to react more quickly than countries with a northern European or corporatist conservative model of social welfare (Esping-Andersen, 1990, Harder and Pringle, 1999, Pringle 1998). This appears to have been the case concern-
ing treatment development for children exhibiting harmful sexual behaviour.

The UK began to assess the development of service provision for these children in 1992 with the publication of “The report of the Committee of Enquiry into children and young people who sexually abuse other children” (NCH, 1992). The committee was responding to the Survey of Treatment Facilities for Young Sexual Abusers (NCH, 1991) “which painted a gloomy picture of our understanding of these areas” (Calder, 1997:1). One of the main criticisms of the report centred on the fact that treatment was based on work with adult sex offenders and ignored the developmental status of children and adolescents.

In 2003, Hackett and Mason published the results of a two-year investigation into the then current state of provision for this group of young people across the UK and Ireland. Their research found that there are nearly 200 services or projects offering intervention to sexually harming young people, but that many of these are generic rather than specialist. Although the report stated that there was a much more sophisticated and professional approach to the work in the UK, it also described service provision as being “patchy” and “unco-ordinated” (Hackett and Masson, 2003). Further to this the UK Children’s Commissioner reported to the UN Committee on the Rights of the Child that:

There is also a severe lack of service provision, including assessment, support and treatment programmes for children and young people exhibiting sexually harmful behaviour. At present there is an inconsistent response to this group at the local level, with different systems and policies operating in different areas and little development of the specialist services required to meet their specific needs. (UK Children’s Commissioners Report to UN Committee on the Rights of the Child, 2008)

Problems in developing service provision in other European countries appear to have been similar to the situation in the UK, but as
stated above, with even greater levels of societal denial in some countries. The attitude of northern European countries during the late 1980s and mid-1990s is a good example of initial denial. Although services are now developing rapidly in northern Europe there was significant reluctance to see this as a social problem in the 1990s.

In 1996, the author of this chapter undertook a comparative analysis of treatment facilities in Denmark and the UK. The report concluded that societal denial of the problem was much greater in Denmark, based upon the fact that there were no official treatment facilities in Denmark in 1996 (Jones, 1996, unpublished). The first Danish treatment facility did not open until 2003 thanks to efforts from NGOs and professionals who had gained knowledge in this area by attending international conferences.

European professionals working on this issue began to form networks, giving rise to the so-called Harreveld Group, which began to meet twice a year in the Netherlands to discuss “working with sexually abusive children in a European context”. In 1999, the European Society for Working with Sexually Abusive Youth (Essay) was formed to establish best practice and compare socio-demographic data. In putting the historical developments in relation to assessment and treatment in Europe into some kind of perspective, it is interesting to look back at the remarks that Ruud Bullens, co-founder of Essay made in his keynote speech at their first conference (Amsterdam, May 2003):

> It must be stated here that we were greatly amazed to see how professionally the treatment of these sexually abusive youth was organised in Great Britain and what amount of scientific research was done in this particular field. Compared with the Dutch situation – which to the best of my knowledge is completely comparable with the situation in the other European countries – Great Britain offers a lot of therapeutic programmes for a lot of juvenile sex offenders.

If we compare the above-mentioned remarks with those made about service provision in the UK by the Children’s Commissioner in 2008,
then it could be suggested that there is still an urgent need for further research and international co-operation between European countries on this issue. It is important to acknowledge that this behaviour is harmful to other children and in need of correction through appropriate assessment and therapeutic intervention. Measures also need to be implemented to assess the impact of treatment. The work of the Essay network has enabled practitioners in Europe to use standardised measures to evaluate their input across Europe using the Adolescent Sex Offender Assessment Pack (ASOAP) developed by psychologist Richard Beckett. This underscores the need for treatment and its evaluation to be carried out by qualified professionals, working within a child’s rights and child protection framework, with a focus on helping the child.

After initial denial of the problem, some countries over-reacted to it with judicial responses that were not always in the best interest of children’s rights. Research has shown that these children and adolescents have a myriad of social and psychological needs that were not met due to possible neglect or abuse in their early childhood. This needs to be addressed within a child protection and therapeutic context.

If we take the United Kingdom as an example, the societal denial that existed at the start of the 1980s meant that very few children were being offered appropriate assessment and treatment. This period was followed by a period of recognition and the introduction of a “risk management approach” when it seemed that all cases were assessed as being “high risk”, with children being put on treatment programmes based on work with adult sex offenders. This was then followed by a more holistic and well-thought out response that provided children and adolescents with more age-appropriate and individual treatment programmes based upon a comprehensive assessment of their needs. This is a very simplistic view of developments in the UK, but it does give a basic analysis of how intervention has developed. There is a need to look critically at developments in the UK and the rest of Europe so we can learn from their past mistakes and pass our knowledge on across borders.
Hacket (2007:1) writes:

About a quarter to a third of all cases of sexual abuse coming to the attention of professionals concern situations where children and young people are the alleged perpetrators of the abuse. Almost all reports on this topic state this same, well worn statistic, and I am sick of it.

Important as professional awareness of this phenomenon is, developing correct responses to children with harmful sexual behaviour is what matters here. It’s time we moved from the statistic to action ... We also need to ensure a balanced and less hysterical approach. Most young people presenting with such behaviour are both risky and vulnerable. It is right that we deal with the risk, but all too often the professional system conspires to increase the vulnerability. The move to resilience-enhancing models of intervention that seek to harness strengths and foster abilities is urgently overdue in the sexual aggression field, where risk management discourses still dominate. We also need to look carefully at the broader social context. In the current landscape of societal anxiety and highly restrictive legislative measures towards adult sex offenders, children and young people are being caught up in a maelstrom of intolerance and fear.

In some countries the response to working with children exhibiting sexually harmful behaviour has been criticised for labelling children as “sex offenders” and not considering children as persons with specific rights. Some children under the age of 18 have even had their personal details put on a sex offender register. It is important to challenge children’s harmful sexual behaviour, but it is equally important not to equate it to that of adult sex offenders. Unlike adults, children are developmentally not capable of the same kind of intellectual capacity for reasoning, planning and understanding the implications of their actions (Crooks et al., 2005).

**Age of criminal responsibility**

A major problem at international level in dealing with the judicial implications of this behaviour is the age of criminal consent, which
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varies greatly in countries across the world. In England and Wales the age of criminal responsibility is 10, but in Sweden and Norway it is 15. This makes it difficult to compare cases at international level because their outcomes will differ due to a lack of harmonisation of European legal systems.

The judicial sanctions that some children receive will have serious lifelong consequences in terms of education and future employment. This could be seen as being in conflict with the United Nations Convention on the Rights of the Child. Article 40 on the administration of youth justice states that:

States Parties recognise the right of every child alleged as, accused of, or recognised as having infringed the penal law to be treated in a manner consistent with the promotion of the child's sense of dignity and worth, which reinforces the child's respect for the human rights and fundamental freedoms of others and which takes into account the child's age and the desirability of promoting the child's reintegration and the child's assuming a constructive role in society....

Defining the problem

Proposing effective therapeutic services to these children and adolescents entails defining the multifaceted and complex nature of this issue, taking into account its different perspectives. First and foremost, a distinction needs to be made between adolescents and younger children, in terms of their emotional, cognitive and social development, making it imperative that assessment and therapy take into account the needs of each individual child and are not based on a “one fits all philosophy”.

Many adolescents will be above the age of criminal responsibility and therefore subject to judicial consequence for their actions. Children below the age of criminal responsibility will probably enter the child welfare systems in most countries and not be subject to judicial proceedings. Although there are no formal rules distinguishing children and adolescents according to age, 13 is generally seen as the
beginning of adolescence in terms of child protection and judicial intervention.

**Terminology**

Working towards a definition of what constitutes sexually harmful behaviour requires us to be more circumspect in relation to the terminology which is used in relation to children and adolescents. Some of the terms that are used do not reflect a child’s rights or a child protection perspective and it is important not to use language extracted from therapeutic work undertaken with adult sex offenders. There should always be a professional understanding that we are referring to children and adolescents who are in a developmental stage in their lives. Public policies, assessment procedures and most treatment protocols developed for adult sex offenders are inappropriate for children and should not be used as a means of intervention. Therefore it is important not to label children and adolescents as “sex offenders”.

According to the Association for Treatment of Abuses (ATSA, 1996:24):

> Adults should take every precaution against policies that label children as deviant, perverted, as sex offenders, or destined to persist in sexual harm. Professionals increasingly use the term *children with sexual behaviour problems* because it labels the behaviour and not the identity of the child (Chaffin and Bonner, 1998; Chaffin et al., 2002). Given that childhood SBP (Sexual Behaviour Problems) may foretell little about a child’s future behaviour, and that labelling risks creating a self-fulfilling prophecy and social burdens, applying labels such as “sex offender,” “predator”, “perpetrator” or variants of these terms are injudicious, especially when that label is likely to outlive any utility or relevance.

**The impact of interactive technologies on sexually harmful behaviour**

Although there is very little research on interactive technologies as a possible pathway into sexually harmful behaviour, it is worth reviewing what we do know about this new area. Children and adolescents
have almost unlimited access to the Internet via personal computers and mobile phones. It is not known how many of them engage in sexual behaviour online or if there is a causal link between deviant use of the interactive technologies and sexually harmful behaviour. Case study analyses indicate a disinhibition effect of pornography on adolescent sexual behaviour (Cooper, Boies and Osborne, 2004), and there is also evidence that viewing highly deviant or violent images increases the risk at least for some adolescents (Quayle and Taylor, 2005).

There is concern that accessing pictures and text with a sexual content may have an adverse impact on current or future sexual and emotional development. A further concern is that looking at online deviant sexual material may act as a catalyst to engage in a sexually problematic way with another child or children, or that it may put a young person at risk of sexual exploitation by others, particularly adults. Another “harm-to-others” scenario relates to children and adolescents victimising other young people by accessing images of child abuse through interactive technologies, or sexually soliciting others in chat rooms or on social network sites.

Adolescents engaging with interactive technologies can be made vulnerable as they are exposed to incorrect information about human sexual behaviour and enhancements of deviant sexual fantasies. The latter are usually further reinforced by masturbation triggered by downloaded material. In 2003 the British NGO Barnardos identified 83 children as being involved in Internet and mobile phone abusive activities and of these, 22 children were identified as having downloaded sexually abusive images of other children. This indicates a need to develop services in this area and undertake more research.

**Understanding sexual development**

To gain an understanding of difference between “normal” sexual development and sexual behaviour that is harmful let us look briefly at what the literature says about healthy sexual development and problematic sexual behaviour. Normal childhood sexual play and exploration is behaviour that occurs spontaneously, intermittently, is
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mutual and non-coercive when it involves other children, and causes no emotional distress. “Normal childhood sexual play and exploration is not a preoccupation and usually does not involve advanced sexual behaviours such as intercourse or oral sex” (ATSA, 2006:3).

With regard to executing sexually harmful behaviour, young children are far less able than adults to engage in complex cognitive processes such as planning, grooming or rationalising. Children have shorter attention spans and more limited impulse control. Children with sexually harmful behaviour problems are more likely to be impulsive rather than compulsive in their actions towards other children and again this is a vital factor in differentiating their actions from those of adolescents and adults. The assessment and treatment of younger children has lagged behind work carried out with adolescents, but now appears to be attracting more attention and resources after an initial failure of recognising the need to work with this group of children.

**Assessment issues**

Assessments should establish the facts of what has happened and make decisions about potential risks with regard to other children in contact with the child and the child who has sexually harmed others. It must be determined if the child is likely to commit further harm, even though research suggests that the vast majority of younger children will not develop further harmful behaviour, especially if appropriate intervention is offered to the child and to the family. The assessment should include information about the child’s family background as it is important to work with the family and involve parents and siblings if possible. Further assessment and management may be needed if the harmful behaviour was directed against a sibling. Clinical assessments are primarily useful for informing intervention and treatment planning and should not be confused with official investigations, for which they may not be relevant.

All intervention measures should take into account that young children do not yet possess the cognitive maturity or the ability to regulate
their emotions that would allow them to use self-understanding as a means of improving emotional and behavioural self-control. Young children's cognitive abilities are better suited to understanding simple rules about behaviour. Agency intervention should always be supported by interagency co-operation when undertaking this work and a multi-agency assessment should be carried out before any management or treatment plans are made. This work should be co-ordinated by an experienced social worker and good practice suggests that two professionals should be involved in the comprehensive assessment. Psychologists should also be involved in relation to any psychometric tests that are deemed necessary within the assessment process.

Sexually harmful behaviour by children and young people creates victims, but most of these children are themselves victims. Research indicates that the vast majority of children who sexually harm other children have been subjected to multiple forms of abuse and neglect within their own families and that this could contribute to the onset of sexually harmful behaviour. According to Hawkes (2009:1): “Research into sexually harmful behaviour (SHB) in children has evolved towards a general recognition that neglect and maltreatment in early childhood, including sexual abuse, may predispose the onset of sexually harmful behaviour.” This underlines all the more the need to assess the family history. Many of the families in question will have already had contact with the social services for reasons other than an incident of sexually harmful behaviour.

As mentioned above, it is generally accepted that two professionals should be assigned to this kind of assessment work as there are many complex issues to consider, in particular because this includes working with families. According to the practice guidelines from the British NGO, the National Society for the Prevention of Cruelty to Children (NSPCC, 2008:7), all assessments should include family information gathered from the parents where appropriate and cover:

- the family history – including its chronology and health matters;
- family relationships;
- previous offending/inappropriate sexual behaviour;
• domestic violence;
• attachment / emotional availability;
• boundaries and family attitudes towards sexuality;
• attitudes towards sexually harmful behaviour and towards the victim;
• methods of discipline.

It is also important to recognise the strengths and weaknesses of families and be able to offer support. Many parents whose children display sexually harmful behaviour may feel lonely and isolated when contact is made with social services. They often face stigma, rejection and hostility from the local community in reaction to their child's behaviour. Research outcomes strongly suggest that involving parents in the assessment is vital to the success of any intervention.

**Treatment**

Treatment should be based upon a comprehensive assessment and implemented by qualified professionals. Evidence suggests that cognitive behavioural treatment and psycho-educational approaches have both been successful in working with children exhibiting sexually harmful behaviour. These approaches can be used in group work or on an individual basis.

ATSA (1996) reports that:

Two randomised trials have been conducted specifically focusing on children with Sexual Behaviour Problem (SBP). Bonner and colleagues (Bonner, Walker, and Berliner, 1999) randomly assigned children with SBP either to a 12-session, psycho-educational, cognitive-behavioural group treatment program (CBT) or a 12-session play therapy group. Short-term reductions in SBP and non-sexual behaviour problems were found among children in both treatment groups. At ten-year follow-up, sex offense arrest and child welfare sexual abuse perpetration report outcomes were significantly in favour of the CBT condition (Carpentier, Silovsky, and Chaffin, in press). Children randomised to CBT had sig-
significantly lower rates of sex offense arrests or sex abuse perpetration reports (2%) than children randomised to play therapy (10%).

Play therapy can also be used with younger children to address difficult issues as some children may not be suitable for group dynamics work. This does not mean that group work should not be used, but each child should be assessed first as to their ability to work in a group and determine whether alternative methods should be used.

**Working with adolescents**

As stated earlier, work with adolescents has been ongoing in some countries since the 1980s with assessment and therapeutic work being well established in many countries. Some adolescents represent a high risk to other children as the characteristics of sexually harmful behaviour committed by some adolescents can be similar to that perpetrated by adult sex offenders. They can engage in both contact (including penetrative acts) and non-contact behaviours and some adolescents do have the cognitive ability to “groom” their victims. There are documented cases of adolescents harming a variety of victims including much younger children as well as peers or adults (NSPCC, 2008).

As mentioned previously, however, research indicates that the vast majority will not go on to abuse children as adults, as was once thought. In a six-year follow up study of 148 adolescents, only 5% had reoffended by the end of the study (Worling and Curwen, 2000). It is important to take this issue seriously and implement appropriate risk assessment and therapeutic responses, but this intervention also needs to reflect the latest research results.

**Assessment issues for adolescents**

It is important for professionals to engage and communicate with adolescents throughout the assessment process. This can be a very difficult task as each individual will react differently to the worker and the assessment procedure. Professionals conducting the assessment
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should be experienced in working with adolescents so they can react accordingly to defensive behaviour. This may include anger, denial and minimisation of the harmful sexual behaviour. Most adolescents react well to humour and it can be used as a method to involve young people in the process. It is important that the worker maintain boundaries and be aware of possible grooming behaviour.

Assessment should include the following:

- a social history including significant loss, trauma and disruption;
- prior experiences of victimisation;
- wider social functioning, relationships and interactions;
- other offending behaviour;
- family environment and parenting style;
- full sexual history, knowledge and attitudes;
- exploration of the alleged sexually harmful behaviour;
- victim awareness and empathy;
- treatment prognosis.

**Assessment tools**

In the United Kingdom, the assessment, intervention and moving on (AIM) assessment framework (Print et al., 2001) provides guidance for a wide range of practitioners and provides a common language and a shared approach to tackling sexually harmful behaviour. This can be adapted to other cultural contexts and environments and is seen as a valuable tool in the assessment process.

In the United States, the Juvenile Sex Offender Assessment Protocol – II (J-SOAP-II), developed by Robert Prentky and Sue Righthand, is a checklist whose purpose is to aid in the systematic review of risk factors that have been identified in the professional literature as associated with sexual and criminal offending. It is designed to be used with boys age 12 to 18. The J-SOAP II may be used to assess the risk of sexual reoffending for non-adjudicated youth with a history
of sexually coercive behaviour, as well as young people adjudicated for sexual offences. This manual describes the development of the J-SOAP-II and provides instructions for its use.

Hackett (2004:3) relates:

Interventions broadly based on a cognitive behavioural framework, with a strong relapse prevention element, are supported in the literature for work with children, young people and their carers. However, intervention should be tailored to the specific needs of the individual child and family, rather than applied mechanistically to all. The emphasis should be on supportive and empathic interactions. Dogmatic inflexible or aggressive approaches are unhelpful.

**Conclusions**

There is now recognition that children and young people can sexually harm other children and that there is a need to develop appropriate service provision that meets the complex assessment and treatment needs of these troubled children. This work needs to be co-ordinated so good practice can be shared nationally and internationally with evidence based research and practice being shared across borders. This will allow for better service provision to be implemented on an international basis with allowances being made for cultural and socio-political differences.

It is clear that the vast majority of children and adolescents exhibiting sexually harmful behaviour have suffered neglect and maltreatment in their childhood. This appears to be a pathway into sexually harmful behaviour and indicates that society needs to be more proactive in identifying and working with children known to be at risk of abuse or neglect. There needs to be further research on this issue, with a focus on international co-operation in undertaking comparative studies and measures of what we already know. More research is also needed on interactive technologies and the impact of deviant and violent sexual images on children who have sexually harmed other children.
The vast majority of children with sexually harmful behaviours will not go on to perpetrate sexual abuse in adulthood. Those children that do present a higher risk of recidivism can be helped to reduce risk levels through appropriate intervention. Intervention with this group of children should be holistic, systemic and goal-specific (NOTA, 2008) and undertaken within a children’s rights and child protection framework. These and other recommendations discussed in this paper are integrated into the basic recommendations listed below.

**Children and young people exhibiting sexually harmful behaviour – recommendations**

- Intervention should be holistic, and focus on children’s needs across all aspects of their lives and development.

- Intervention should be systemic, involving families and parents in order to improve the children’s social environments, attachments and relationships.

- Intervention should be goal-specific and designed to address concrete issues.

- Pan-European information campaigns should be run to inform the general public of signs that could help identify a child engaged in sexually harmful behaviour, and how they can get help.

- A public health approach should also be used to inform the general public about this issue. (See www.stopitnow.org.uk for more information.)

- Professionals should also receive appropriate training and advice on how to intervene in these cases.

- When identified, sexually harmful behaviour must be taken seriously by all relevant agencies, with care taken to distinguish between experimental behaviour and exploitative and harmful behaviour.
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- Professionals must have the means to intervene early in cases of children with a history of maltreatment or trauma to prevent the development of abusive behaviour.

- Research on the conditions leading to sexually harmful behaviour, and appropriate therapeutic responses should be integrated into undergraduate curriculums for future social workers, psychologists and other professionals working for children.

- Based on the latest research evidence and practice, training protocols should be developed for qualified social workers and psychologists.

- Training on the developmental needs of children with respect to sentencing policies for adolescents should be developed for professionals working in the judicial field.

- A child's rights and child protection perspective should be maintained at all times.

- More research should be undertaken on the impact of interactive technologies on sexually harmful behaviour.

- Families should be involved in all professional interventions. This should be recognised as being as important as individual work with the child.

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