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Harmful sexual behaviours by children

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Contents

Background

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)

Research in 2017 identified a 5% increase in recorded sexual offending in Scotland and indicated this increase was linked to a growth in online sexual offending and was involving younger children, with a large proportion of harmful sexual behaviour towards children being carried out by children[1]. This led to an Expert Group being created by the Scottish Government. The purpose of this Group was to consider the evidence, review current responses and consider potential actions to prevent and respond to these behaviours.

This Expert Group on Preventing Sexual Offending by Children and Young People published a report in January 2020 called Prevention of and Responses to Harmful Sexual Behaviour by Children and Young People[2]. One of the proposals made within this report was to commission further research examining the impact of childhood experiences as potential causes or links to harmful sexual behaviour in Scotland.

Aim

The aim of this study was to start to fill these research gaps. The specific research aims were:

1. To examine and describe the childhood experiences of children referred to the Interventions for Vulnerable Youth (IVY) project who are displaying Harmful Sexual Behaviour (HSB)
2. To explore potential links between childhood experiences and HSB
3. To illustrate potential patterns of childhood experiences and HSB

Method

Data

As HSB is still of quite low prevalence across Scotland, the decision was made to use secondary analysis of an existing dataset that had been captured by the IVY project. This source data was chosen as it includes a large quantity of rich detail on the life experience of children who pose a very high risk to other people from across Scotland, around half of who had displayed HSB. The IVY project is a specialist psychological and social work service

[1] https://www.gov.scot/publications/recorded-crime-scotland-2016-17/

[2] https://www.gov.scot/publications/expert-group-preventing-sexual-offending-involving-children-young-people-prevention-responses-harmful-sexual-behaviour-children-young-people/

which conducts risk assessment, formulation and management of children (aged 12 -18 years) with complex social, emotional and behavioural difficulties. These children are assessed as posing a risk to others, usually as a result of violent or harmful sexual behaviour (HSB). The project is now based at Kibble Education and Care Centre but was previously was hosted within CYCJ for six years and was structured around three Levels of intervention. Level 1 is the consultation stage and involves referrers and other professionals working with the child attending a consultation meeting with a multi-disciplinary IVY team to discuss and share information about the child's presenting needs, risk and background history. The IVY team then produce a Risk Analysis Report, using a Structured Professional Judgement approach, which includes information on the young person's background, risk factor ratings, risk formulation, risk scenarios, and recommendations for risk management.

Ethics

The research was governed by Ethical Approval from University of Strathclyde Ethics Committee which allowed for secondary analysis of anonymised Level 1 information in the IVY dataset. Referrers to the IVY project provided consent for referral information and the Level 1 Risk Analysis Report to be used for research purposes.

In order to minimise risks of disclosure a unique code was used to identify families and children and no personal or identifiable information is shared within the report. Case studies are an amalgam of multiple cases although reflective of individual cases. To further ensure anonymity, frequency data tables generated do not feature fewer than five individuals.

All of the data extracted from the IVY project was anonymised and only accessed by the researcher and internal management. Electronic data was stored on the CYCJ restricted folder and access to this folder is only available to the researcher and internal management.

Identifying those children displaying HSB and a comparison group

In order to create a sample of children displaying HSB, the referral information and risk analysis reports of 219 children referred to IVY between 2013 and 2019 were examined using a structured case file examination tool (see Appendix A). First children who were displaying HSB were identified and thereafter details of their childhood experiences were documented using the tool. The variables included within this tool were based on previous literature, included within the Expert Group for Preventing Sexual Offending (2020) and augmented by practitioner input. The draft case file examination tool was circulated throughout the multi-disciplinary team within CYCJ for comment and feedback during the design phase of the study.

An existing non-HSB sample of those children referred to IVY over the same timescale who did not display HSB was used as a comparison. The database contained the ages and genders of the children and also recorded their adverse childhood experiences[3] which could be matched to the non-HSB group. These adverse childhood experiences were: domestic violence; parental abandonment through separation or divorce; a parent with a mental health condition; being the victim of abuse (physical, sexual and/or emotional); being the victim of

[3] As identified within Couper, S and Mackie, P. 2016, 'Polishing the Diamonds' Addressing Adverse Childhood Experiences in Scotland, *Scottish Public Health Network (ScotPHN)*

neglect (physical and emotional); a member of the household being in prison; growing up in a household in which there are adults experiencing alcohol and drug use problems.

Limitations of the sample

Making use of secondary analysis of data that has already been collected for another purpose brings with it some limitations and caveats, and it is important to recognise and understand the reason for missing or unclear data:

- The referral forms and Risk Analysis Report completed at Level 1 and used as the basis of the database are not exhaustive and not designed to record the child's life experiences to date.
- The author of the documents focused on the immediate risks and needs of that child and include details pertinent to that, including their own professional interpretation
- There is researcher interpretation with regard to completing the case file examination tool. The reasoning behind some of the decisions to include or not include within certain variables are further described in the Appendix.
- Not every incident of possible HSB led to formal charges. This could be due to lack of evidence; the incident being dealt with by the Children's Hearings System; the case not yet being finalised by the Court; or indeed the desire, by the victim or their family for the incident to be resolved informally.
- It is also important to acknowledge that both the HSB sample and non-HSB comparison samples are relatively small and consist of children who are presenting with high levels of need, in most cases have received many types of intervention and, as will be described later in the report, are extremely vulnerable.

Findings

The HSB sample was made up of 97 children with documented HSB. This behaviour is both on a continuum of seriousness and ranges in HSB type, from accusations of rape, to concerns around use of extreme pornography, to children putting themselves at risk of harm with risky sexual activity. This wide range of HSB types are explored later within the report. The type of documented concern also ranged from those individuals who had been formally charged with a sexual offence to others where there was a reasonable suspicion that they were engaging in HSB.

The vast majority of the sample were male (89%, n=86) and white British (99%, n=96) and the majority were living away from home in a residential establishment or secure care (58%, n=56), living with family, extended family or foster family (40%, n=39) with the remainder (<2%) in their own tenancy or remanded in custody. The ages of the children ranged from 12 to 18[4] with a mean of 14.97 years. The children were referred from 27 local authorities across Scotland.

[4] IVY project works with children ages from 12 to 17 years, one individual was referred but then the consultation was held after he had turned 18 years old.

Types of HSB by children

Five main categories of HSB were identified: contact, non-contact, online/electronic media forms of HSB, putting self at risk and accessing pornography. However, in 43 children (44% of the sample) there were multiple forms of HSB identified, as a result these main categories contain repeat individuals. In addition some of the HSB displayed did not overtly or intentionally 'harm' another individual but instead could be described as placing the child themselves at risk with sexual behaviour such as underage sexual activity, for example with strangers. Non-contact HSB also included incidents of highly sexualised language or actions such as exposing themselves.

When the gender of the children within each category was examined, females made up the majority of those children who could be described as 'putting self at risk'. Across all other categories however, boys made up the majority. Where the HSB was carried out by internet or phone and did not result in direct physical contact, this was entirely carried out by boys. In the case of accessing pornography online in a way that raised concerns among professionals (i.e. not considered age or stage appropriate) the children were all male and when this small group were looked at more closely it was found they also all had a diagnosis of Autism Spectrum Disorder (ASD). The literature and other studies have suggested that this type of behaviour pattern may reflect a need by the ASD individual to collect and order images rather than a sexual intent, or indeed access pornography in an attempt to gain information about sex, leading to unintentional online offending in some cases (Allely & Dubin, 2018)

Table 1 shows there were some differences in the types of HSB displayed by the genders although the small numbers of girls in the sample means they cannot be compared statistically.

Table 1: Types of HSB

HSB type	Number	% of sample	Male	Female
Contact	64	66%	60	<5
Non-contact	48	49%	47	<5
Use of internet/phone	12	12%	12	-
Described as 'Putting self at risk'	10	10%	<5	8
Accessing pornography	<5	<5%	<5	-

Victims and locations of the HSB

Within the records the victim of each incident of HSB was not always recorded. However in some cases it was possible to identify if there were single or multiple victims, the relationship of the victim to the child and a broad location where the HSB took place.

For 12 (12%) of the children a single victim of their HSB was identified, while for 58 (60%) of the children there were multiple identified victims; this level of data was not available in 27 cases. The identified victims of these incidents fell into six broad categories, including: biological family members; extended family members/carers, friends, acquaintances (known to the child); staff members (which could include school or residential house staff); or a stranger to the child.

Among the 65 cases where this information was recorded, the most frequent target of the child's HSB were acquaintances of the child, with them being targeted by 39 (40%) of the children in the sample. Strangers were targeted by 18 (19%); friends targeted by 16 (16%); other family members/carers by 14 (14%); and staff members by 5 (5%). Fifteen (15%) of the children also targeted members of their biological family e.g. brothers or sisters or parents. In 36 cases there were multiple types of victim identified that had been the focus of the HSB.

The location of the HSB incidents were coded into four main types: the family home (this would include the family home or the home in which the child was resident at the time); the home of the victim; within a school; and in a social setting (which could include the wider community). The most frequent location of incidents was the family home, which involved 32 children; social locations which involved 27 children; school settings which included 22 children; and the home of the victim, which included eight children. However, 41 (42%) of the children had multiple incidents recorded and these often took place in multiple locations, in the case of 26 of the children multiple locations were identified.

Intra-familial HSB

For 15 children their HSB included intra-familial victims; these would be defined as close family members. When these cases were examined in more detail it was possible to ascertain that in the majority of cases, 11 of the 15 identified, the HSB involved another victim as well as family members. In only two cases family members were the only documented victims and in a further two cases this was not clear. However, where there was a record of intra-familial HSB this was frequently the first recorded incident type with eight of the 15 cases recording incidents with intra-familial victims prior to other victims or types of HSB. In one case the intra-familial incident was recorded as taking place after another type of HSB, and in six cases the order of incidents was not clear in the records.

In the case of 13 of 15 children displaying intra-familial HSB these incidents took place within the family home. In two cases the location was not recorded. Most of the children displaying intra-familial HSB experienced multiple placements (13 of the 15 children) and all were male. The average age of first suspected or confirmed HSB of those children who perpetrated intra-familial HSB was slightly higher (11.93 years) than those who did not (11.25 years) but this average might be impacted by a delay in the victim disclosing the behaviour, which was documented in two cases.

Early identification of concerns

The age at which concerns about atypical or concerning sexual behaviours were first identified varied across the sample from pre-school children to 17 years old. The average (mean) age at which reference was made to atypical sexual behaviour was 11 years old. With regard to those instances where concerns were raised about very young pre-school children, they related to what was described as sexualised behaviour and/or use of sexualised language. It is also worth reiterating that all of the children included in this sample have gone on to display HSB, as such, instances of behaviour, even potentially developmentally appropriate behaviour from their childhood, tends to be scrutinised through the lens of their presentation now.

Comparing the mean age of when these concerns were first recorded between genders there is relatively little difference. Boys in the sample began exhibiting concerning sexual behaviours or suspected HSB at a mean age of 11.33 years (ranging from three years to 17 years) and the girls in the sample started exhibiting these concerning behaviours at age 11.55 years (ranging from five years to 11 years).

Potential vulnerabilities

Mental health and Developmental disorders

Within the sample 14% (n=14) had been diagnosed with ASD, with a further 16% (n=15) with suspected ASD. In addition 23% (n=22) had been diagnosed with a learning disability with a further 12% (n=12) with a suspected learning disability that might need additional assessment. Foetal Alcohol Spectrum Disorder was identified or suspected in five of the children in the sample. Moreover, 33% (n=32) of the sample had a diagnosed mental health condition with a further 28% (n=27) where the professionals involved suspected there may be a mental health condition not yet diagnosed. Of these conditions the most frequently identified and recorded was ADHD (30%) with a further 4% of children in the sample where ADHD was suspected but not yet assessed.

A large number of the sample (n=50, 52%) presented with multiple additional needs, however this number only refers to diagnoses; many of the children in the sample were awaiting additional diagnoses or professionals working with them suspected they had additional disabilities or mental health needs.

A history of self-harm was documented in 40% (n= 39) of the children (this information was not recorded in four cases) and 24% (n=23) of the children would be considered a suicide risk by the professionals in their lives, again this information was not available in seven cases.

Sexual abuse

Twenty two percent (n=21) of the children had been sexually abused by an adult and a further 18% (n=17) had been a victim of HSB carried out by another child. In addition, it was recorded that 40% (n=39) had been exposed to pornography in their childhoods; this tended

to be viewed within their home and either accessed by the child or shared with them by an adult.

A study by Hackett et al (2013) suggests that two thirds of children who had engaged in harmful sexual behaviour had experienced some kind of abuse, neglect or trauma. In addition (as highlighted within the Expert Group report) studies have identified that the younger the child who engages in HSB is, the more likely they are to have experienced sexual abuse (Kendall-Tackett, Meyer Williams, and Finkelhor, 1993; Friedrich, Davies, Feher, and Wright, 2003; Friedrich, Trane and Gully, 2005).

Within this research, the age of HSB onset was compared between those who had experienced sexual abuse and those who had not using a statistical test and reflecting the findings above. The age of HSB onset was significantly lower among those children where there was sexual abuse in childhood recorded (10.5 years) compared to those where this was not (12 years). Full details of all the statistical tests, and their explanations, can be found in Appendix B.

Peer Relationships

In 49% (n=57) cases the child was described as isolated, with 32% (n=31) of them described as socially excluded and 29% (n=28) having recorded issues with their peers. However, it is unclear if these social integration concerns were prior to any HSB or a result of either being rejected by their peers or being excluded from free association by the adults in their lives in an attempt to keep them and other potential victims safe.

In addition 14% (n=14) of the children had engaged in bullying behaviour with 22% (n=21) having been bullied at some point. Details were scarce with regard to these incidents and it could be an underestimate if it was not felt to be relevant by the professionals writing the referral to the IVY project. It also appeared this generally related to incidents at school rather than in the community.

Risky behaviour

Fifty-two percent (n=50) of the children in the sample were felt to be at risk of victimisation. This refers both to those children described as putting themselves at risk as part of their HSB; or as a result of their additional support needs making them more vulnerable to other individuals; or children for whom, were the offences they were accused of to become public, might be placed at risk.

Other risky behaviour included drug and alcohol misuse. Thirty five percent (n=34) of the children in the sample had a history of substance misuse, with six misusing drugs, less than five misusing alcohol and 25 misusing both alcohol and drugs.

Involvement with support services and social work

Thirty three percent (n=32) were involved with statutory services before the age of five years which includes 10% (n=10) of children recorded as having contact with statutory services at birth or within the first year, 50% (n=49) had statutory contact thereafter and 9% (n=9) of the sample had no record of statutory involvement or were involved with services on a voluntary basis.

In seven cases there is a record of statutory service involvement but no age is recorded. Within the sample there was a record of 43% (n=42) of the children having been registered for child protection concerns at least at one point in their lives, while less than five were recorded as still being on a child protection order. However, it is worth noting that this was rarely clear within the records and could be an underestimate.

Living situation

Eighty percent (n=78) of the children had lived in multiple places throughout their lives, ranging from two places (17%, n=16) to 15 places in the case of one child. The mean number of different places children were recorded to have lived in was 4.4 throughout their lives.

Interestingly all of the children who had remained in one place throughout their lives were male (n=19); in contrast, all of the girls within the sample had lived in multiple different places. Twenty (21%) children had at one time been placed in secure care, while seven (7%) had experienced some time in custody.

Parents

Although 59 (60%) children were not living with their biological family at the time they were referred to IVY, the majority of the children had some form of continuing relationship with their biological parents. The parents of many of the children in this study had ongoing trauma and/or vulnerabilities in their lives.

Parental mental health issues were identified in the case of 38 (39%) children and misusing drugs and alcohol was also common, with 36 (37%) of the children's parents misusing alcohol and 31 (32%) recorded as misusing drugs. Domestic violence also featured in the lives of 50 (51%) of the children. For 33 (34%) children their parents had experience of the criminal justice system (e.g. being charged with an offence) of which 17 (18%) had been imprisoned. And although not always recorded there was a note that six (6%) of the parents were care experienced themselves, and in five cases their children were also accommodated, thus perpetuating the cycle.

The age of HSB onset appeared to be lower among those children where it was recorded that their parents had experience of the care system or where they had experience of the justice system; however, the numbers in these groups were very small.

Education

The education status of the child at the time of referral to IVY was recorded in 90 cases. Thirteen of the children were recorded as no longer receiving any form of education, either due to age or lack of engagement in education. Additional support was provided to the majority of the children either within mainstream school (n=17) or as a bespoke specialist offer (n=19) or within secure care or residential school (n=15). Three of the children were described as attending further education or college with additional support and eight described as undertaking some form of life skills training or work experience type course (n=8).

Table 2: Education provision

Education type	N	% of children
Specialised education	19	20
Mainstream school with additional supports	17	18
Mainstream school	15	16
Residential school or secure education provision	15	16
Does not attend school	13	13
Work experience or training	8	8
Further education/college with additional supports	<5	<5
Not recorded	*7*	*7*
Total	97	100

There was a record of 21 of the children having been excluded at least once from school, although as noted previously, unless school exclusion was relevant to the reason for referral to IVY it is possible that not all details would be included in the referral form and Level 1 consultation and so this may be an underestimate. However, there are many descriptions of attempts to support the child, meet their needs and manage their risk whilst ensuring they receive education input.

Loss

Twenty eight (29%) of the children in the sample had experienced one or multiple bereavement(s) that was documented within their referral or Risk Analysis Report, and of these 11 (12%) were recent bereavements, within the last year. The bereavements included the death of a parent or carer (n=14), the loss of a grandparent (n=11), the loss of another family member (n= 5) and loss of a peer or friend (n=2). Among eight of the children, there was a record of multiple losses.

Police involvement

Each individual in the sample was documented to have been involved in HSB; however, as previously described, there is a continuum of seriousness, and variation of response, included within the sample and 63 (65%) of the children had been formally charged with an offence of HSB. The numbers are very small when the genders are examined, but only 18% of the girls were charged with HSB compared with 71% of the boys. This may well be related to the types of HSB displayed by the different genders, with a disproportionately high number of girls' HSB related to what was described as 'putting themselves at risk sexually'.

Furthermore, there was some information relating to additional offending behaviour, as it was recorded that 48 (49%) of children were charged with a non-HSB related offence. Forty one percent (n=40) of the children were charged with an offence of violence (this included 63% of the girls in the sample and 38% of the boys), and 34% (n=33) of children in the sample were charged with another type of offence, such as vandalism or theft etc. This number included 45% of the girls in the sample and 33% of the boys. The numbers are

small; however, the comparatively high number of girls being charged with further offences may be one way they come to police or social work attention, therefore leading to the identification of their HSB.

Another way the children in this sample might come to the attention of the police is when they are reported missing from home, school or where they are currently resident. Forty one percent (n=40) of the children in this research were recorded as having absconded at one point, although in some cases this happened on multiple occasions. Again, when this risk factor is examined the number of girls reported as having absconded is 90% of the sample (n=9) while the number of boys was 36% (n=31). Although this sample is very small, previous research has identified there can be a gendered response when children go missing, with perceptions of risk and vulnerability in girls leading to increased levels of concern and reporting when they abscond (Kempf-Leonard & Johansson, 2007).

Differences between children who display HSB and children who engage in other harmful behaviours

In comparing the prevalence of these Adverse Childhood Experiences (ACEs) between children displaying HSB and the comparison group where no HSB was documented, only two ACEs were statistically more commonly recorded in the backgrounds of children displaying HSB (see Appendix B for the full statistical analysis). There were significantly more children with documented previous sexual abuse found within the children who display HSB (22%) than those not showing HSB (9%) and a significantly greater number of children who displayed HSB experienced physical neglect (55%) when compared with those children who did not display HSB (31%).

Table 3: Number and percentage of children with recorded Adverse Childhood Experiences

	Children displaying HSB (n = 97)	**Children not displaying HSB (n =78)**
Parental separation	71 (73%)	61 (78%)
Experience of emotional neglect	56 (58%)	33 (42%)
Experience of physical neglect	53 (55%)	24 (31%)*
Domestic violence in household	50 (52%)	39 (50%)
Parental mental health issues	38 (39%)	33 (42%)
Parental alcohol use	36 (37%)	28 (36%)
Parental drug use	31 (32%)	21 (27%)
Experience of physical abuse	30 (31%)	21 (27%)
Experience of emotional abuse	22 (23%)	19 (24%)
Experience of sexual abuse	21 (22%)	7 (9%)*
Parental incarceration	17 (18%)	19 (24%)

* Identifies where there was a statistically significant difference in prevalence between the two samples

As described above, there is a higher incidence of sexual abuse recorded overall (22%) among the children who displayed HSB. A statistical analysis (see Table c in Appendix B) found that, for children who were displaying HSB, there was no difference between the boys and girls in terms of the prevalence of sexual abuse (27% of girls and 21% of boys in the sample). However, within the group of children who did not show HSB, the number of girls with a record of being abused sexually was significantly higher (39%) than the boys in the sample (3%). The numbers are too small and the database has too many limitations to make specific assertions about what this might mean in terms of the impact of sexual abuse on the different genders, but it indicates further exploration of this might be important.

As previously described in table 3 above, when the two groups of children were compared in terms of prevalence of each of the ACEs separately, there were differences found in experience of sexual abuse and experience of physical neglect. However, in order to explore if there was a difference in pattern between those who had displayed HSB and those who had not and the types of ACEs recorded, a statistical test[5] (see Table d in Appendix B) indicated no differences were identified between the two groups and the pattern of ACEs they had experienced.

The majority of children in the HSB sample and in the non-HSB sample had multiple ACEs recorded, this number ranged from none identified (nine in the HSB sample and six in the non-HSB sample) to 11 ACEs identified (zero in the HSB sample and two in the non-HSB sample). The median number of ACEs identified in the HSB sample was 5.00 and was 4.00 in the non-HSB sample. Using a Mann-Whitney test to compare the samples on the total number of reported ACEs revealed no significant differences between the samples and number of recorded ACEs.

It is clear that those children from the comparison sample whose harmful behaviour did not include sexual behaviour experienced very similar multiple ACEs and equally chaotic childhoods with, for example, parental separation and domestic violence being prevalent in a high number of the childhoods of the children and young people in both samples.

Conclusions

When children who display HSB are examined in detail there is clear evidence of neglect and abuse. Their childhoods are characterised by parental separation, domestic violence, parents with additional needs, and frequent places to live. High numbers of children in the sample had also been diagnosed with additional needs such as learning disabilities, ASD or mental health needs, while even more await formal diagnoses. The children are often described as isolated or socially excluded with many harming themselves, at risk of suicide or at risk of victimisation.

The age from which children displaying HSB were involved with statutory services highlights how many of these were born into vulnerability and need, with many families involved with statutory services before the child was born or with statutory service involvement before the age of five years.

[5] [5] *Log-linear analysis* is a technique used in statistics to examine the relationship between more than two categorical variables

As reflected in the literature, for the children in this study, sexual abuse also appeared to play a role in the age at which HSB onset was identified, with those children who had experienced sexual abuse showing HSB at a significantly earlier stage than those who had not. Although again, it is worth reiterating that as a result of their sexual abuse there may have been additional scrutiny on these children, leading to the earlier identification of concerning atypical behaviours.

In those cases where there was documented intra-familial HSB a large number of those children were recorded as having targeted the family member before external victims. This could suggest that for some children this form of HSB is a 'first step' before they progress to other victims or types of HSB, or indeed it might suggest that intra-familial HSB is more likely to be recognised at an early stage and therefore recorded. However, the numbers included within this sample were low and so further research would help clarify this.

In comparing the childhood experiences of vulnerable children in the two samples there appear to be few identifiable risks that would indicate a child is going to display HSB specifically; yet children who had experienced sexual abuse or physical neglect were disproportionately found within the HSB sample. Both samples had equally high levels of trauma with little to indicate why they had displayed HSB as opposed to other behaviours. In terms of fulfilling the aims of the study, the childhood experiences of children displaying HSB in the sample have been described, and links between some childhood experiences and HSB have been identified. Yet in terms of identifying patterns of multiple childhood experiences, no discerning patterns have been found, although the data constraints may have limited our ability to identify these.

AGGREGATE CASE STUDIES

Three case studies based on real children's experiences but aggregated to maintain anonymity are included below, these are intended to illustrate the real life contexts and circumstances experienced by the children included in this report.

Case Study 1: 'Jason'

Jason was born to parents with additional support needs and briefly raised in a household characterised by alcohol misuse, domestic violence and neglect. Jason has Foetal Alcohol Syndrome. Although he and his siblings were removed from his parents' care at around one year old due to a failure to thrive, the children were placed with a family member. At some point he returned to his parents' care, it is unclear how this happened or how it was planned or supported. At around seven years old he was removed again from his parents care to foster care, which he struggled to cope with becoming distressed and he began soiling and smearing faeces in his room. There were also concerns about sexually inappropriate behaviour between Jason and a younger sibling.

Throughout multiple foster homes, his contact with family and extended family continued but there remained a lack of boundaries and Jason has since amassed a large amount of pornography and acted inappropriately with a younger female known to his extended family (this consisted of sexual touching) and again with one of his previous foster carers. He had been relatively settled with his current foster carers for three years at time of referral to the IVY project.

Jason received additional Pupil Support Assistance at school; he struggled to develop or maintain peer relationships and was socially isolated except for the adults in his life. He had obsessive interests and was known to take and hide items such as nappies and underwear belonging to others, in his room. Jason had previously been referred to CAMHS, it is recorded he did not fit the criteria and so was not provided support from there. His foster carers, with social work support, decided to remove his access to the internet due to the nature of his searches, which involved images of young children. A referral was made to IVY to help them better understand his behaviour and the best response to this.

Case Study 2: 'Julie'

Julie is 16 years old and had recently been placed in secure care because of concerns about her safety.

Julie had a very chaotic and neglectful childhood, adults around her were involved in sexual offending against other children and adults, and despite making allegations of sexual abuse herself, there was no record of specialised support or the police following up these allegations until her own sexualised behaviour was identified as concerning by her school when she was seven years old. Julie had multiple moves from her biological family to different foster homes, then residential care within children's houses, and thereafter a period of time in secure care. Altogether there is a record of more than a dozen different placements.

Julie displayed violence towards staff members and police officers, these incidents had been dealt with by the Children's Hearings System. She was accused of a serious sexual assault on a peer at school and frequently absconded, being found with older men unknown to her carers. The professionals around her were concerned that her risk from harm was escalating, as was her use of alcohol and self-harm, which takes the form of cutting. Other concerns have included her use of cannabis and online behaviour which takes the form of accessing very extreme pornography. These developments have resulted in the professionals around her making a referral to the IVY project to better understand her trauma and needs.

Julie does not have any formal diagnoses, she was assessed for both mental health concerns and autism spectrum disorder and did not meet the criteria for diagnosis, but her mood can present as very low. Julie does not engage with professionals in her life and has reacted with violence during attempts to discuss her sexualised behaviour aimed towards staff and other children.

Julie had no close friendships or lasting relationships, she struggled with making and maintaining friendships and has little contact with family members. There is little recorded about her education other than a note that following sexualised behaviours she was excluded from both nursery and primary school; she received in-house education during times when she was placed in a residential establishment and again when she was placed in secure care but there is no information recorded on her attainment or plans for her future.

Case Study 3: 'Jack'

Jack, who has just turned 18 years old, has been charged with sending explicit sexual images of himself to young girls online, there are also concerns he may have been exploited by adults into sharing sexually explicit images (of self or others).

As a child he was sexually abused within the family home. He experienced physical abuse, poor parental care and supervision, chronic neglect and was exposed to domestic violence during his childhood. With his mother and siblings, he moved homes frequently, often presenting as homeless. Jack and his siblings were placed on the Child Protection register. He was accommodated at the age of nine, staying with a succession of foster carers but appears relatively settled in his current foster placement where he has now

been living for four years. His sister is noted as having died when he was around 9 or 10 years old but there is no further information recorded about this or the impact it might have had.

Initially his concerning behaviour related to incidents where he threatened family members with a knife and it was recorded he became involved in shoplifting. His harmful sexual behaviour began at the age of nine in school with several sexual assaults on vulnerable peers and younger children and other forms of displaying sexualised behaviours within the school. At this time Jack engaged with a more focused intervention following no further action by the children's panel. Although it was noted this intervention focused more on general behaviour rather than sexual behaviour, it is unclear if Jack ever received additional support and intervention regarding his harmful sexual behaviour.

Within his current foster placement his school attendance improved, and he has now left school and is attending college. However, in an effort to protect both Jack and his peers his foster carers made a decision to limit his social interactions that left him very isolated from his peers, and now Jack struggles with social and interpersonal interactions. Jack currently has no lasting friendships or relationships and is socially isolated, spending much of his time in the evenings online. He is currently due to face charges of allegedly sending inappropriate sexual images to a child. Jack currently is choosing to have no contact with either of his parents or his siblings.

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Appendix

A: Inclusion in the sample

In order to be included within the HSB sample for this study both the referral form(s) and Risk Analysis Reports, where these were available, were examined by a single researcher.

As described, these documents are not exhaustive and therefore limited to an extent in terms of content and focus.

Cases were included in the sample if:

- HSB was clearly described and it resulted in a police response
- HSB was clearly described and it resulted in a children's panel or social work response
- HSB was admitted by the child
- HSB was documented on multiple occasions (numbers of incidents, types of incidents) but no formal steps taken

Cases were not included within the sample if there was:

- Only one reference to an incident and thereafter no further HSB was documented
- A suspicion of HSB but there was no response or formal action
- If the suspected HSB was deemed to be age/stage appropriate and there were no further incidents recorded

B: Full Statistical Tables

a) Comparing age of onset of HSB between children who had been sexually abused and children who had not (page 7)

A Mann Whitney U test was used to compare the difference in age of onset between the two groups. This statistical test allows two groups to be compared, and is often used where there are small samples, or unusually skewed data (as in the IVY data). Where the calculated probability (p) is less than 0.05, we can assume that there is a 95% likelihood that any differences observed between the two groups did not occur by chance. This is marked with an *.

	Number	Median age of onset of HSB	U Statistic	Z	Probability
Had been sexually abused	20	10.50	500.500	-2.297	p = 0.022 *
Had not been sexually abused	75	12.00			

b) Comparing exposure to Adverse Childhood Experiences between children displaying HSB and children not displaying HSB (page 10).

A Chi Square Statistical Test was used to compare the differences between the two groups of children and their exposure to the difference Adverse Childhood Experiences. Where the calculated probability (p) is less than 0.05, we can assume that there is a 95% likelihood that any differences observed between the two groups did not occur by chance. This is marked with an *. Where the probability is less than 0.01 we can assume that there is a 99% likelihood that any differences observed between the two groups did not occur by chance. This is marked **. If a probability number is not marked with any asterisks, this means it is not a significant difference.

	Children displaying HSB (n = 97)	Children not displaying HSB (n =78)	Pearson Chi Square (χ)	Probability
Parental separation	71	61	0.346	p=0.556
Experience of emotional neglect	56	33	3.522	p=0.061
Experience of physical neglect	53	24	9.052	p=0.003 **
Domestic violence in household	50	39	0.003	p=0.959
Parental mental health issues	38	33	0.070	p=0.791
Parental alcohol use	36	28	0.000	p=0.994
Parental drug use	31	21	0.312	p=0.577
Experience of physical abuse	30	21	0.170	p=0.680
Experience of emotional abuse	22	19	0.007	P0=0.935
Experience of sexual abuse	21	7	4.813	p=0.028 *
Parental incarceration	17	19	0.853	p=0.356

c) Comparing gender differences in exposure to sexual abuse between children displaying HSB and children not displaying HSB (page 11)

A Chi Square test was used to compare the differences between boys and girls exposure to sexual abuse, among those displaying HSB ad those who were not displaying HSB. Where $p < 0.001$, it can be assumed that there is a 99.9% likelihood that the differences observed did on occur by chance. This is marked ***.

Children not displaying HSB				
	Had been sexually abused	Had not been sexually abused	Pearson Chi Square (χ)	Probability
Girls (n=13)	5	8	12.555	p<0.001 ***
Boys (n = 65)	2	63		
Children displaying HSB				
	Had been sexually abused	Had not been sexually abused	Pearson Chi Square (χ)	Probability
Girls (n=11)	3	8	0.008	p=0.927
Boys (n = 86)	18	68		

d) Log-linear analysis for presence of harmful sexual behaviour and no harmful sexual behaviour with adverse childhood experiences (page 12)

The Log-linear Analysis was carried out (in the form sample (1,2) and ACE (1,11)). There was no two way interaction between sample and ACE, no differences were identified between the samples and the pattern of ACEs they had experienced.

K way and higher order effects are zero			
	df	L.R Chisq	p
1	21	166.334	.000
2	10	11.630	.311
Tests of partial association			
	df	Partial Chisq	p
Adverse childhood experiences	10	133.967	.000
Sample type	1	20.738	.000

e) Comparing gender differences in total number of ACEs between children displaying HSB and children not displaying HSB (page 12)

A Mann Whitney U statistical test was used to compare differences in the number of ACEs experienced by children displaying HSB compared to children not displaying HSB. No significant differences were found.

	Number	**Median number of ACEs**	**U Statistic**	**Z**	**Probability**
Displaying HSB	97	5.00	3,372.500	-1.240	p = 0.215
Not displaying HSB	78	4.00			

C: Structured Case File Identification Tool

Variable	**Codes**
Unique id number	
IVY referral number	
Date of birth	
Write in ethnicity if recorded	
Age at referral	
Local authority	
Parent info	married cohabiting single parent
No of siblings living in the same home	
No of siblings living elsewhere	

No of other family members in the same home (not incl. parents or siblings)	
More about family	
Write in postcode	
Current accommodation at referral	family home with extended family children's house secure care close support
Current accommodation if changed	family home with extended family children's house secure care close support
Reason recorded for IVY referral	
Has offending behaviour been recorded	yes no
Did this offending involve HSB	yes no
Did this offending involve violence	yes no
Did this offending involve other types of crime	yes no
MORE about the offending	
Mention of substance misuse in notes	yes no
Which substance	drugs alcohol other
Describe the substance misuse	
Mention of violence in notes	yes no
Mention of use of pornography in notes	yes no
Age of first suspected HSB	
Age at first confirmed HSB	
Suspected driver of HSB	sexual preoccupation sex as coping fear of peer rejection

	anger sexual preference lack of sexual knowledge multiple drivers unclear
Suspected driver of HSB more	
Number of known victims	
Number of victims suspected	
More about the HSB if recorded	
More about the victims	
More about the location of incidents	
What has been the response to the HSB	
Does the HSB appear to be escalating	yes no
Did any HSB include physical coercion	yes no
Did any HSB include psychological coercion	yes no
HSB incident 1 who is the victim	biological family other family friend acquaintance stranger
HSB incident 1 where did it take place	family home victims home school setting social setting
HSB incident 1 what type of HSB	contact non-contact internet/phone
Any further details about incident 1	
HSB incident 2 who is the victim	biological family other family friend acquaintance stranger
HSB incident 2 where did it take place	family home victims home

	school setting social setting
HSB incident 2 what type of HSB	contact non-contact internet/phone
Any further details about incident 2	
HSB incident 3 who is the victim	biological family other family friend acquaintance stranger
HSB incident 3 where did it take place	family home victims home school setting social setting
HSB incident 3 what type of HSB	contact non-contact internet/phone
Any further details about incident 3	
More than 3 victims please describe here	
Has the child been a victim of HSB by another child	yes no
More about this incident	
Has the child been formally charged with HSB	yes no
More about these charges	
Age at first HSB charge	
Has the child been formally charged with other offences	yes no
More about these other offences	
Age at first other offence charge	
ACE child experienced sexual abuse	yes no
ACE physical abuse	yes no
ACE child experienced emotional neglect	yes no
ACE child experienced physical neglect	yes no

ACE parental separation	yes no
ACE parental MH issues	yes no
ACE parental drug use	yes no
ACE parental alcohol use	yes no
ACE parent in prison	yes no
ACE domestic violence in household	yes no
Have parents experience of justice system	yes no
Have parents experience of care system	yes no
Has child experienced bereavement	yes no
Has child experienced bereavement in the last year	yes no
More about bereavements, who, when, relationship etc.	
Has child displayed self-harming behaviour	yes no
Is child considered a suicide risk	yes no
More about the suicide risk	
Has child previously placed in secure or custody	secure custody both
Has child record of bullying behaviour	yes no
Has child record of being bullied	yes no
Diagnosed ASD	yes no
Suspected ASD	yes no
More about ASD	

Diagnosed LD	yes no
Suspected LD	yes no
More about LD	
Diagnosed MH condition	yes no
Suspected MH condition	yes no
Child risk of victimisation	
Risk of victimisation MORE	
Child exposure to pornography	yes no
Child history of absconding	yes no
Child ever a victim of sexual abuse	yes no
By whom, what type and when	
Education type	
Contact with statutory agencies	yes no
Date of first contact with statutory agencies	
Type of stat service now 1	
Type of stat service now 2	
Type of stat service now 3	
MORE statutory service contact - list	
Current legal status	
Current order type	
Ever subject to CP registration	yes no
Currently subject to CP registration	