

Assessing Harmful Sexual Behaviour Among Youth: Does Professional Background Affect AIM3 Scoring?

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Preface

The work for this article has allowed me to get greater knowledge in a subject I find important and interesting. It has been a long process that has simultaneously been educational, exciting and even frustrating at times.

I want to thank Monica Jensen for the opportunity to learn from her data and the hours of study space at her offices. I also want to thank her for all her good tips and discussions about the data along the way. I also want to thank Ragnhild Bjørknes for all her help and her belief in me and this project. I also want to thank Stine Lehmann for being so kind and helpful taking over from Ragnhild and all her good advice in the past few months, as well for handling all my stressed-out e-mails. Thank you to my fellow students who have shared their thoughts along the way.

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Abstrakt

Denne kvantitative masteroppgaven handler om AIM3, som står for «assessment/intervention/moving on» og er den tredje versjonen av dette kartleggingsverktøyet. AIM3 er et kartleggingsverktøy for barn som har, eller er mistenkt for å ha utført skadelig seksuell atferd mot andre barn. Verktøyet er til for å hjelpe profesjonelle å identifisere om barnets behov er møtt både når det gjelder seksuell atferd og ikke-seksuell atferd. Formålet med oppgaven er å se om verktøyet fungerer når ulike profesjonelle skal kartlegge samme barnet. Problemstillingen er «om bakgrunnen til profesjonelle som bruker AIM3 har noen effekt på scoren barnet får». Jeg har brukt en spørreundersøkelse som psykologspesialist/ PhD kandidat Monica Jensen har laget og sendt ut til tverrfaglige profesjonelle som har deltatt i et kurs om AIM3. Jeg har også brukt to vignetter som deltakerne har brukt AIM3 for å score to ulike barn. Jeg har utført deskriptive analyser og t-tester. De viktigste funnene er at på en av sakene har tiden deltakerne har brukt på analysen hatt en signifikant effekt på resultatet på scoringen. Det er ingen variabler som viser en signifikant effekt på begge barna. Det ser ut som det er en naturlig distribusjon på scoren og at de fleste deltakerne har scoret innenfor den forventede feilmarginen på verktøyet. Det kan bety at det er et verktøy som kan brukes for å hjelpe barnevernet og andre instanser å kartlegge behovene til et barn som har utført skadelig seksuell atferd, men på grunn av deltaker tallet så bør det forskes videre på.

Nøkkelord; AIM3, Skadelig seksuell atferd, SSA, Kartleggingsverktøy, Tverrfaglig fagpersoner.

Abstract

This quantitative article is about AIM3, which stands for “*assessment/intervention/moving on*”, which is the third version of this assessment tool. AIM3 is a tool for young people who have or are suspected to have conducted harmful sexual behaviours toward other children. The tool is made to help professionals to identify whether the child’s needs have been met both sexually and non-sexually. The purpose of this article is to look at whether the tool works when different professionals assess the same child. The main research question is “whether the background of the professionals using AIM3 affect the scoring of the instrument?”. I have used a questionnaire that has been filled out by interdisciplinary professionals who have completed an AIM3 course. I have also used two case scoring results

where the participants used AIM3 to score two different children. I have done descriptive analysis as well as t-tests. The most important finding of this study was that time spent on the assessment has had a significant effect on the results of the score. There are no variables that show a significant effect on both children. There is a natural distribution for most of the scoring, with most of the participants being within the expected margin of error. This could mean that this is a tool that the child welfare services can use to assess the needs of a child who has conducted harmful sexual behaviours. Due to the participant number being low in this study it should be researched further.

Keywords; AIM3, harmful sexual behaviours, HSB, assessment tool, interdisciplinary professionals

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1.0 Introduction

This article will look at AIM3 (assessment/intervention/moving on), which is the third version of AIM (Leonard and Hackett, 2019). This assessment tool is used by professionals that work with children or young people suspected for or that have proven to conduct harmful sexual behaviour (HSB) against other children (Leonard and Hackett, 2019). The purpose of this article is to look at whether there are any disparities between how different professionals assess the same cases. If they assess them similarly, if there are any variables among the participants that make the score of the assessment different. Since this study began there have been 16 courses around Norway with a total of 252 multidisciplinary professionals having participated and are now capable of using this tool in their work assessments. It is an assessment tool designed to look at the entire person's life, and not just their sexual behaviours (Leonard and Hackett, 2019). There has been little research on this new tool, and whether it works for professionals from different backgrounds. Which is why this article will look at how background can affect the tool. As Norway is spending a lot of resources on training their professionals to use this tool to assess children, I find it important to look at whether there is any point in doing that.

The main research question of this study is “whether the background of the professionals using AIM3 affect the scoring of the instrument?” My hypothesis is that those with a higher education, more experience assessing cases where children and HSB are involved and more experience, in general, will score the children lower and be more consistent with how they score them.

This master thesis comprises two parts. The Kappe, and the article. The article will be written following the author guidelines for the journal of Child Abuse and Neglect which allows for 35 pages total with abstract, title page, text, references, tables and figures. The article itself will include an introduction, methods, results, discussion, limitations and conclusion. This Kappe-document is a supporting document to the article and will include a more in-depth literature review, different theoretical frameworks, a more thorough description of methods, and a short summary of results. This supporting document allows for 15-18 pages excluding the front page, preface, abstract, table of contents and bibliography.

2.0 Literature Review

2.1 Children and young people who conduct HSB

Harmful sexual behaviour (HSB) can be defined as behaviour that violates others, is excessive, forced, threatening or crosses a border which indicates a need for immediate reaction or action from adults (Øverli et al., 2018). HSB includes the use of force (psychical strength, threats, age, size, status), responding with negative behaviour (rage, anger, aggression), where the perpetrator does not take responsibility, the behaviour is repeated, and it is hard to stop (Jensen et al., 2016). Historically, one thinks of adult men as perpetrators of sexual abuse. In recent years, it has become clear that children also perform HSB against other children (Jensen et al., 2016). Ericsson found in 2021 that sexuality is an area that have experienced big shifts in perspectives. What was normal yesterday, is now problematic or harmful and the other way around (Ericsson, 2021). Masturbation used to be seen as a harmful sin and is now viewed as something harmless and normal. Homosexuality was previously viewed as something perverted but is now celebrated (Ericsson, 2021). These changes require professionals with competence in these subjects that also have a sensitivity for culture and knowledge about different perspectives on the subject (Ericsson, 2021).

Johnson suggested in 2009 that in the *“homes of children who molest, the children are very aware of the trauma and violence in the parents’/caretakers’ lives and often become part of the drama as the other parent pulls them in as an ally or a scapegoat”* (p. 87). Johnson argued that when a child lives in a dysfunctional family filled with violence, the children may believe aggression and sex to be complementary elements which then causes confusion in the sexual development of the child (Johnson, 2009). The areas that differ for young people who sexually abuse include a generally more unsophisticated perpetration and grooming, and less of a pattern for their sexual arousal and interests (Griffin et al., 2008). In recent years there has been an increase in awareness of HSB performed by young people, and in a study done in the United Kingdom (UK) they found that *“65.9% of the contact sexual abuse reported by children and young people (0-17s) was perpetrated by other children and young people under the age of 18”* (Radford et al., 2011, p. 9). The International Journal of Child Abuse and Neglect has recently published an issue about the problematic sexual behaviours of children and young people of *“Austria, Ghana, Israel and the United States (U.S.)”* (Ibrahim, 2021, p. 205). Which highlights the increased world attention towards this issue (Ibrahim, 2021).

According to a community study done by John Taylor (2003) in the late 90s, it was found that 36% of those children found to have done harmful sexual abuse towards other children had all shown behavioural, emotional and learning difficulties in an educational setting. Whilst, as high as 44% of the children in the study had been referred to a professional to get help with behavioural and emotional problems (Taylor, 2003). As high as 70% of the sample had shown to have one or more problems at school, which is consistent with findings from other studies that have shown some form of HSB (Taylor, 2003). From this study, we can conclude that most young people with HSB come from families that are highly problematic and have experienced multiple adversities and disadvantages during their childhoods (Leonard and Hackett, 2019).

2.2 Assessment of children and young people who conduct HSB

In an assessment of a child's or young person's sexual behaviours, Chaffin and colleagues (2002) found that any assessment should include, firstly, an analysis of the behaviours, what motivated the child or young person, how it started, what kind of behaviours were exhibited, how the child responds to correction of the behaviours and whether there have been any changes in the behaviours (Hackett, 2011). Secondly, they found that it should include a detailed history from the family and the child where they pay special attention to traumatic events, family losses, moving and whether there have been any episodes of substitute care. Thirdly, whether the child has had any experiences of victimisation, with as much detail of that as possible. Fourthly, an analysis of the child's interactions, relationships and wider social functioning where they include both the strengths and deficits. Fifth, whether the child has any other behavioural issues such as ADHD or post-traumatic responses. Finally, the family environment, how the parenting styles are, the family disciplinary practices, how sex and sexuality are expressed and viewed, the supervision level, and how the carer has responded to the child's sexual behaviours (Chaffin et al., 2002, as cited by Hackett, 2011). These are all factors that have been used to create AIM2 and AIM3. Having this approach ensures that the level of response is in line with the level of risk in the individual child or young person (Hackett, 2011). It ensures that children and young persons who present with low-risk inappropriate sexual behaviours receive support on a level that matches their needs and that does not subject them to intervention programmes that are disproportionately intrusive, damaging and long-term (Hackett, 2011). Whilst also giving the children who have highly HSB receive the specialist and intensive support needed for their risk management

(Hackett, 2011). Risk assessment tools have traditionally only looked at the deficits of the young person, however recently the strengths of the young person had started to be considered alongside the risks and deficits (Griffin et al., 2008). Research shows that incorporation of strengths in assessments can have a great impact on how likely the young people are to generally recidivism (Griffin et al., 2008). In research done by Gilgun on adult sexual offenders in 1990, it showed that an important part of reducing recidivism was having an emotional confidant as well as having the “*presence of healthy peer, family and community relationships*” (Griffin et al., 2008, p. 212).

Munro (2020) considered two different ways of doing a risk assessment, one being an actuarial assessment, which involves an objective process to reach the decision that is algorithmic and formal. The other being a clinical assessment, which relies on a subjective conclusion that has been reached by a human clinical judge (Munro, 2020). These assessments are in the head, informal, subjective and impressionistic (Munro, 2020). Often a mixture of the two methods is used, and what type of information they collect as well as how that information is weighted will affect what kind of protection is then offered (Munro, 2020). Munro (2020) gives the example of how to get details of a criminal record by reading the relevant documents, but the parent/child attachment and the quality of that do require professional judgment. When using clinical judgment, you require professionals to make intuitive assessments from the information collected, whilst when using an actuarial instrument, the evidence uses a statistical formula to reach an answer by rating numerical data (Munro, 2020). This, in turn, makes it more useful to consider risk assessment instruments as something to contribute to a structured approach to collect information, and a formal and intuitive method of deciphering it (Munro, 2020). In a meta-analysis done by Grove and Meehl comparing 136 clinical and actuarial studies it was found that in near half (64) of the studies, actuarial predictions showed superiority, only eight showed the same for clinical predictions, whilst in the last 64 it was shown to have no significant difference between clinical and actuarial (Munro, 2020). It is not how you gather the information that defines the actuarial approach, it is how it is then dealt with (Munro, 2020). It is not intuition that is used to reach an answer, but rather statistics, it is doing what the clinician tries to do informally, but in a formal matter (Munro, 2020). By using an actuarial instrument, you use a statistical formula and use the best available evidence, whilst the clinician uses that evidence in an informal way which ends up being likely to be inaccurate (Munro, 2020). A concern of using

assessment tools is whether it will be overemphasised in practice, and that people have the tendency to have excessive confidence in computer produced results, making those who are using these automated systems more likely to not consider contradictory evidence (Munro, 2020). Many of the tools that exist are designed to give professionals support for their decisions, and the designers of these tools tend to stress how the tool should be among the many factors the professional needs to consider (Munro, 2020). Some professionals may not want to use their expertise to reach a different decision than the one the tool recommends (Munro, 2020). If there is an unfavourable outcome, the professional can blame the tool as there is safety behind it, and they might not have been able to justify going against its recommendation (Munro, 2020). Munro then concluded that if there is a defensive culture at work, it is more likely that automation bias will happen (2020).

The regional resource centre for violence, traumatic stress and suicide prevention (RVTS) in Norway has created a list of things to do in the handling of harmful sexual behaviours (RVTS, 2022). The first point of their list was to immediately stop the behaviour, and to not wait to observe and evaluate. The second point was to take care of both parties, both the victim and the perpetrator. They also recommend supporting the parents or carers of the children upon discovery. The third point was to work together with several social agencies to get an overview of the situation. The fourth was to build a safety plan for all parties to prevent the behaviours from continuing. The fifth and last being to consider referring the children to one or more social services to get help from professionals (RVTS, 2022). In a report by the national information centre of violence and traumatic stress (NKVTS) they found that the treatment options for children and young people with HSB was the lowest in their study of treatment options for children who had either been exposed to violence or HSB or children who conducted violence or HSB (Holt et al., 2016). They found in total 71 treatment units around Norway. The reasoning for the different social units to not offer treatment options for children with HSB was that there were either no referrals with that issue or there was not enough competence among the staff (Holt et al., 2016). A different report by the NKVTS found that Norway was missing an official public institutional treatment option with a high treatment competency (Askeland et al., 2017). They also found that a national framework that differentiate the levels of treatment whilst obligating the different agencies to cooperate and get involved so no one agency gets left alone with the most serious cases was very much needed in Norway (Askeland et al., 2017).

2.3 The AIM framework

In the UK the original AIM framework was the first assessment tool to both incorporate strengths and risks and then rate the individuals either “*high or low strengths and concerns*” (Griffin et al., 2008, p. 212). The purpose of the original framework was to help practitioners have a guideline when gathering information, and to promote coworking and meetings between multidisciplinary professionals held by children’s services departments (Griffin et al., 2008). When an evaluation of the assessment tool was done it suggested several improvement points, such as providing a medium outcome and making a distinction between “*apparently overlapping strengths and concerns items*” (Griffin et al., 2008, p. 213). In 2007 the original framework was updated and AIM2 was created to incorporate recommendations to improve the tool (Griffin et al., 2008). This tool had four domains, as opposed to AIM3 having five, with domain one being sexually and non-sexually harmful behaviours together as opposed to two different domains as AIM3 has (Griffin et al., 2008). AIM2 was designed for “*young men of mainstream educational ability, aged between 12 and 18 years, who are known to have sexually abused others*” (Griffin et al., 2008, p. 213). According to Simon Hackett (2011), it has become increasingly recognised in recent years that intervention programmes that are designed to exclusively focus on the young person’s sexually abusive behaviours are not valuable. He found that rather, there should be a broader focus on enhancing the young person’s life skills as well as direct attention towards their social isolation and potential family problems, looking into what kind of opportunities the education system offers them, and improving their relationship with carers and parents (Hackett, 2011). In 2008 Griffin et al., found, in a study of AIM2 that the limitation of AIM2 was that as this assessment of young people who sexually offend was such a complex task that it could not with AIM2 be reduced “*accurately to a simple procedure*” (p. 222). By establishing that they also concluded that, although the tool can be an aid in the assessment, professionals still must exercise their own judgment (Griffin et al., 2008). A strength that was found in AIM2, that still carries on to AIM3 is the importance of assessing strengths as well as the risk behaviours in high-risk young people (Griffin et al., 2008). Griffin et al., (2008) believed that identifying and building upon the strengths of the young person could be the way forward in risk-needs assessment, and by using that in treatment, it could help reduce the risk in young people who have committed sexual offences.

2.3 Professional influence on assessment tools

Whenever we plan a sequence of physical or mental activities that end up failing to achieve their intended outcome, we generalise it as an “*error*” (Reason, 1990 as cited by Sicora et al, 2021). Reason also found that there are two main types of error, those being “*errors in execution*” and “*errors in planning or in problem solving*” (Reason, 1990 as cited by Sicora et al, 2021, p. 1067). Sicora et al (2021) found that looking at that distinction was helpful in social work, especially when an in-depth and detailed evaluation was not completed and consequently an intervention fails. In Sicora et al’s (2021, p. 1072) research, they found that in Italy, participants of the study listed “*time, relationship (with service users and colleagues) and personal skills (‘management’ of emotions and cognitive process)*” as the three causes for mistakes. Some also highlighted how important training was, and how risky it is to not have adequate vocational training (Sicora et al, 2021). In Italy, they also found that when social workers have too much confidence in themselves, especially if it creates a sense of omnipotence, it can be quite dangerous regarding making mistakes (Sicora et al, 2021). All the participants in the Italian part of the study found that intuition was a fundamental part of social work (Sicora et al, 2021). In the same study, they found that in China, the participants named personal competence skills, such as emotions, cognitive process and management. Vocational training, which here includes job training as well as education, and social approval in the professional environment as the leading causes of mistakes (Sicora et al, 2021). For their Chinese participants, they found that all but one acknowledged that at least 50% of their work was influenced by intuition, which they believed to reflect their experience (Sicora et al, 2021). So much so that the social workers that were the most experienced used intuition in complex situations as a form of “*pre-assessment*” (Sicora et al, 2021, p. 1077).

In the UK Kirkman and Melrose (2014) found that people relied mostly on their intuition when they must make decisions with limited information and quickly. They also found during field visits that it was in fact in those kinds of circumstances many social workers had to make decisions (Kirkman and Melrose, 2014). Intuitive judgments are normally a response you make unconsciously based on experience and prior knowledge gained over a lifetime that is automatic and rapid (Kirkman and Melrose, 2014). There are two different kinds of intuitive judgments, those that the general population can make out and those that are deployed and developed by experts, usually due to professional training or experience

(Kirkman and Melrose, 2014). Those kinds of judgments often result in predictable and consistent errors in judgment, due to their simple methods that are prone to bias (Kirkman and Melrose, 2014). Due to people's intuitive judgments being mainly based on what they think will happen based on how they remember a similar event, it is highly influenced by a bias which can lead to systematic errors in judgment (Kirkman and Melrose, 2014). Kirkman and Melrose found in 2014 that often the more experienced social workers tend to underuse analytic tools by only using them to check their decisions, rather than help them make them. Whilst novices tend to over-use them by not recognising patterns in situations themselves, and therefore following procedures and guidelines thoroughly which could lead to a hindering of skilled intuition (Kirkman and Melrose, 2014). They found that experts often have a better overall picture of the past, present and future which leads them to be able to not follow the rules the same way novices do (Kirkman and Melrose, 2014).

3.0 Theoretical Framework

3.1 Understanding children who conduct HSB

There are two fundamental goals of scientific theories of human behaviour, prediction and explanation (Ward and Beech, 2006). Essentially, a theory is when unobserved aspects of the world are then described, and it may consist of a systematic set of ideas and a collection of interrelated laws. By looking at a phenomenon, a theory can explain why they have certain properties, and why they exist (Ward and Beech, 2006). The Integrated Theory of Sexual Offending (ITSO) tries to explain sexual offending by looking at the risk factors associated, which Ward and Beech (2006) believe fall into four broad categories with the first being static risk factors, more known as historic factors. This includes a prior history of violence and crime and adverse developmental events. The second is dynamic risk factors, or dispositional factors. This includes the general level of anti-sociality and impulsivity. The third is risk factors for criminal behaviours, such as contextual antecedents to violence, lack of positive social support and deviant social networks. Finally, the fourth is clinical factors that include social difficulties and emotional problems. Those vulnerabilities, or rather, a combination of those may under some certainties result in illegal sexual behaviours (Ward and Beech, 2006).

Burk and Burkhart found in 2003 that the reliance on coping with sexualised actions, such as sexual acts with others and masturbation could be due to the early life stressors of a high-risk child. This includes such events as low self-esteem, poor parent/child attachment bonds,

inadequate emotional coping skills, poor relationship qualities and prior sexual abuse. When using those kinds of coping mechanisms, they are using them as a form of escape from the difficult issues that happened to them during early development. According to Burk and Burkhart, sexual coping depends on behavioural conditioning which incentivizes the increased dependence on sexual coping, therefore inclining individuals towards sexual offending and increasing the probability of a repetition of the sexual offence once it has been committed (2003).

According to Leonard and Hackett, young people that have HSB often have a combination of social skill deficits, high levels of social anxiety and a lack of sexual knowledge (2019). They proposed that sometimes this combination of emotional loneliness, low self-esteem, low competence and feelings of sexual inadequacy can be developmentally damaging for young people (Leonard and Hackett, 2019). This can in turn lead to abusive and inappropriate sexual interactions with children and inappropriate intimate relationships in general (Leonard and Hackett, 2019). Some young people replicate their own experiences of sexual abuse in the way they express their HSB (Leonard and Hackett, 2019). In a study by Veneziano et al (2000, p. 372) they found that adolescent males who had been sexually victimized themselves were more likely to “*select victims and sexual behaviours that were reflective of their own sexual victimization*”. In 2007, Vizard et al reported that 92% of the children in their sample of 280 young people presenting with sexually abusive behaviours had “*suffered neglect, witnessed domestic violence, or experienced one form of abuse*” (p. 62). They also found that 73% of the children had experienced their parents’ divorce, separate or the death of at least one parent, with only five per cent of them living with their biological parents (Vizard et al., 2007). More than half of them had “*experienced inconsistent or overly punitive parenting, and 44% were exposed to lax sexual boundaries within the family*” (Vizard et al., 2007, p. 61). They also found that 58% were socially isolated, largely because of their behavioural problems (Vizard et al., 2007). There is not one thing that will make a young person more likely to sexually abuse others, which is why AIM is focused on getting a more holistic and wider perspective of the young person in an assessment, looking at both historical factors, developmental, family and so on (Leonard and Hackett, 2019).

3.2 Theory behind AIM

It is important for an assessment framework like AIM3 to assess whether young people with HSB are likely to show the same trend that non-sexually offending juveniles show of growing out of the offending or if they are likely to escalate the sexually abusive behaviour and increase it as they grow up (Leonard and Hackett, 2019). This is particularly important due to the assumption that many believe, although data has not shown to support it, that young people that show HSB grow into adult sex offenders (Chaffin et al, 2002 as cited by Leonard and Hackett, 2019). Some studies have shown to indicate an average sexual reoffending rate is between three percent and 14% (Prentky et al, 2000 as cited by Leonard and Hackett, 2019). Whilst a 10-year longitudinal study done by Hagan and Gust-Brey (1999) found that 90% of the young people had been involved with at least one crime as an adult, however only 16% of them had a sexual reoffence. The Ministry of Justice found between 2010 and 2011 that out of 4,632 adult offenders that had previously offended as juveniles in England and Wales, only a small proportion of the many types of reoffending identified were sexual offences (Ministry of Justice, 2013 as cited by Leonard and Hackett, 2019). In a different study done by McCann and Lussier in 2008 including 3,189 juvenile sex offenders they found that for any type of crime, the recidivism was 53%, however the average sexual reoffending was 12.2%. They found in the same study that number of victims were not related to recidivism, however the gender (those with male victims), age (either child or an adult victim) and the relationship between the offender and victim (stranger victim) showed to significantly impact whether they were likely to reoffend (McCann and Lussier, 2008). In summary, studies on reoffending suggest that most young people that commit sexual abuse do not continue that trend into adulthood (Leonard and Hackett, 2019). It is still important for an assessment framework to assess the likelihood of recidivism, even though it is not recorded that juvenile sexual offenders often sexually offend as adults.

When creating AIM3, Leonard and Hackett looked at the integration of aetiology and risk in sexual offenders, and the theoretical framework Ward and Beech established in 2006. Ward and Beech (2006) pointed out that most risk assessment tools rely almost exclusively on factors that cannot change (static), such as lack of long-term relationships, previous history of offence, and general criminality. When doing a risk assessment for sex offenders they found limitations to that actuarial approach. Such as no way of figuring out future recidivism since the actuarial scales give not a certainty, but rather a probability (Ward and Beech, 2006).

Another limitation was that sometimes unusual individuals can have misleading characteristics that may lead clinicians who rely too much on assessment instruments. Which would then ignore those who are not represented as well in the studies used to test or make the assessment tools (Ward and Beech, 2006). They found that the assessment tools that exist do not currently indicate what dispositional/clinical factors that need to be addressed for the reduction of risk. Ward and Beech (2006) also found that the instruments that exist look toward more long-term risks and do not consider the factors that indicate imminent reoffending. To try to deal with these limitations when using strictly static factor in actuarial instruments, researchers have tried to incorporate more dynamic factors to tailor it to an individual (Ward and Beech, 2006). These new, more dynamic risk factors include their attitudes that are more supportive of sexual assault, deviant sexual interests, their general self-regulation/self-management problems and their socio-affected problems (Ward and Beech, 2006). Ward and Beech's (2006) model propose that there are four definite and interconnected psychological mechanisms that are shown to be present among people who molest children, those being; distorted sexual scripts; social skill and intimacy deficits; cognitive distortions; and emotional dysregulations. Ward and Beech (2006) found that each of these four mechanisms represents a certain pathway for offence with different behavioural and psychological profiles with also separate underlying and historic deficits. They found that several different variables needed to be present to do a risk assessment, such as developmental variables, vulnerability factors, psychological markers, sexual self-regulation, offence supportive cognitions. As well a level of interpersonal functioning, assessing self-management/general self-regulation problems, historical risk markers, triggering/contextual events and finally state dynamic factors (Ward and Beech, 2006). Which Leonard and Hackett have taken inspiration from when building AIM3.

Assessment of children who have displayed HSB can be done for several different reasons, such as when making decisions about child protection or child welfare, during a clinical assessment in a mental health setting, or as a part of a youth and criminal justice process (Allardyce & Yates, 2018). There are different times and stages to do the assessment, such as straight after concerns are raised to respond immediately and get early interventions in place. If a young person has committed a serious sexual offence, you could assess them before sentencing, or when intervention measures have been completed so you could look at the progress and whether there is a risk going forward to evaluate if continued measures are

needed (Allardyce & Yates, 2018). To get a comprehensive assessment, it needs to be able to answer why the young person has done HSB? Are they likely to complete such behaviour again? If so, to whom and in what circumstances could it happen again? What interventions are needed short term to manage the risks? Are there indicators of the risk decreasing or increasing? What interventions are needed long term to support prosocial development and reduce risks? Finally, in what way will the young person's progress be measured (Allardyce & Yates, 2018)? Norway has up until recent years lacked a multi-agency assessment and intervention system that is differentiated and systematic to assess children and adolescents who have shown problematic or HSB (Jensen et al., 2020). According to Jensen et al., the HSB interventions in Norway for adolescents have historically been mainly treatment-oriented, unsystematic, with mixed risks and delivered through public health and social outpatient services. Which has led to a shortage of cases where the issue is serious behavioural problems to be adjudicated or registered with the police/Barnehus level (Jensen et al., 2020). Most cases of children/adolescents with serious behavioural problems will be registered with the Child Welfare Services (CWS) (Jensen et al., 2020).

3.3 Test-theory – are standardised testing necessary?

Internationally, as well as in Norway there is a tendency to standardize child welfare services (CWS) by basing the knowledge on scientific methods to improve the practice by strengthening the quality and the professionals' knowledge bases (Sletten & Ellingsen, 2020). This also makes sure to strengthen the decision-making and helps the accountability in these services (Sletten & Ellingsen, 2020). Such tools are not based on the judgment of the individual, but rather on guidelines and forms of pre-decided actions (Sletten & Ellingsen, 2020). Sletten and Ellingsen (2020) did find some concerns which had been put forth, that these kinds of standardization will affect the professional's skills, oversimplify practice and limit the professionals' actions. Another argument has been that making social work more auditable and transparent is troublesome due to the social work's complexity (Sletten & Ellingsen, 2020). They also argue that such standardization risks the professional to not being able to meet the need of individuals due to the simplification of human existence which is in nature complex (2020). In the CWS, professionals often deal with family situations that are complex, and despite ambiguity, uncertainty and fallibility, action is often needed (Sletten & Ellingsen, 2020). This makes the professional need to apply tacit and explicit knowledge that often needs to be both sensible and local, which can be difficult when such standardized tools

often insist on everything being explicit (Sletten & Ellingsen, 2020). Norway is a country with strong redistributive and egalitarian values (Sletten & Ellingsen, 2020). The Norwegian CWS has a relatively low threshold for early interventions, and their aim is to promote a healthy childhood whilst preventing risk by using both compulsory and voluntary measures with the core principle of what the best interest of the child is, as well as a child-centric and service-oriented approach (Sletten & Ellingsen, 2020). To legitimize professionals' work there was a need to produce evidence-based practice. To do that, they linked science and knowledge by experts to the current standards, which ultimately increased the legitimacy (Sletten & Ellingsen, 2020). When dealing with risky situations there needs to be a certain quality of the professional practice which could explain the increased reliance on rules and procedures (Sletten & Ellingsen, 2020). There are also some studies that have suggested standardized tools may increase workload and be too time-consuming, which then has a negative effect on the capacity of social workers (Sletten & Ellingsen, 2020). It has also shown that CWS professionals can use it to structure and focus their work more, whilst also providing them with a language to convey their work more precisely whilst also getting more information from their subjects by using the assessments (Sletten & Ellingsen, 2020). Some research has also shown that when taking a more holistic approach the tools can provide more involvement from the user whilst also strengthening the professional role of social workers by allowing them to gain legitimacy and increase their confidence (Sletten & Ellingsen, 2020).

4.0 Methods

For this research, I will look at data excerpt collected from the “*Children and adolescents in Norway who have displayed harmful sexual behaviours to other minors*” project as of the 20th of January 2022 by psychology specialist and PhD candidate Monica Jensen who is doing this research in collaboration with the institute for health, milieu and equality at the University of Bergen and Betanien Hospital (Jensen, 2019). The project is supported by the AIM project in the UK; however, the data collection, analysis and publishing of the results are formally independent of them. The main aim of the study is to test whether the background of professionals affects how they use AIM3.

4.1 Research Philosophy and Approach

Social science is, for many considered a “*soft science*” due to the subject matter being the social life of humans, which is difficult to precisely measure (Neuman, 2014, p. 9). When

conducting social research there are several theoretical perspectives to look at, for this research a positivist approach will be used. Positivist social science (PSS) “*emphasizes discovering casual laws, careful empirical observations, and value-free research*” (Neuman, 2014, p. 97). It is a way to organise empirical observations to look at individual behaviour to “*discover and confirm a set of probabilistic casual laws that can be used to predict general patterns of human activity*” (Neuman, 2014, p. 97). I will use a deductive approach within PSS, which is an approach to confirming a theory that begins with a theoretical relationship and “*works toward more concrete empirical evidence*” (Neuman, 2014, p. 69).

For this research, a quantitative approach was chosen due to the research question. To do a quantitative research study, many participants need to be gathered to get a statistical approach to the data collected (Neuman, 2014). To look at how the background of the participants influences their answers in the assessment, a quantitative approach is needed. A major advantage of using questionnaires as a data collection method is that you can collect a wide range of data from many participants, which will then allow you to make determinations about the statistics of the different dimensions of the questions you are asking (Leavy, 2017). The different characteristics of quantitative research are “*deductive approaches to the research process aimed at providing, disproving, or lending credence to existing theories*”, which involves “*measuring variables and testing relationships between variables in order to reveal patterns, correlations, or casual relationships*” (Leavy, 2017, p. 9). This approach is good when your primary purpose is to explain or evaluate (Leavy, 2017). This is what we are trying to do here, evaluate whether different variables of a participant’s background will influence how the assessment tool works.

4.2 Measures

AIM3 contains a five-factor structure which is designed to make the practitioner look at the entirety of a young person’s life, and not just their sexual behaviours. The five main factors are 1. Sexual behaviour, 2. Non-Sexual behaviour, 3. Development, 4. Environment/family, 5. Self-Regulation. Within each of these factors, there are five sub-factors to look at, and more to look at within those factors. Meaning that altogether there are 25 factors to consider. To look at sexual behaviour, which could be argued is the most important factor in the assessment, the five different factors are “*nature of the HSB*”, “*extent of HSB*”, “*victim characteristics*”, “*sexual aggression and violence*” and “*sexual knowledge, attitudes and*

interests” (Leonard and Hackett, 2019, p. 49). When assessing these sub-factors there is a lot to consider, and whether there was an attempt at penetration, what object was used, and the age of the victim is only a few of them (Leonard and Hackett, 2019). When considering domain two, non-sexual behaviour, the sub-factors are “*non-sexual criminality*”, “*non-sexual aggression and anti-social behaviour*”, “*alcohol and drugs*”, “*general behaviour*”, and “*mental health and well-being*” (Leonard and Hackett, 2019, p. 49). When assessing this domain, the practitioner needs to consider offending that was not sexual in nature, if there has been a recent escalation in aggression, impulsive behaviour, mental health diagnoses, social isolation and loneliness to mention a few (Leonard and Hackett, 2019). For domain three, developmental, the sub-factors are “*trauma and victimisation*”, “*childhood and adolescent adversity*”, “*attachment*”, “*family functioning*”, and “*health, intellectual and emotional functioning*” (Leonard and Hackett, 2019, p. 49). When assessing these factors, a few of the things to consider is whether there has been any childhood abuse or unresolved trauma, domestic abuse, the quality of attachments with carers or parents, and emotional regulation (Leonard and Hackett, 2019). For domain four, environmental/family, the sub-factors are “*stability and safety*”, “*parental or carer supervision*”, “*relationships*”, “*peer group*”, and “*education, employment and leisure*” (Leonard and Hackett, 2019, p. 49). What the practitioners need to consider for this domain is the stability and safety of their living environment, the quality and extent of their relationships with peers, their engagement with school or employment and their daily structure (Leonard and Hackett, 2019). For domain five, self-regulation, the sub-factors are “*responsibility*”, “*motivation and engagement*”, “*future perspective*”, “*problem solving*” and “*social competence*” (Leonard and Hackett, 2019, p. 49). When doing the assessment, the practitioner needs to consider the attitude the person has towards the HSB, their motivation to address said HSB, their pro-social plans and goals, their coping strategies, and life skills in general (Leonard and Hackett, 2019).

This is to get a holistic approach to the young person to look at both their risk and protective aspects across the different parts of their life (Leonard and Hackett, 2019, p. 48). This way professionals can look at the young person’s sexual behaviour in context with their wider development and functioning (Leonard and Hackett, 2019) AIM3’s aim is to see how the young person’s historical factors have impacted how they function in daily life and how they present themselves, the purpose is not simply to look at what historical factors are present (Leonard and Hackett, 2019, p. 48). This can help the professional to understand why the

young person has developed HSB and identify which aspects of the young person's life need interventions (Leonard and Hackett, 2019).

4.3 Participants

Out of the 252 interdisciplinary professionals that participated in the 16 different courses throughout Norway since this project started, 92 people agreed to be a part of the study, whilst 48 people ended up taking part in it. Out of those 48 people, 52.1% worked at "Special Health Services (BUP/BUPA/PHBU)", whilst two, or 4.2% of people worked for the municipal health service, as well as 4.2% worked at "Habilitation services for children (HABU)", see table one in the article for further details. The professionals have various levels of experience analysing HSB in children and young persons in the last five years of working, with almost half of them having between one and five cases of experience where a child or young person has been suspected of HSB. 62.5% had no experience with any AIM2 case assessments. Ten participants responded "other" in both profession and workplace. For profession, the ten participants elaborated with "psychology student", "social worker with specialisation in psychiatric health work", two said "social worker", "criminologist", "clinical social worker and family therapist", "assistant professor with promotion, subject teacher for drama and theatre with pedagogy and psychology", "clinical social worker", "social worker and family therapist", and "social worker specialist". For the workplace the ten participants elaborated with "resource centre", two said "habilitation services for adults", "municipal doctorate", "private child protective services", "special health services (BUP/BUPA/PHBU)", "private practice", and "follow up foster homes".

4.4 Analyses

Before doing any analysing, I needed to make sure the data is clean and there were no outliers. When I first ran a descriptive analysis, I had not realised that "99=no answer" needed to be put in the discrete missing value box, which made it tricky to spot outliers. After fixing that, I also put "9-not applicable" in the same box. I then made sure every missing data in the data view had 99 in it, so no data was open, and SPSS could count all the missing data as missing data. I then run the analysis again. This made it a lot easier to spot any outliers. Then I went through Chapter four "cleaning up your act" from "Using Multivariate Statistics" fourth edition by Barbara Tabachnick and Linda Fidell and ran the suggested analysis to make sure my data was clean and ready for the main analysis.

The study manager created a codebook for SPSS in word, creating the code and variables I then put into SPSS. The study manager anonymised every participant's contribution by replacing their name with a code. I plotted every case and questionnaire in SPSS. 98 has been used as a variable for "other". First, I created the raw data file, with the cases being scored "0,2,4" like in an actual AIM3 assessment. In this file, I included every raw data, including the comments some of the participants have added. After, I created a new data file, where I coded "0,2,4" to mean "1,2,3" to make it more suitable for SPSS. I also made sure I had plotted everything correctly and ran a descriptive analysis to make sure the minimum value of the cases was one and the maximum value was three. I also made sure the standard deviations seemed to be correct. I found three mistakes, where four was the maximum value, where I then went back into the questionnaires to find out what that four was supposed to be plotted as. From then I created the file I wanted to work in, where I changed "age" and the different "experience" variables from no values to grouping them into two different categories for SPSS to analyse the variables more easily.

There are, according to Julie Pallant (2020, p. 214) some general assumptions that need to be fulfilled for the analysis to be appropriate such as "*random sampling*", which is an anonymous sample of the people who are relevant for this research. The next assumption is the "*independence of observations*" (Pallant, 2020, p. 214), and as this questionnaire and cases were scored alone, I do believe this assumption is fulfilled. The next assumption is "*normal distribution*" which states the population sample has "*normally distributed scores on the continuous, dependent and independent variables*", she also states that with a sample size of 30+ participants any violation of this assumption will not cause a big problem (Pallant, 2020, p. 214). The last assumption is "*homogeneity of variance*" which assumes the samples obtained from the population are of "*equal variance*" (Pallant, 2020, p. 215), although as IBM SPSS presents results for both outcomes, I will not break this assumption. As the point of the study is to look at the differences between the population, the times where equal variance is not assumed, it is pointed out in the results section of the article.

To do the analysis I performed a series of descriptive analyses as well as independent sample t-tests to find out if there were any statistically significant differences in the scoring of Alexander and Thomas based on the background of the professionals.

4.5 Ethical Considerations

In every research, there need to be ethical considerations. Being ethical gives us a limitation on the choices we can make to find the truth (Bulmer 2001, p. 45). Ethics say, “*while truth is good, respect for human dignity is better*” (Bulmer 2001, p. 45). In the form asking for participants for this study, it is thoroughly stated what it means to participate. It is stated that they will receive three cases to evaluate using AIM3 and a questionnaire to fill out. That each questionnaire will take around 50-100 minutes to fill out, and the questionnaire will take 30-45 minutes to answer. It is also stated that it is voluntary to participate, and they can withdraw their consent to participate at any time, no questions asked, with the guarantee that their personal information will then be deleted. The participant’s information is confidential, with only the research manager having access to personal information. The participant’s name, and information have been replaced by a code that is saved separately from the main data. Any published data will not contain any identifiable information. When the project is finished all data will be anonymized. All participants have signed a consent form that states they have received and understood the information about the project, they have had the opportunity to ask questions, and they consent to have their personal information stored until the project is finished. By doing informed consent on adult, professional participants, the ethical considerations have been considered. The project has been approved and ethically cleared by the Norwegian centre for research data (NSD).

5.0 Summary of Results

The most important variable, showing the most statistically significant differences in the scoring of the cases was time spent on the assessment. It only explains differences in Thomas’s case, and time shows no significance for any of Alexander’s domains. There is the same number of participants that spent between zero and 60 minutes for both Alexander and Thomas, as well as those who spent over 61 minutes, meaning there is no difference in time spent on the assessments. Despite this, the time spent on Thomas’s assessment has had a significant effect on the scoring on three out of five domains, and no significant effect on any of Alexander’s domains. There are no variables that show any significant difference in both cases and no variables that explain differences in domain two. Which could potentially mean the difference is in the cases themselves, or something else entirely that has not been analysed in this study. See the main article for more information.

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Attachment 1; Article

Assessing Harmful Sexual Behaviour Among Youth: Does Professional Background Affect AIM3 Scoring?

Abstrakt

Denne kvantitative masteroppgaven handler om AIM3, som står for «assessment/intervention/moving on» og er den tredje versjonen av dette kartleggingsverktøyet. AIM3 er et kartleggingsverktøy for barn som har, eller er mistenkt for å ha utført skadelig seksuell atferd mot andre barn. Verktøyet er til for å hjelpe profesjonelle å identifisere om barnets behov er møtt både når det gjelder seksuell atferd og ikke-seksuell atferd. Formålet med oppgaven er å se om verktøyet fungerer når ulike profesjonelle skal kartlegge samme barnet. Problemstillingen er «om bakgrunnen til profesjonelle som bruker AIM3 har noen effekt på scoren barnet får». Jeg har brukt en spørreundersøkelse som psykologspesialist/ PhD kandidat Monica Jensen har laget og sendt ut til tverrfaglige profesjonelle som har deltatt i et kurs om AIM3. Jeg har også brukt to vignetter som deltakerne har brukt AIM3 for å score to ulike barn. Jeg har utført deskriptive analyser og t-tester. De viktigste funnene er at på en av sakene har tiden deltakerne har brukt på analysen hatt en signifikant effekt på resultatet på scoringen. Det er ingen variabler som viser en signifikant effekt på begge barna. Det ser ut som det er en naturlig distribusjon på scoren og at de fleste deltakerne har scoret innenfor den forventede feilmarginen på verktøyet. Det kan bety at det er et verktøy som kan brukes for å hjelpe barnevernet og andre instanser å kartlegge behovene til et barn som har utført skadelig seksuell atferd, men på grunn av deltaker tallet så bør det forskes videre på.

Nøkkelord; AIM3, Skadelig seksuell atferd, SSA, Kartleggingsverktøy, Tverrfaglig fagpersoner.

Abstract

This quantitative article is about AIM3, which stands for “*assessment/intervention/moving on*”, which is the third version of this assessment tool. AIM3 is a tool for young people who have or are suspected to have conducted harmful sexual behaviours toward other children. The tool is made to help professionals to identify whether the child’s needs have been met both sexually and non-sexually. The purpose of this article is to look at whether the tool works when different professionals assess the same child. The main research question is “whether the background of the professionals using AIM3 affect the scoring of the instrument?”. I have used a questionnaire that has been filled out by interdisciplinary professionals who have completed an AIM3 course. I have also used two case scoring results where the participants used AIM3 to score two different children. I have done descriptive analysis as well as t-tests. The most important finding of this study was that time spent on the assessment has had a significant effect on the results of the score. There are no variables that show a significant effect on both children. There is a natural distribution for most of the scoring, with most of the participants being within the expected margin of error. This could mean that this is a tool that the child welfare services can use to assess the needs of a child who has conducted harmful sexual behaviours. Due to the participant number being low in this study it should be researched further.

Keywords; AIM3, harmful sexual behaviours, HSB, assessment tool, interdisciplinary professionals.

Introduction

Since the 1990s, several studies have shown that a substantial part of sexual abuse against children is committed by children under the age of eighteen (Allardyce & Yates, 2018). Hackett estimated in 2016 that out of all sexual offences against children in the UK, at least one-third are committed by other children (Allardyce & Yates, 2018). In the mid-1980s, several early intervention programmes were established in the United States (US) that initiated the conversation and knowledge on sexual abuse by young people (Leonard and Hackett, 2019). It was not until the 1990's that the existence of sexual abuse by young people was brought into professional consciousness in the United Kingdom (UK) (Leonard and Hackett, 2019). Since then, it has had a steady increase in awareness, and most local areas in the UK have some sort of course on the topic, with many of them using the AIM tool (Leonard and Hackett, 2019). There are several different ways children are impacted by experiencing sexual abuse during childhood, but the consensus is that it is associated with severely compromised physical and mental health outcomes, that usually endure into adulthood (Allardyce & Yates, 2018). There has in later years been an increase in recorded sexual crime, which could be an indication of growing confidence from the victim in reporting the crime to the authorities (Allardyce & Yates, 2018). In line with this trend, it has now been more likely that situations where a young person (12-18 years old) sexually abuses a child (under 12 years old) or peer, will be reported (Allardyce & Yates, 2018). In fact, the number of reported sexual offences committed by a child against another child has between 2013 and 2016 risen in England and Wales by 71%, and between 2016 and 2017 it rose by another seven percent (Allardyce & Yates, 2018). This does not necessarily mean there are any more crimes committed, but that victims or guardians of victims have been more comfortable reporting the crimes more frequently, but it does show us that it is a prevalent issue.

In this article, the focus is the assessment tool AIM3 which stands for “*assessment/intervention/moving on*”. AIM3 is the third version of the instrument. The AIM3 is designed to help professional practitioners to assess harmful sexual behaviour (HSB) within several different domains of a young person’s life and identify if their needs are met both sexual and nonsexual (Leonard & Hackett, 2019). The different domains are sexual behaviour, nonsexual behaviour, developmental, environmental/family, and self-regulation (Leonard & Hackett, 2019). It is designed to encourage the practitioner to look at the entirety of the young person’s life, and not only their sexual behaviour (Leonard & Hackett, 2019). There is no universally agreed definition of the term “*harmful sexual behaviour*”. One definition used is “*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*” (Allardyce & Yates, 2018, p. 12). As AIM3 was developed in 2019 there has been very little research on the reliability and effectiveness of the instrument. Professionals that work with children all have different instruments and tools to help them identify problems and help them talk to the children, which helps them to be more consistent throughout the country. It is important to make sure that these instruments and tools measure what we want them to measure.

Data suggests that a substantial proportion of child sexual abuse is perpetrated by other children and young people. In the US, a study done by Finkelhor and colleagues (2009) found that of all sex offenders, juvenile sex offenders comprise of 25.8%, whilst they comprised of 35.6% of offenders against juvenile victims. In a population study done in the UK involving 2275 adolescents, it was found that 65.9% of the sexual abuse were perpetrated by children and young people under the age of 18 and were reported by children and young people under

the age of 17 (Radford et al., 2011). In the same study it was also found that most perpetrators were male, and most victims were teenage girls between 15 and 17 years old (Radford et al., 2011). It was also found that in majority of cases, the victim knew their perpetrator (Radford et al., 2011). International numbers have shown that around 20% of all rapes and 20-50% of all sexual abuse against children and teenagers are committed by teenage boys (Jensen et al., 2016). Factors that have been associated with HSB against other children include exposure to or witnessing psychical violence and drug abuse in the family, being a gang member, suicidal behaviour, having an early sexual debut, being a victim of sexual abuse and using pornography (Jensen et al., 2016). It has also been shown that adolescents that have experienced HSB themselves are three times more likely to perform HSB against others (Jensen et al., 2016). Vizard found in 2006 that a total of “20% of all convictions for sexual offences in the UK were acquired by children and young people between ten and 20 years old” (Vizard, 2006, p. 3), and around 34% of “all sexual abuse coming to the attention of the professional system” (Erooga and Masson, 2006, as cited by Hackett, 2014, p. 10).

For a long time, it was assumed that sexually abused children sexually abuse others, however, many other factors may have a correlation to those kinds of behaviours (Hackett, 2014). Such factors include “neurological, intellectual, biological, genetic, psychological, social and environmental features” (Hackett, 2014, p. 29). This leads to the more current theories of why some children sexually abuse other children to be a combination of “familial, social, economic and developmental factors” with the inclusion of neglect, violence in the family, the presence of physical abuse, being exposed to sexually explicit media and poor parenting (Hackett, 2014, p. 29). According to Hall and colleagues (2002), there were three areas that showed the biggest difference across the groups, with the first being the element of the sexual abuse experience the child had experienced themselves. Children who were exposed to

sadistic elements in their abuse, who were forced to be an active participant by their perpetrator and that experienced sexual arousal during the abuse had a higher chance to develop inappropriate sexual behaviours (Hall et al., 2002). Secondly, the social modelling experiences of the child were important, the children who bore witness to the abuse of other children and that were participating in child-to-child sexual activity were more likely to model that behaviour with other children (Hall et al., 2002). Thirdly, the children's families could either contribute to or inhibit the development of HSB. Children who were sexually abused and came from a family where the parent-child role was distorted, where the sexual attitudes were inappropriate (Hall et al., 2002). Where criminality or violence was involved, where the interaction between the members of the family was poor, and finally if the parents had histories of maltreatment the child had a higher chance of developing problematic or harmful sexual behaviours (Hall et al., 2002).

Due to AIM3 being published in 2019, there are not many, if any, studies using this assessment tool. Therefore, a thorough evaluation of the AIM3 is needed to get a better understanding of whether it is an assessment tool that will work for interdisciplinary professionals throughout Norway. An analysis of AIM2 has found that a big limitation was that the assessment tool is not applicable for young people with learning disabilities, young females, and people under 12 years of age (Griffin et al., 2008). Although AIM3 is also designed for young males between 12 and 18 years old who are known to sexually abuse, it may, on contrary to AIM2, be used on young women, with a degree of caution (Leonard and Hackett, 2019). AIM3 has also preceded AIM2 by being able to be used for young people with learning disabilities, however, there still needs to be caveats, such as adapting interview style and the language used when doing these assessments (Leonard and Hackett, 2019).

There is a separate AIM for children under 12 years old (Carson, 2019). As most of the

research evidence and practice knowledge on HSB in young people have been based on samples of predominantly young men, caution needs to be used when using this assessment tool with groups falling outside of this group, such as women and people with learning and developmental disabilities (Leonard & Hackett, 2019).

Due to the relatively high prevalence of HSB, there is a need for instruments that can aid the assessment of HSB among health professionals. Participants of a focus group for child welfare professionals in Norway reported that having an assessment tool to talk about sensitive issues in a systematic way was helpful and gave a sense of security to the professionals (Øverli et al., 2018). There are several different tools for professionals to use, such as the KATE-form, which stands for mapping or assessment of potentially traumatising experiences (Øverli et al., 2018), and the traffic light tool, which is used to differentiate between the different types of sexual behaviour and whether it is okay, problematic or harmful (Øverli et al., 2018). AIM was developed in England and is now used in Norway to further educate about problematic and harmful sexual behaviour with children (Øverli et al., 2018). AIM has a basic course that gives a basic consciousness and professional knowledge to discover and identify problematic and harmful sexual behaviour with children and young people (Øverli et al., 2018). AIM2 is then an investigation course which gives you information about assessing on a supervision and follow-up level (Øverli et al., 2018).

Reghr (2018) found that although generally having experience in practice will increase confidence in professional decision making, novices that have very little experience have been found to have more confidence in their judgment of risk than considerably more experienced social workers. They found that a reduction of overconfidence happens when professionals progress in their competence and inherently become aware of the complexities of clinical

situations. As well as the importance of context which then increase the individual's awareness of their own abilities and ultimately makes them more realistic about their expertise level (Reghr, 2018). The way to reach an expert level is by a stepwise process that starts with a novice that is just learning the rules for practice and follows that strictly (Reghr, 2018). Once they have done that, they start to recognise further elements to consider and apply their knowledge to real situations as an advanced beginner (Reghr, 2018). After they reach competence, they have an awareness of the extensive range of factors that play into judgments (Reghr, 2018). They reach expertise once they can develop intuitive boundaries of comfort and competence whilst mastering novel situations and resisting routines that are familiar (Reghr, 2018). Social workers can truly begin to improve their decision-making when they recognise what stage they are in their own development (Reghr, 2018). Overconfidence is dangerous because it can cause a professional to not be able to stray from their initial judgment and fully consider information that could conflict with that, and then reach premature conclusions (Reghr, 2018). They also found that the fear of liability, litigation and public shame are factors that can be damaging to the decision-making process for social workers (Reghr, 2018). This could potentially mean that the experience level of the individual doing an AIM3 assessment, may have an impact on it, whether it is being more cautious or less cautious in the assessment, as well as the perceived public shame of having a young person labelled as high risk for HSB.

In conclusion, previous research on the AIM3 is limited, which is why an article researching the effects and uses of AIM3 is needed. The research question of the present study is therefore: Does the background of the professionals using AIM3 affect the scoring of the instrument? My hypothesis is that those with higher education, more experience assessing

cases where children and harmful sexual behaviour are involved and more experience, in general, will score the children lower and be more consistent with how they score them.

Methods

Research Design and Procedure

I will look at data excerpt collected from the “*Children and adolescents in Norway who have displayed harmful sexual behaviours to other minors*” project as of the 20th of January 2022 by psychology specialist and PhD candidate Monica Jensen in collaboration with the institute for health, milieu and equality at the University of Bergen and Betanien Hospital (Jensen, 2019). As well as three cases created by Monica Jensen, scored by the participants from the questionnaire, using AIM3. The project is supported by the AIM project in the UK; the data collection, analysis and publishing of the results are formally independent of them.

After completing the AIM3 course, the participants have received one custom-made questionnaire about themselves and their professional experience, as well as three constructed cases of children and young persons with harmful sexual behaviour to read through and score using the methods taught in the AIM3 course. A group of interdisciplinary professionals from all around Norway have participated in an AIM3 course from 2020 to 2022. The courses had an open, free invitation for every professional in Norway to be able to participate.

To do the descriptive analysis, I wanted to choose two of the made-up cases the professionals scored, as there are five domains in an AIM3 assessment, 25 different factors for each assessment, and using all three would be a lot of analysis. To choose I ran a descriptive analysis on each of the different sum scores of the five different domains, where I found that

case two, Thomas, had the highest standard deviation in three of the five domains. Whilst case one, Alexander and case three, Julian only had the highest standard deviation in one main domain each. I also found that case one – Alexander had the smallest standard deviation in domains two through five. Due to this, I decided to use cases one and two, Alexander and Thomas as I wanted to look at the cases with the highest and lowest standard deviation to find out why there is a difference. To make sure the standard deviation was not caused by the participants finding the case to be unrealistic in real life, I ran a frequency analysis where 71% of participants scored Alexander (case one) to be “very realistic” and 29% of the participants scored the same case to be “quite realistic”. For Thomas (case two) 63% of the participants found the case to be “very realistic”, 35% found it to be “quite realistic” and 2% found it to be “not very realistic”. For the third case, only 44% found it to be “very realistic”, which is why I will focus on Thomas and Alexander.

Measures

AIM3

AIM3, which is the focus of this dissertation, is an assessment framework including 25 items that are designed to help practitioners to consider the relevant targets for intervention, levels of supervision and quantifying risk (Leonard and Hackett, 2019). AIM3 is designed to provide practitioners with “*a structured framework to assist in analysing the HSB in the overall context of the young person*” (Leonard & Hackett, 2019, p. 8). AIM3 intends to be responsive and dynamic to systematic, developmental, and behavioural change (Leonard & Hackett, 2019). The items are organised into five main domains, including, sexual behaviour which looks at the extent and nature of the behaviour, sexual aggression, interests and attitudes (Leonard and Hackett, 2019). Non-sexual behaviours, meaning mental health, non-sexual aggression, criminality that is not sexually intended, drug and alcohol use and their

general behaviours (Leonard and Hackett, 2019). Developmental, which looks at their childhood, how the family functions, their emotional and intellectual functioning, trauma and attachment (Leonard and Hackett, 2019). Environmental/family which examines the supervision from parents or carers, their safety and stability, how their relationships are, how they experience peer groups, and how they spend their leisure time, education and employment (Leonard and Hackett, 2019). Finally, domain five is self-regulation which details how the individual understands their own behaviour and its impact on it, their skills at self-regulation, their perspective of the future, their social competence and problem solving (Leonard and Hackett, 2019).

The different variables in the cases are scored zero (*no general concern within this factor*), two (*some concern*) or four (*significant concern*) and then each variable in the five different domains is added together to create a “green”, “yellow” or “red” sum score (Leonard and Hackett, 2019, p. 53). The children are in the green zone if their sum score is between zero and four, in the yellow zone if their sum score is between six and 12, and in the red zone if their sum score is between 14 and 20 (Leonard and Hackett, 2019). By doing this, it is “*possible to build an overall profile of the young person’s presentation at that point in time, highlighting specific needs and strengths both within and between each of the Domains*” (Leonard and Hackett, 2019, p. 53) By plotting the scores into a graph with a colour coding where red identifies areas of “*immediate intervention*”, amber requiring “*attention in interventions*” and green as areas of strength it gives the practitioner a visual representation of the different areas of strength and concern (Leonard & Hackett, 2019, p. 9). This overall analysis of the young person combined with the graph profile helps the practitioner to identify the areas of immediate, short term and long-term intervention for both the young person and their parent/carer (Leonard & Hackett, 2019).

Participants' professional background

As well as doing three different AIM3 assessments, the participants included in this article have all filled out a custom-made questionnaire in order to give a background about their education, profession, work experience in general and specifically with children and their families, different courses completed, how much time they used on the AIM3 assessment and so on. In the questionnaire, they were also given the opportunity to give feedback on the questionnaire, the cases as well as how useful they found AIM3 and how likely they were to use the assessment tool in the future. The questionnaire was created by psychology specialist and PhD candidate Monica Jensen. The profession variable has been grouped into two variables, those with social health education and those with psychology education. Those with psychology education are authorised health care professionals with a minimum six-year education. Those with social health education are mainly different types of social workers with a minimum three-year education.

Demographic Information

The demographic needed for this study are professionals around Norway who work with children or young people, that may come into a situation where they need to do an assessment of a young person that is suspected of or has conducted HSB towards other children or young people. This includes different kinds of social workers, psychologists and other relevant professions. For this project, only professionals that have completed a course in AIM3 were invited to participate.

Data and Methods

Participants

There have been so far, 16 courses with 252 professionals participating, 92 people decided to join in for further studies, whilst 48 people completed the study and sent in both the questionnaire and the three different cases. According to the data, most of the participants have at least a year of experience working directly with children and their families, and only 33% of the participants have under ten years of experience, with the rest having 11 or more years' experience. The participants have all signed up for an AIM3 course and during that course, they were asked to participate in the study as an extension of the course. This is because AIM3 is developed to be used by different kinds of professionals from different sectors, and most people signing up for the AIM3 course already have experience with children and young people with problematic or harmful sexual behaviours.

Table 1. Presentation of participants

		<i>Frequency</i>	<i>Valid Percentage</i>
<i>Sex</i> (n=48)	Male	11	23 %
	Female	37	77 %
<i>Age</i> (n=35)	20–40 years old	14	40 %
	41+ years old	21	60 %
<i>Profession</i> (n=48)	Social Worker/Clinical Social Worker	5	10 %
	Pedagogue/Clinical pedagogue	3	6 %
		9	19 %

	Child Welfare Educator/ Clinical Child Welfare Educator	21	44 %
	Psychologist/Psychology Specialist	10	21 %
	Other		
<i>Profession Grouped</i> (n=48)	Social health education	27	56 %
	Psychologist/Psychology specialist	21	44 %
<i>Workplace</i> (n=48)	Municipal Health Services	2	4 %
	The Office for Children, Youth and Family Affairs (Bufetat)/Children- and Family Agency	6	13 %
	Special Health Services (BUP/BUPA/PHBU)	25	52 %
	The States Children's House	5	10 %
	The National Mediation Service/The Probation Service	1	2 %
	Habilitation Services for Children (HABU)	2	4 %
	Other		

		7	15 %
<i>Workplace Grouped</i> (n=48)	Special Health Services	25	52 %
	Other Health/ Social Work Services	16	48 %
<i>Experience working with children and their families (n=47)</i>	0-10 years' experience	16	34 %
	11 or more years' experience	31	66 %
<i>Direct work w/ children suspected w/ HSB in the last 5 years (n=48)</i>	No experience	13	27 %
	1 or more case experience	35	73 %
<i>AIM2 assessment with main responsibility (n=48)</i>	No experience	30	62,5 %
	1 or more case experience	18	37,5 %
<i>AIM2 assessment with part responsibility (n=47)</i>	No experience	30	64 %
	1 or more case experience	17	36 %
<i>Time spent assessing Alexander (n=48)</i>	0-60 minutes	32	67 %
	61+ minutes	16	33%

<i>Time spent assessing</i>	0-60 minutes	32	67 %
<i>Thomas (n=48)</i>	61+ minutes	16	33 %

Percentages have been rounded off.

Analysis

For the analysis I will be using IBM SPSS and performing multivariate descriptive analysis, crosstabs and T-tests. T-tests are the main form of analysis done, looking at the mean difference between two groups (Allen et al., 2008). For this research, an independent t-test is more appropriate, as the participants have been divided into two separate groups within the different variables due to the low number of participants (Allen et al., 2008). In the tests I will be looking at whether the different backgrounds of the professionals (or time used during the assessment) have caused a significant change in the mean score, meaning it is larger than the “*expected natural variability*” (Allen et al., 2008, p. 36). According to Allen et al, it is more likely to find statistically significant differences in larger samples, which can influence this research, as the sample size is low. In order to calculate the effect size for the t-tests I will use *eta squared* as it is one of the most used, and I want to look at the “*proportion of variance in the dependent variable that is explained by the independent variable*” (Pallant, 2020, p. 254). Due to IBM SPSS not providing the eta squared in the output for t-tests, I will use the following formula to calculate it by hand; $\text{Eta squared} = \frac{t^2}{t^2 + (N_1 + N_2 - 2)}$. I will also use Cohen’s proposed guidelines to interpret the strength of the value (Pallant, 2020). The guideline being .01 = small effect, .06 = moderate effect, and .14 = large effect (Pallant, 2020). In order to find out if there are any differences between the different independent factors of sex, age, work experience, time spent on the assessment, and education, I conducted a series of independent t-tests with the sum scores of the two different assessments as the dependent variables.

To deal with missing data, I first removed the case the participants that only completed the case assessment they did in the actual AIM3 course, this is due to them not having completed the questionnaire so there would be no independent variable to compare it to. As well as legal reasons in case of publishing, as that case is still being used in AIM3 courses. There is no missing data in the sum scores, however a few in the questionnaire. For those missing data, I made sure to put them in the “missing data” column in SPSS so that SPSS will properly count them as missing data. “99” is used for missing. I also stated in table one how many responses there were for each relevant question in the questionnaire.

Results

The independent t-test results comparing Alexander and Thomas’s sum scores to sex showed no significant numbers for males and females, with the highest difference being for sum score one (sexual behaviour) for Alexander. The magnitude of the difference was very small ($\eta^2 = .02$), if following the guidelines proposed by Cohen in 1988 for interpreting it (Pallant, 2020). When running a t-test for the workplace, overall experience as a professional, experience working directly with children/young people suspected of HSB, experience working directly with children/young people/their families, experience using AIM2 for assessments, and finally time spent on Alexander’s assessment, it shows no significant difference in mean scores. This could be because of the low participant number, or simply that workplace and that experience does not explain the difference in scoring. I will only include the tables showing a significant difference.

Alexander

The T-test comparing age to the sum scores showed a couple of significant numbers. The third sum score (developmental) for Alexander showed a *p-value* of .05 (two-tailed) which means that there is a significant difference in the mean score between those 20-40 years old and those 41 and older for that sum score (Pallant, 2020). The effect size was large with -.14, which means that 14% of the variance in the developmental sum score for Alexander is explained by the age of the participants. The other significant sum score explained by age is number four, environmental/family for Alexander, where the *p-value* showed .02, which is considered a significant difference in the mean score (Pallant, 2020). The magnitude of that difference showed -.23, which is a largely negative effect, meaning 23% of the difference in that sum score is explained by the age of the participants. This means that the younger participants scored Domain three and four lower than the participants 41 years old and older, by a significant number. See Table two.

Table 2. T-test for the age of participants and sum scores.

	20-40 years old			41+ years old			Mean Difference	95% CI	df	t	p	Partial eta squared
	n	M	SD	n	M	SD						
Alexander 1	14	12.57	3.63	21	12.67	3.25	-.095	-2.48, 2.29	33	-.08	.94	-.0002
Thomas 1	14	14.57	3.72	21	14.76	2.93	-.19	-2.48, 2.1	33	-.17	.87	-.001
Alexander 2	14	2.86	1.29	21	3.24	1.73	-.38	-1.48, .72	33	-.70	.49	-.02
Thomas 2	14	7.00	2.69	21	7.24	3.38	-.24	-2.43, 1.95	33	-.22	.83	-.002
Alexander 3	14	7.29	2.16	21	8.57	1.57	-1.29	-2.57, -.004	33	-2.04	.05	-.14
Thomas 3	14	14.00	6.13	21	15.05	5.39	-1.05	-5.04, 2.95	33	-.53	.60	-.01
Alexander 4	14	3.14	1.29	21	4.67	2.03	-1.52	-2.77, -.27	33	-2.48	.02	-.23
Thomas 4	14	12.57	5.84	21	12.38	5.68	.19	-3.84, 4.22	33	.10	.92	.0003
Alexander 5	14	7.57	2.10	21	7.81	2.75	-.24	-2.00, 1.53	33	-.27	.79	-.002
Thomas 5	14	9.29	2.43	21	9.62	4.27	-.33	-2.65, 1.98	32.39	-.29	.77	-.003

Numbers have been rounded off to the nearest two decimals.

When running an independent t-test on experience having the main responsibility of an AIM2 assessment (the previous version of the assessment tool) against the sum scores for Alexander and Thomas the two variables that shows a significant number are “Alexander 4” and “Alexander 5”. Meaning that for this experience variable, those with higher experience, scored domain four and five higher than those with lower experience, with a significant difference in scoring. See Table three for more information.

Table 3. T-test for experience with AIM2 assessment with main responsibility and sum scores.

	No experience with main responsibility AIM2 assessment			1 or more case experience with main responsibility AIM2 assessment			Mean Difference	95% CI	df	t	p	Partial eta squared
	n	M	SD	n	M	SD						
Alexander 1	30	12.27	3.92	18	13.56	2.53	-1.29	-3.37, .79	46	-1.25	.22	-.04
Thomas 1	30	15.27	2.85	18	14.44	3.26	.82	-.98, 2.63	46	.92	.36	.02
Alexander 2	30	3.27	2.20	18	3.44	1.79	-.18	-1.41, 1.06	46	-.29	.77	-.002
Thomas 2	30	7.33	2.70	18	7.00	3.52	.33	-1.48, 2.15	46	.37	.71	.003
Alexander 3	30	7.80	2.25	18	8.22	1.35	-.42	-1.60, .76	46	-.72	.48	-.01
Thomas 3	30	14.27	5.27	18	15.33	5.49	-1.07	-4.28, 2.15	46	-.67	.51	-.01
Alexander 4	30	3.47	1.81	18	5.00	1.72	-1.53	-2.60, -.47	46	-2.89	.01	-.22
Thomas 4	30	11.40	5.33	18	13.11	5.95	-1.71	-5.05, 1.63	46	-1.03	.31	-.02
Alexander 5	30	7.27	2.55	18	8.78	2.29	-1.51	-2.99, -.04	46	-2.07	.05	-.10
Thomas 5	30	9.87	4.49	18	10.11	3.53	-.24	-2.74, 2.25	46	-.20	.85	-.001

Numbers have been rounded off to the nearest two decimals.

Thomas

When testing group differences based on the education level of the participants, the only slightly significant variable was domain one for Thomas (sexual behaviour). Here the *p-value* was also .05, which is a significant difference in the mean scores of the different educational levels, the magnitude of that difference was only .08, which is considered a moderate effect. Only explaining eight percent of the difference in the sum score for education. Meaning that those with a social health education scored Thomas higher in domain one than those with psychologist education. See Table four.

Table 4. T-test for the education of participants and sum scores.

	Social health education			Psychologist/psychology specialist			Mean Difference	95% CI	df	t	p	Partial eta squared
	n	M	SD	n	M	SD						
Alexander 1	27	12.30	3.79	21	13.33	3.06	-1.04	-3.08, 1.01	46	-1.02	.31	-.02
Thomas 1	27	15.70	2.52	21	14.00	3.35	1.70	-.001, 3.41	46	2.01	.05	.08
Alexander 2	27	3.41	2.53	21	3.24	1.18	.17	-1.03, 1.34	46	.28	.78	.002
Thomas 2	27	7.63	2.88	21	6.67	3.12	.96	-.79, 2.71	46	1.11	.27	.03
Alexander 3	27	7.93	2.11	21	8.00	1.79	-.07	-1.23, 1.08	46	-.13	.90	-.0004
Thomas 3	27	15.33	5.44	21	13.81	5.17	1.52	-1.60, 4.64	46	.98	.33	.02
Alexander 4	27	4.37	1.93	21	3.62	1.86	.75	-.36, 1.86	46	1.36	.18	.04
Thomas 4	27	12.89	5.67	21	10.95	5.39	1.94	-1.31, 5.19	46	1.20	.24	.03
Alexander 5	27	7.93	2.39	21	7.71	2.78	.21	-1.29, 1.71	46	.28	.78	.002
Thomas 5	27	10.15	4.30	21	9.71	3.96	.43	-2.00	46	.36	.72	.003

Numbers have been rounded off to the nearest two decimals.

The variable with the biggest statistical difference was for time spent on Thomas's assessment. Where domain three, developmental, showed a *p-value* of .01 which is considered a significant difference in the mean scores, where those who spent less time scored Thomas higher than those who spent more time on the assessment. The magnitude of the difference

was .17, meaning 17% of the difference in the mean score is explained by how long the participant spent on the assessment. For domain four, environmental/family, the *p-value* showed .001, which is also considered significant, where the participants who spent less time again scored him higher than those who spent more than an hour on the assessment. The magnitude of the difference here was .3, meaning that 30% of the difference in the mean score for domain four can be explained by how long they spent on the assessment. For domain five, self-regulation, the *p-value* was again .001, here, the participants who spent more time on the assessment scored him higher than those who spent an hour or less on the assessment. The magnitude of the difference was -.95, meaning that 95% of the difference in the mean score can be explained by the time spent on the assessment, which is the most significant number out of all the t-tests. See table five.

Table 5. T-test for completion time on Thomas’s assessment and sum scores for Thomas.

	0-60 minutes spent on Thomas’s assessment			61+ minutes spent on Thomas’s assessment			Mean Difference	95% CI	df	t	p	Partial eta squared
	n	M	SD	n	M	SD						
Thomas 1	32	15.13	3.09	16	14.63	2.9	.50	-1.37, 2.37	46	.54	.59	.01
Thomas 2	32	7.44	2.70	16	6.75	3.57	.50	-1.40, 2.78	23.87	.68	.50	.01
Thomas 3	32	16.38	3.88	16	11.25	6.23	5.13	1.58, 8.67	21.0	3.01	.01	.17
Thomas 4	32	14.19	4.41	16	7.75	5.26	6.44	3.54, 9.34	46	4.47	.001	.3
Thomas 5	32	8.31	3.26	16	13.25	3.72	-4.94	-7.04, -2.83	46	-4.73	.001	-.95

Numbers have been rounded off to the nearest two decimals.

Discussion

The purpose of this article was to find whether any of the backgrounds of the professionals, or time spent on the assessment, were associated with how they scored two different boys using

AIM3. The AIM3 tool allows for a certain margin of error when professionals score children. The tool states that you can score someone green and yellow or yellow and green and still be within that margin of error (Leonard and Hackett, 2019). An undesirable outcome is that someone sees no cause for intervention (green), whilst someone else sees the same person as in need of immediate intervention (red) within the same domain (Leonard and Hackett, 2019). This means that even though there are some significant differences in the way the different professionals have scored the two children, mostly all of them are within that expected margin of error. Before professionals can use AIM3 they need to go through a two-day course learning about the assessment tool itself. After they need to perform an assessment of a child using AIM3 and score them how they deem appropriate, it is then checked and “graded” by the person in charge of the course, and if they are within the expected margin of error, they are deemed qualified to use the tool. In real life practice, it is recommended that they perform assessments in pairs or discuss answers with another professional. A few of the participants stated in the questionnaire that they were uncomfortable scoring alone in this study, which could also have an impact on their answers due to insecurities about scoring someone on their own.

The t-tests revealed significant differences in the mean scores for Domain three (developmental), four (environment/family) and five (self-regulation) for Alexander. The age of the participants explained a significant difference for domains three and four with a large magnitude of difference. The higher age scored him higher concern in both domains. Experience with the main responsibility of AIM2 assessments explained a significant difference in domains four and five with a large magnitude of difference for Alexander. Those with more experience scored Alexander higher than those with less experience, which lines up

with the age of participants as well. This could mean that higher experience and higher age mean more accurate scoring, but without a correct solution, it is hard to say.

The t-tests revealed significant differences in the mean scores for domains one (sexual behaviour), three (developmental), four (environment/family) and five (self-regulation) for Thomas. The education level of participants explained a significant difference in domain one, only with a moderate magnitude of difference. Those with a social health education scored him higher than those with a psychology education. The variable explaining most of the significant differences in Thomas's domains was the completion time of the assessment. Showing a difference in domains three, four and five, all with very high effects. Those spending more time to complete the assessment scored him lower on domains three and four, whilst higher on domain five. This means that for domains one, three and four those with a "lower" educational level and those who spent less time completing the assessment have shown a higher concern than those who spent longer on the assessment and with a higher educational level.

Sicora et al. (2021), found that most professionals found intuition to be a really important tool when doing assessments, and Kirkman and Melrose (2014) found that intuition is mostly deployed by experts that have years of experience, even though it is found to cause errors in judgment. This could explain several of the variables shown to have relevance to the scoring in this study. As there are no right answers on how the boys should have been scored, there is no telling if the older participants scored him more correctly (perhaps relying more on intuition) or not, or if those spending more time on the assessment (and perhaps relying less on intuition) is more correct. We only know that age and time influences the scoring.

What is interesting is that there is no variable that explains the differences in the assessment of both cases. There are some variables that explain differences in scoring for Alexander, and some that explain differences for Thomas, however, no variables for both boys. Reghr found in 2018 that although generally, experience increase confidence in decision-making in a professional setting, some novices with little experience have been found to be overly confident, and more confident in their judgments of risk than the experienced workers. He also found that when novices start getting some form of competence, they realise how complex different situations can be. Whilst also realising the importance of context which essentially makes them become more realistic about their abilities which then reduces the risk of overconfidence (Reghr, 2018). This could explain why those with higher age and more experience with the main responsibility of AIM2 assessments have scored Alexander higher and therefore are more concerned for him. This could also be influenced by what Kirkman and Melrose (2014, p. 22) described in their report, that once people gain experience doing something, their future decisions can be strongly influenced by “*their ability to rapidly recall a similar example or event*”. Meaning that perhaps those who are a bit older and have more experience with young people in that same situation could potentially be influenced by something that they have heard of happening previously or have experienced themselves through working longer (Kirkman and Melrose 2014). My hypothesis was that those with higher education and experience would score the boys lower due to them not being overly cautious with their scoring as I expected those with fewer years of education and experience to be. This only proved true for domain one for Thomas, when those with psychology education (minimum six-year education) scored Thomas lower than those with social health education (minimum three years). This was the one significant number which only had a

medium effect, making my hypothesis extremely weak, and proven wrong by Alexander and somewhat by Thomas.

Completion time was the biggest indicator of a difference in scoring in the results, with all three of the domains it affected having a high effect. For domains three (development) and four (environment/family) the participants who spent more than 61 minutes on the assessment scored Thomas lower, whilst for domain five (self-regulation) it was those who spent 60 minutes or less that scored him lower. Now that could be because there was higher concern in domain five than in three and four, which would coincide with what the majority scored him as. When professionals are overconfident, they can and often do prematurely reach conclusions and essentially do not thoroughly consider the information that differs from their initial judgment (Reghr, 2018). Which could potentially explain why time indicated a difference in scoring. Sletten and Ellingsen (2020) found that some studies have suggested that standardized tools may just increase workload and be too time-consuming, which then has a negative effect on the capacity of social workers. Which could mean that if this tool needs at least an hour for the most effective scoring to happen, it could be too time-consuming for social workers with an already infamous workload. Although when you consider the seriousness of this subject, one would assume that proper time and support will be given when doing AIM3 assessments on real children who have been suspected of or conducted HSB. Standardized assessment and testing have been shown to also have a positive effect on social workers by legitimizing the professional's work by linking their work to science and expert knowledge (Sletten & Ellingsen, 2020). As HSBs are normally risky situations in need of quality professional practice it is natural for them to have an increased reliance on procedures and rules (Sletten & Ellingsen, 2020). AIM3 takes a holistic approach to assessment as research has shown to provide more involvement from the user whilst also

strengthening the professional role of social workers as it increases their confidence and their legitimacy (Sletten & Ellingsen, 2020). It is also a way to strengthen decision-making and helps the accountability in the child welfare services (Sletten & Ellingsen, 2020). The study found some variables to influence scoring, but with some precautions, such as giving sufficient time for assessment and doing assessment in pairs or teams, studies would suggest having a structured way to do assessments is still beneficial.

In this study, a positive social science approach was used to try to discover the causal laws of the scoring of AIM3 to see if there were any general patterns within the scoring of the children. The study did find some correlation, although without further research we cannot know if it is because of causation or simply a correlation. I started with a theory, that those with higher education are less concerned due to their experience and intuition and will therefore score children in general lower in the assessment. This did prove true for one of the domains, see table four, for the rest, the participants with more experience generally scored the children higher than the ones with less experience. By using a deductive approach, I tested my theory and proved it mostly wrong. By proving it wrong it could show that perhaps it tends to be the opposite. Perhaps because of experience and intuition, the ones with more experience can recall poor outcomes they have had previously and therefore be more cautious.

Although there was no variable that showed any significant difference in scoring for the same domain in both cases, the professionals did score Alexander on average more consistently than they did Thomas. Most participants spent the same amount of time on both cases; however, they scored the first case (Alexander) more consistently than their last case (Thomas). One could assume that the participants would become more confident in the use of the assessment tool after already scoring a case, yet the consistency in the scoring among the

professionals went down. Could that be due to what Kirman and Melrose found in 2014, that what staff encountered at the beginning of their shift, often contributed to how the rest of their cases were perceived? They found that if social workers had recently “*encountered a lot of very severe cases then the severity of the new case may be underestimated simply because it is not as severe as the unrepresentative sample brought to mind*” (Kirkman and Melrose, 2014, p. 25). In this study, the professionals have scored Alexander lower on average than they have scored Thomas. Could it then have the opposite effect on Kirkman and Melrose’s study? They also found that when dealing with moderate cases amongst milder cases, those moderate cases seemed to be more severe in comparison to social workers (Kirman and Melrose, 2014), could that have impacted how the professionals scores Alexander and Thomas? As we have not been able to read the case descriptions for this study, it is hard to tell, although it presents an interesting thought.

Limitations

For this study there have been a few limitations worth noting. One is the number of participants in the study. As there are only 48 participants out of the 252 professionals that can use AIM3 in Norway as of the 20th of January 2022, it does not give an accurate representation of those able to use the tool in Norway. We can therefore not really trust the relevancy and analysis of this data. I have also had to group participants into smaller groups than perhaps wanted due to the participant number. The number of participants has also limited what kind of analysis is possible for this data. Another limitation is not having access to the case descriptions for the boys, being unable to look for any obvious differences in the cases themselves to show why there is such a difference in the scoring of the boys. A further limitation is that there is no right answer, making it impossible to pinpoint who is right and

wrong and whether being younger is an advantage or disadvantage, or whether taking longer doing the assessment is an advantage or disadvantage when doing any AIM3 assessments.

One more limitation is missing data. As many as 13 participants did not answer the question about their age, which equates to 35% of the participants. As that variable had a significance on two of Alexander's sum scores, having 100% of the participants answering that question could potentially have given a different output in the analysis.

Implications and Conclusion

Harmful sexual behaviours toward children and young people caused by young people are a widespread problem that has perhaps not been historically given the attention needed. AIM3 is an assessment tool made to support professionals in their decisions on possible interventions and to find the young person's strengths and weaknesses within the entirety of their lives, not just their sexual behaviours (Leonard and Hackett, 2019). Norway has not had a systematic multiagency and intervention system to assess young people who have shown problematic or harmful sexual behaviour (Jensen et al., 2020). Norwegian child welfare professionals have also reported that having assessment tools to help them systematically talk about sensitive issues gives them a sense of security (Øverli et al., 2018). This could mean that even though this study shows AIM3 to have some statistically significant differences in scoring, it could still give professionals a systematic way of assessing this specific group of adolescents as well as a sense of security in their work.

This article tries to find whether how much time, what kind of education, and how the experience level of professionals will influence how they score two different children using AIM3. Despite the limitations of this study, the results do seem to show that AIM3 is a

relatively reliable tool where its results will not be too reliant on the background of the different professionals. As there are no variables that show any significant difference in both cases and no variables that explain differences in domain two. The most important variable, showing the most statistically significant differences in the scoring of the cases seems to be the time spent on the assessment. It only explains differences in Thomas's case, and time shows no significance for any of Alexander's domains. This could have implications for practice in the sense that professionals need to be provided with sufficient time to complete the assessments. It could also be beneficial for professionals to do the assessments together, as several of the participants commented on the questionnaire that they felt uncomfortable scoring alone and would have preferred someone to bounce their ideas and thoughts off. Which Patras and Klest found in their study as well, that therapists who worked in a cluster of three were happier with their work than those working alone or in groups of two (2016). Since there was no variable that showed a significant difference in scoring for both cases, it could mean there was a difference in the cases themselves, and different background variables could affect different types of cases. It could also mean that although the variables showed a significant difference in one of the cases, it is not enough to show a difference in all cases scored using AIM3. This could mean that the assessment tool and the training that the professionals must go through are thorough and reliable enough that background does not influence scoring. This again could mean that the resources being used to train professionals in Norway are being put to good use and will hopefully have a positive effect on how young people with HSB will be assessed and be helped.

Although this study does seem to show AIM3 to be a tool professionals can confidently use to aid their assessments of children with harmful sexual behaviours, it is a newer tool in need of further studies. This study only has 48 participants in it, and although everything helps in

research, and this could be helpful, further studies on this topic are needed. Further research with more participants could show more significant differences in scoring based on the background that have not been present in this study. There is research backing the theoretical framework of AIM3, and this study does seem to line up with their expected margins of error for different professionals scoring the same case. As most professionals scored the domains within the same level of worry (green, yellow or red). Some scored outside of that, but mostly green and yellow or yellow and red, which the developers of the tool expect from professionals using it. This leads me to the conclusion that my hypothesis has been partly proven wrong. There were some variables showing significant differences in scoring, although none of them were significant in both cases. This does seem to be a positive thing, as it does show a more uniform scoring between the participants, implying a more reliable tool. This leads me to believe that although background can have an effect, the fact that it is still within their expected margin of error, it is a tool that can and probably should be used in Norway to assess this group of young people, although further research is needed.

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Attachment 2; Questionnaire

AIM3 Utredningsmodellen og inter-rater reliabilitet

Spørreskjema til fagpersoner

Noen spørsmål er blitt utelatt grunnet pågående forskning som bruker dette spørreskjema.

Dette er en oversikt over de spørsmålene som har vært relevant til min masteroppgave

«Assessing Harmful Sexual Behaviour Among Youth: Does Professional Background Effect

AIM3 Scoring?». Denne spørreundersøkelsen er utviklet av psykologi spesialist og PhD

kandidat Monica Jensen.

1. Det første spørsmålet var om hvilket lovlig kjønn de ulike profesjonelle identifiserte seg ved, hvor de ulike svarkategoriene var
 - a. Kvinne
 - b. Mann.
2. Så ble det spurt om alder. Der var det et åpent svar kategori. Her har jeg senere kategorisert det i grupper.
3. Så ble det spurt om hvilken utdanning/profesjon de har. Der var svarkategoriene
 - a. Sosionom/klinisk sosionom
 - b. Pedagog/klinisk pedagog
 - c. Barnevernspedagog/klinisk barnevernspedagog
 - d. Psykolog/psykologspesialist
 - e. Lege/psykiater
 - f. Sykepleier/psykiatrisk sykepleier/helsesykepleier
 - a. Annet (vennligst spesifiser)

4. Det ble så spurt om hvor de jobber nå, med svarkategoriene;
 - a. Kommunal helse
 - b. Kommunal barneverntjeneste
 - c. Bufetat / barne- og familie-etat
 - d. Spesialisthelsetjenesten (BUP/BUPA/PHBU)
 - e. Statens Barnehus Konfliktrådet/ Friomsorgen
 - f. Habiliteringstjenesten for barn
 - g. Annet (vennligst spesifiser)
5. Så ble det spurt om hvor mange års yrkeserfaring de har som fagperson totalt. Her var det et åpent svar om antall år. Senere kategoriserte jeg det i grupper.
6. Deretter hvor mange års yrkeserfaring de hadde fra direkte arbeid med barn/ungdom/deres familier. Der var det også spesifisert at direkte betyr «samtaler, kartlegging, behandling og oppfølging». Her var det også et åpent svar kategori med antall år, som jeg også kategoriserte etterpå.
7. Så ble det spurt om hvor mange saker de har jobbet direkte med barn/ungdom som er sterkt mistenkt for eller som har utøvd problematisk eller skadelig seksuell atferd (SSA) de siste fem yrkesaktive år. Her ble det også spesifisert hva direkte betyr. Her var det et åpent svar kategori som jeg senere har gruppert.
8. Så hvor lang tid de brukte på AIM3 skåringen av de ulike kasusbeskrivelsene, der var det en åpen svarkategori for hvert enkelt kasus som jeg senere grupperte.
 - a. Kasus ALEXANDER
 - b. Kasus THOMAS
 - c. Kasus JULIAN
9. Så hvor realistisk eller urealistisk de opplevde kasusbeskrivelsene, der de fikk svar alternativer for hver enkelt kasus

- a. Ikke realistisk
- b. Lite realistisk
- c. Verken realistisk eller urealistisk
- d. Ganske realistisk
- e. Svært realistisk

10. Spørsmål nummer 10 var ikke relevant for masteroppgaven.

11. Her ble det spurt om hvor mange AIM2 utredninger de hadde hatt hovedansvar for.

Her var det en åpen svarkategori for totalt antall saker. Her grupperte jeg det senere.

12. Her ble det spurt om hvor mange AIM2 utredninger de hadde hatt delansvar for. Her

var det en åpen svarkategori for totalt antall saker. Her grupperte jeg det senere.

13. Spørsmål nummer 13 var ikke relevant for masteroppgaven.

14. Her ble det spurt om hvilke SSA-verktøy de hadde brukt de siste fem yrkesaktive

årene i kartlegging/utredning av barn/ungdom/ deres familier. Her var svarkategoriene

- a. Ikke i det hele tatt
- b. Ikke særlig ofte
- c. Litt
- d. Ganske ofte
- e. Svært ofte

Og de verktøyene som det ble spurt om var;

- a. AIM2 utredning (norsk versjon 2017)
- b. Trafikklyset Seksuell Atferd (norsk versjon 2011/2017)
- c. ASAP - "The Adolescent Sexual Abuser Project Assessment" (norsk versjon 2004)
- d. ERASOR - "Estimate of Risk Adolescent Sexual Offense Recidivism" (norsk versjon udatert)

e. Annet SSA verktøy (vennligst spesifiser):

f. Annet SSA verktøy (vennligst spesifiser):

g. Annet SSA verktøy (vennligst spesifiser):

I det samme spørsmålet var det også et ikke aktuelt, ikke hatt kartlegging/utredningssaker alternativ.

15- 20. Ikke relevant for masteroppgaven.

21. Her var det en åpen svarkategori om kommentarer til AIM3-kurset.

22. Her var det en åpen svarkategori om kommentarer til AIM3- verktøyet.

23. Her var det en åpen svarkategori om kommentarer til kasusbeskrivelsene eller spørreskjemaet i undersøkelsen.

Attachment 3; AIM3 score sheets

Appendix 3: AIM3 Scoring and Analysis Sheet

Domain One - Sexual Behaviour

Factor	Factor Score
1. Nature of the Harmful Sexual Behaviour	4
	2
Rationale:	0
2. Extent of Harmful Sexual Behaviour	4
	2
Rationale:	0
3. Victim Characteristics	4
	2
Rationale:	0
4. Sexual Aggression and Violence	4
	2
Rationale:	0
5. Sexual Knowledge, Attitudes and Interests	4
	2
Rationale:	0
Outline what is your overall analysis of the concerns and strengths within this Domain	
Outline what are the interventions you are recommending which would address the identified concerns and enhance the strengths within this Domain	
Domain Score	/20

Domain Two - Non-Sexual Behaviour

Factor	Factor Score
1. Non-Sexual Criminality	4
	2
Rationale:	0
2. Non – Sexual Aggression and Anti-Social Behaviour	4
	2
Rationale:	0
3. Alcohol and Drugs	4
	2
Rationale:	0
4. General Behaviour	4
	2
Rationale:	0
5. Mental Health and Well-being	4
	2
Rationale:	0
Outline what is your overall analysis of the concerns and strengths within this Domain	
Outline what are the interventions you are recommending which would address the identified concerns and enhance the strengths within this Domain	
Domain Score	/20

Domain Three - Developmental

Factor	Factor Score
1. Trauma and Victimization	4
Rationale:	2
	0
2. Childhood and Adolescent Adversity	4
Rationale:	2
	0
3. Attachment	4
Rationale:	2
	0
4. Family Functioning	4
Rationale:	2
	0
5. Health, Intellectual and Emotional Functioning	4
Rationale:	2
	0
Outline what is your overall analysis of the concerns and strengths within this Domain	
Outline what are the interventions you are recommending which would address the identified concerns and enhance the strengths within this Domain	
Domain Score	/20

Domain Four - Environmental / Family

Factor	Factor Score
1. Stability and Safety	4
Rationale:	2
	0
2. Parental / Carer Supervision	4
Rationale:	2
	0
3. Relationships	4
Rationale:	2
	0
4. Peer Group	4
Rationale:	2
	0
5. Education, Employment and Leisure	4
Rationale:	2
	0
Outline what is your overall analysis of the concerns and strengths within this Domain	
Outline what are the interventions you are recommending which would address the identified concerns and enhance the strengths within this Domain	
Domain Score	/20

Domain Five - Self-Regulation

Factor	Factor Score
1. Responsibility	4
	2
Rationale:	0
2. Motivation and Engagement	4
	2
Rationale:	0
3. Future Perspective	4
	2
Rationale:	0
4. Problem Solving	4
	2
Rationale:	0
5. Social Competence	4
	2
Rationale:	0
Outline what is your overall analysis of the concerns and strengths within this Domain	
Outline what are the interventions you are recommending which would address the identified concerns and enhance the strengths within this Domain	
Domain Score	/20