Clinicians' Lived Experience of Using the AIM3 Assessment Model to Assess Harmful Sexual Behaviour in Adolescents

Tom Hume

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Supervisor: Dr. Liesje Donkin

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Glossary

AIM	-	Assessment, Intervention, Moving-on
CYP	-	Children and Young People
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Attestation of Authorship

I hereby declare that this submission is my own work and that, to the best of my knowledge and belief, it contains no material previously published or written by another person (except where explicitly defined in the acknowledgements), nor material which to a substantial extent has been submitted for the award of any other degree or diploma of a university or other institution of higher learning.

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Abstract

Harmful sexual behaviour (HSB) is a universal issue transcending class, race and economic status. The harm that HSB causes to individuals, families, and society cannot be overstated. However, the shame and secrecy around it make it a universal taboo, creating difficulties in discovering the true extent. As something which causes so much harm, it is vital that we have the tools to be able to intervene and to treat this behaviour to be able to create societies that are free from sexual abuse. The AIM3 is the tool that is used by specialist clinicians to assess the HSB exhibited by CYP, and to help establish goals for their clinical intervention. It does this by scoring the young person (YP) across five domains: sexual behaviour; general behaviour; developmental; environmental; self-regulation. This study explored the lived experience of clinicians who specialise in treating HSB, and their use of the AIM3 model of assessment in this work.

Six clinicians agreed to participate in this study, exploring their experiences of using the AIM3 in their work. Semi-structured interviews were used to look at their perspectives on this assessment model. Thematic analysis was used to analyse the data that was collected from the interviews. Six key themes were identified which were then discussed in relation to current research on HSB and its occurrence in a New Zealand context. It was discovered that the clinicians had a very favourable view of the AIM3, although there were some areas of concern. Clinicians noted that cultural issues were sometimes invisible, and there was sometimes a risk of bias or subjectivity in scoring. Most of the clinicians felt as though those potential issues could be mitigated through their own experience, or through co-working.

Chapter 1 - Introduction

Aim

The purpose of this research is to explore and understand the lived experiences of clinicians' use of the AIM3 model of assessment, in their work with Children and Young People (CYP) that present with Harmful Sexual Behaviour (HSB). The reason for this was to deepen the understanding of the ways in which this assessment tool helps them in their work, and to discover both the strengths and weaknesses that they may have discovered in their use of it.

Rationale

HSB causes a large amount of harm to many people in society, and can lead to long-term consequences for the mental health and well-being of both perpetrators and victims. While it may be understood that adults can carry out much of the HSB that occurs, what is less well known is that CYP also carry out a significant proportion of all cases of HSB. Clinicians work in this field, in order to help those who present with HSB to recover from their past behaviour, and go on to live safe lives, free from sexual offending. This study looks at the main tool used in a New Zealand context to assess and treat HSB in CYP, known as the AIM3. The AIM3 is the third iteration of the Assessment – Intervention – Moving on (AIM) project.

This research has grown out of my own personal interest and experience as a clinician who uses the AIM3 to assess and treat CYP with HSB. In my work as a clinician I find the AIM3 to be a useful tool, which is very effective at helping to gain a holistic understanding of my clients lives, as well as setting intervention targets for their treatment. I was also aware that the AIM3 had not been used in the field for a particularly long period of time, as it was developed rather recently in 2019, and as a result of this there was a dearth of literature on how it was being used in the field. In

addition to this I had a professional curiosity, in wanting to discover how my colleagues, and other experts in the field found this assessment tool for their work. To discover these professionals experiences I carried out semi-structured interviews, and used a thematic analysis from a critical realist perspective in order to interpret and understand their responses.

It is my hope that this research will extend the understanding of the ways in which the AIM3 is used in the field by professionals, as well as provide some insight into its use in a New Zealand context. Furthermore, I hope to discover the experiences of the clinicians in using it with young people, and their feedback on both the strengths and weaknesses of the AIM3 in their work.

This dissertation is intended to contribute to the established literature around harmful sexual behaviour in adolescents, by exploring the experiences of professionals' use of the leading assessment tool in a New Zealand context.

Chapter 2 - Literature Review

This chapter critically analyses and reviews literature related to this study. Firstly this review will look at the children and young people (CYP) who carry out harmful sexual behaviour (HSB). It explores the prevalence of HSB committed by young people, as well as exploring the nature of their violence and perspective on the impact of that HSB. There is then an exploration of the clusters of risk which are often present for young people with HSB and may in some instances be able to help to identify and intervene before anybody is harmed. The effectiveness of therapeutic interventions and a look at the life course outcomes for youth with HSB are then explored, looking at long-term follow-up studies that show what constitutes "success" of treatment, beyond a simple lack of recidivism. This review then looks at some of the relationships that are impacted by young people with HSB, such as with their parents, along with how the family can be supportive as they go through the therapeutic process. Next, the review will look at how the unique context of New Zealand manages treatment, including some of the Māori health models, and the challenges in implementing treatment plans developed overseas. There will then be a look at some of the different treatment models for sexual offenders which have been used over the years such as the risk-need models, and the Good Lives model. Finally, we will look at the AIM project, particularly its latest iteration – The AIM3 – as this is the treatment model used by the three leading New Zealand organisations that treat HSB in CYP, Safe Network, Wellstop, and Stop.

The Young People who carry out HSB

There are few behaviours that an individual can engage in which can cause more distress than HSB. The consequences of HSB are widespread, impacting negatively on victims, victims' families, wider society, perpetrators, perpetrators' families, and even care professionals themselves (Pelech et al., 2021). While many people may understand that adults carry out much of the known HSB, what is less well

known is that a large amount of HSB is carried out by CYP (Veneziano & Veneziano, 2002). Some estimates being that between 30 TO 50% of HSB experienced by CYP is carried out by other peer-aged children (McKibbin et al., 2022). Due to the significant amount of harm that can result from HSB, clinicians must develop adequate tools to assess and treat HSB perpetrated by CYP and not just those in adult populations.

It is also important to note that just because CYP perpetrators of HSB can be young does not diminish the seriousness of the harm they can inflict on others. CYP can engage in HSB, which sometimes can be very violent and sadistic (Hackett et al. 2006). Some studies have looked at cases of HSB by young people to gain a understanding of the nature of their behaviours. It has been found that in some instances, CYP may appear to be less sophisticated in their manner of gaining compliance, yet can still engage in troubling manipulative behaviours such as bribing, blackmailing and grooming. While some of the CYP with HSB may use violence in order to gain compliance, the majority used threats and other coercive behaviours (Vizard, Hickey, French, et al 2007).

Much of the data collected around the HSB of CYP gets captured as qualitative, or statistical data, which can have the unintended effect of potentially sanitising the seriousness of the behaviour (Leclerc & Felson, 2016). One study by Balfe et al. (2021) attempted to gain a deeper understanding of the nature of the violence carried out by CYP with HSB. Researchers contacted nine different organisations which deal with HSB in the United Kingdom, including those which offer treatment in both community-based, and specialist residencies. The researchers gained permission to access the case files of ex-clients and took a representative sample of the files accessed. In total, the researchers looked at 117 cases of HSB in which violence was present. Of the 117 files, only six were related to females with HSB, so their results were excluded, focusing instead on the 111 files of males with HSB. The Balfe et al. (2021) study shows in confronting detail, just why the HSB of CYP can be so serious, finding seven

key themes related to their offending: offences against children vs against adults; where the offences occur; tactics and planning; callousness; motivations for the assaults, and reactions afterwards; view of self and offence; and non-sexual violence. This shows the high level of harm that can be inflicted on victims, their loved ones, and the wider community by CYP, and helps to explain why it is so important that professionals work with stakeholders to try and reduce instances of HSB in the community.

These studies show that the serious nature of the HSB that CYP can commit have already been looked at, giving great insight into their behaviour in rich detail. The personal nature of these past pieces of research helps to avoid the unintentionally sanitising tendencies of qualitative research by examining personal accounts and impact.

Clusters of Risk

As part of the work towards reducing incidents of HSB, a study was carried out by McKibbin et al. (2022) looking at clusters of risk factors of HSB by CYP. The purpose was to try and identify opportunities for early intervention amongst young people who may be at risk of developing HSB. The researchers used semi-structured interviews with 13 professionals, all with significant expertise in this field to explore risk factors. The data found five different risk factor clusters all associated with the onset of HSB amongst CYP. These were: being sexually curious; having a sexual interest in children; living with childhood trauma; living with contextual violence; and using pornography. Identifying various clusters of risk for early onset HSB is invaluable, as it has been shown that early interventions for young people with HSB significantly reduces harmful behaviours as well as improving general behaviour and emotional functioning (Silovsky et al. 2019). Many of the clusters of risk were found to co-occur with each other, and it wasn't uncommon for CYP to have several of the risk factors identified. Amongst the risk factors, use of pornography was common, although it was

difficult to establish a causal connection due to many CYP using pornography, without going on to exhibit HSB (McKibbin et al. 2022). Living with trauma was another common risk factor for HSB, as was often associated with unsafe in living environments and poor supervision by parents.

Clusters of risk factors can be of aid to professionals seeking to decrease instances of HSB. Having an awareness of these particular risk factors may help professionals in their interventions for clients who have already offended but may also provide opportunities for earlier intervention by institutions such as schools, or community sexual health institutions. Ey and McInnes (2018) have shown that due to their close contact with CYP, teachers are often uniquely well-placed to identify potential HSB amongst their students before it occurs and intervene accordingly.

Identifying professionals to speak to in this instance has provided a wealth of knowledge in rich detail, allowing researchers to identify risk factors for future HSB and potentially intervene before any harm occurs. The lived experience of those whose expertise lies in this field serve as a useful source of knowledge for researchers seeking greater insight into these patterns of behaviour.

Life Course Outcomes

Follow up studies have shown that when young people engage in HSB, interventions can be very successful in stopping future HSB. Some estimates in follow up studies looking at recidivism have demonstrated that after successfully completing an intervention, the likelihood of re-engaging in HSB can be as low as 6% (Hackett et al., 2022). However successful life course outcomes can not only be measured in times of low recidivism for HSB and should also take a “whole-person” approach, that aims to help an individual to develop further successes in their life as well. Many young people (YP) who offend sexually, do not go on to engage in further HSB, so stopping YP from engaging in HSB again, which was already unlikely to occur, cannot be considered a great success. What can be of value to measure then, is whether engaging in HSB as

a young person is predictive of further developmental difficulties or other problematic life outcomes. A study by Hackett et al., (2022) sought to answer those questions by looking at long term outcomes for a sample of 69 adults who had engaged in HSB as children and adolescents. This was determined to be an important area of study, as it helps with understanding better the results of interventions designed with aiding both desistance and resilience. Researchers analysed 700 historical case files for things such as: the nature of the HSB; prior general criminal convictions; experiences of personal abuse; and histories of sexual victimisation. In the next stage of the researchers traced down a sample of the ex-service users to be interviewed, of which 69 took part (64 male, 5 female). The average age of the sample population was 14 at the time of the HSB, and were followed up on average, 13 years after their interventions. To establish successful life out comes, researchers used Farrington et al.'s (2009) life course outcomes, with a few additional factors. Most of the participants who agreed to be followed up had not re-offended, with only 6% of them having re-offended sexually. Other participants had gone on to offend, although not sexually, approximately 9% of the sample. The study's focus on successful life outcomes showed that there were diverse results, and in some instances negative developmental outcomes which were unrelated to any kind of offending, such as ongoing effects of shame or prejudice against them. Those who reported successful life outcomes had gone on to lead relatively normal and happy lives, leaving behind the past harmful behaviours and no longer considering themselves to be a risk to others. Those who reported negative outcomes spoke about challenging life circumstances, which were often unstable with a large amount of distress and discontent. Many of them spoke about their past HSB as something that they had never moved on from and had continually negatively impacted upon them throughout the course of their lives.

Few variables that influenced whether outcomes were likely to be successful or unsuccessful were related to the nature of the HSB itself that had been engaged in by the young people, instead being often related to wider aspects of their lives, such as

having a trauma background or poor attachment. Understanding the individual factors that led to successful or unsuccessful outcomes is of great value, as it can aid clinicians to target those predictors in therapy and help YP to go on to live good lives. Often YP that had reported unsuccessful outcomes had co-occurrence of other traumatic experiences, general anti-social behaviour and other non-sexual offending. They reported having lives that were unstable or chaotic, poor relationships, drug & alcohol issues, and challenges with their mental health. They often struggled to understand and contextualise the labelling of their person as a "sex offender" and found it difficult to build a coherent narrative for their lives to help explain their past HSB.

Some of the YP that reported successful outcomes were those who had had their own experiences of sexual victimisation at a younger age. It may be that those individuals were then better able to move on as they could contextualise their behaviour further, by framing their own HSB as a result of their earlier experiences (Hackett et al. 2022). These individuals regretted their past HSB and were able to acknowledge and take ownership of that part of their past, and to commit to not harming others again in the future. They often had an optimistic outlook, and projects that they wanted to achieve that gave purpose and motivation.

Both of groups that reported successful and unsuccessful outcomes also reported experiences of ongoing stigma. Professionals and police would on occasion make reference to it, even when it was sometimes many years in the past (Hackett et al., 2022). This made it hard for YPs to move on, and often left them with a lingering concern that their past actions may still expose them to social consequences in the present day.

The Hackett et al. (2022) research shows the importance for the clinicians to work on helping their clients build a strong coherent narrative for the young person, that helps them contextualise their past behaviours, acknowledge, take responsibility for it,

and move on. It emphasises the need to focus on building up multiple areas of an individual's social and emotional skills, while helping them to create a meaningful life path. By interviewing YP on their experiences, and their subsequent life outcomes, this qualitative research is able to gather first-hand accounts of what they found to be helpful about their interventions.

Parents of CYP with HSB

Understanding the experiences and unique perspectives of people who have been impacted by HSB is vital to deepening the knowledge to meaningfully work in that field. YP who have been themselves, either perpetrators or victims of this HSB are often interviewed. As are those who have completed therapeutic processes in residences designed to help treat individuals with HSB (Gorden et al., 2021).

Parents of young people who have engaged in HSB are also people whose input can be invaluable for evaluating the effectiveness of the various models and methodologies designed for interventions to target this subset of behaviours. The perspectives and input from parents can be of vital importance for numerous reasons. For one they are the key stakeholders in their young person's life and have the most intimate knowledge of their child's unique characteristics and personality. For another they are often co-habiting with their child and are therefore going to be in a vital position for being able to supervise them, ensure they are sticking to safety plans, and staying on the right track. Due to these reasons, parents can be considered to be key agents for change for the CYP as they engage in the therapeutic process (Carpentier, Silovsky, &Chaffin, 2006).

That parents can have such a large and important role to play in the treatment of CYP with HSB is not surprising, given the influence they have over their children's lives. As a result of this professionals will often work closely with the parents to try and improve the therapeutic outcomes. Working closely with the parent has been shown to have a great effect, and is strongly supported by research (Carpentier, Silovsky, &

Chaffin, 2006) with numerous approaches being suggested, such as the *Think Family* approach (Diggins, 2009) and even more modern treatment models, such as the AIM3 (Leonard & Hackett, 2019). With so much support for family-focused interventions, and the importance placed on them, it is not surprising they are often encouraged as one of the most effective ways in intervening with CYP with HSB. It may be concerning therefore that a national review of HSB service providers in the UK found that very few practitioners were doing much family work, choosing instead to focus on individualised therapy with the young person directly (Smith, Bradbury-Jones, Lazenbatt, & Taylor, 2013).

Family influences can be a great regulating aspect for youth with HSB. The contexts of those family structures may both influence the young person's behaviour and be influenced in turn by the consequences of the young person's HSB. Some literature suggests that there may be higher rates of abuse victimisation in these family structures, in addition to higher levels of conflict, arguing and general instability (Gray, Pithers, Busconi & Houchens, 1999). Given the importance of the family relationship in assisting with the therapeutic process, alongside the possibility that family history may give rise to the circumstances that lead to a young person to engage in HSB, it has been theorised that attachment theory plays a large part in both the cause and treatment of HSB (Burton, 2000).

Parents may themselves be deeply impacted as a result of their child's HSB. It can be very challenging to know how to support a child after they have engaged in what may be very shocking behaviour. This can then become a barrier to continuing to build or maintain healthy attachment again afterwards. A study by Archer et Al (2019) explored the parents' perspectives on the parent-child relationship after their child's engagement in HSB. Six parents whose children had engaged in HSB participated in semi-structured-interviews about their lived experience. An Interpretive phenomenological analysis was used to interpret the data, from which arose five key

themes: feelings evoked; searching for meaning; child's identity as fragmented; wanting distance; and moving forwards. The Archer et al (2019) study illustrates clearly the complexities that arise in the parent-child relationship following HSB. Showing how the parent will be emotionally impacted yet can still process those complex emotions and build or maintain healthy attachment with their child to facilitate the therapeutic process.

These above studies are invaluable, as they show the importance of family influences in treatment. These studies show that already a significant amount of research has been carried out that explores the experiences of parents with CYP who have presented with HSB. Gaining insight into the parent-child relationship has provided ways in which therapeutic interventions can both assist and be assisted by the family unit.

NZ Context

Many models designed to assess HSB in CYP are developed in other countries and as such are not always entirely applicable to a New Zealand context. Most of the models used have been developed in the United States or the United Kingdom. The AIM3 is no exception to this, as it has been developed in a UK context. There is something to be said for a one-size-fits-all approach, as it can be used on many different people without needing to change too much. However New Zealand does have a unique cultural context. Some models have been developed for working clinically in New Zealand, such as Te Whare Tapa Wha, (Durie., 1994) and Te Pae Mahutonga (Durie., 1999). Many clients in NZ are likely to carry further difficulties which have impacted them generationally, such as the impact of colonisation. Since a large amount of the therapeutic relationship is within connection between the client, and the clinician, and understanding of the unique cultural perspectives and the use of culturally supportive models may assist this process.

Māori models in New Zealand are distinct from many western models in that they are more holistic in their scope, looking at much wider aspects of a client's experience (Durie., 1999). A more recent Māori health model, The Meihana Model (Pitama et al., 2007) extended upon Te Whare Tapa Wha, to include Taio, the physical environment, and Iwi-Katoa, the societal structures. While not explicitly acknowledging Māori or other cultural perspectives, the AIM3 is similar in some ways to these Māori models, as it too does look holistically at the clients, and includes domains such as developmental, environmental and self-regulation. Whether or not these additional domains are enough to cater to the needs of clients of different cultural backgrounds will be of interest to this study.

Assessment tools for HSB

While there exists numerous assessment and treatment tools designed to help adults who have presented with HSB, research has shown that CYP are better served by models which have been developed with their particular needs in mind, rather than adapting models designed to serve an adult population (Griffin et al., 2008). To this end, numerous models have been developed in order to help specialist clinicians working with CYP who present with HSB. After assessment models have been created, they undergo evaluations in order to determine their effectiveness. In response to these evaluations, they are often updated to ensure that they keep abreast with the latest research, as well as to address any potential shortcomings of the models.

Treatment guides come in a variety of different forms, they are distinct from assessment models as they dont assess, focusing rather on delivering a curriculum. One such is guide is the clinical manual *Change for good*. This was a workbook with a CD-ROM that served as a curriculum to take a young person with HSB through a treatment process. *Change for Good* provides not only a workbook and exercises, but also theoretical knowledge, and information to help clinicians working in this field. Like many of the current intervention guides for HSB, *Change for Good* also focuses on a

whole person approach, aiming to help the young person to develop holistically in all areas of their lives. Some criticisms of this manual do exist however, as it caters more to clinicians of an intermediate experience, more experienced clinicians will likely have already developed their own modules to help treat HSB. In addition, it can be criticised for being overly proscriptive, as while it is designed to be individualised, clinicians can on occasion end up taking too much of a cookie cutter approach, and thus take clients only through the workbook, at the expense of other therapeutic modalities, such as family, art and group therapies (McCrory & Kingsley. 2011).

Another model that can be used to aid professionals in their understanding of CYP sexual behaviours is the Brook Traffic Light Tool (2013). This is a handy guide that groups various behaviours based upon CYP developmental norms. As the name suggests it uses traffic light colours to group sexual behaviours into green, amber and red categories, associated with non-concerning, concerning, or highly concerning behaviours for the CYP's developmental age. This can help adults working with those children to know how to respond when such behaviours are exhibited. The Brook Traffic Light Tool was reviewed by King-Hill (2021) to determine the views of professionals who have used it. King-Hill used a mixed methods approach, comprising of questionnaires and interviews. Overall, she found that confidence amongst professionals was raised in their abilities to appropriately place CYP sexual behaviours in the various categories, and multi-agency responses were improved when using the manual. Some of the professionals who used the tool discovered that they had some difficulties in placing sexual behaviours of CYP into appropriate categories when the behaviour wasn't explicitly listed, showing that greater contextual training is necessary in order to be able to accurately assess said behaviours. It was found to be of use for professionals such as teachers, who may not necessarily be trained in the specifics of HSB, although they still found it useful to contextualise the behaviours they came across in their profession. In general, the Brook Traffic Light Tool serves as a handy reference guide for those who work with CYP.

Risk-Needs model and Good Lives model

In the early 1990's the dominant model for offender rehabilitation was the Risk-Needs-Responsivity (RNR) model (Andrews, Bonta & Hoge, 1990). This was a risk-based model, which sought to identify the kinds of risks an offender posed, and attempt to mitigate or reduce that risk through targeted interventions. These interventions were based upon the perceived 'need' that the offender was trying to meet by their criminal behaviour. This approach, while showing validity and success, was criticised for being too reactive in it its formulations, as it attempted to stop recidivism by avoiding harm to the community, rather than by helping offenders to improve their quality of life (Ward & Stewart, 2003). This meant that the only real reason for improving the lives of offenders was so that they wouldn't go on to harm others, rather than attempting to authentically help them to lead better lives. Unfortunately, this approach leads to problems with regards to the responsivity of the clients, who may not find this to be a particularly motivating reason for them to engage with treatment.

In response to some of these criticisms of the risk-based approach, Ward & Stewart (2003) developed the Good Lives Model, which aimed to take a more authentically therapeutic approach to helping those with past offences by attempting to meet their human needs and levels of well-being. The idea was that those who had offended in the past were likely attempting to meet some of their needs in maladaptive or criminal ways, and by giving these people the skills to be able to meet their needs in good and prosocial ways their desire to commit criminal or harmful behaviours would reduce. The Good Lives Model was therefore designed to try and authentically help individuals to live better kinds of lives, and to meet their needs in safe and socially-acceptable ways. It was found that by using "approach goals" found in the Good Lives Model, in substitution for the "avoidance goals" of the Risk-Needs approach, therapeutic alliances were stronger, there was greater clinical effectiveness, and there was a much greater buy-in to the process by the client.

The AIM Project

The AIM project was created in response to the recognition that CYP needed an assessment tool which served their own unique characteristics, rather than just re-purposing adult models (Rasmussen, 2004). In 2001, the AIM project responded to this need by releasing the AIM (Assessment, Intervention and Moving on) assessment model (Print et Al, 2001). Literature was beginning to recognise that while there may be some overlap between the HSB of adults and CYP, in general CYP had a greater fluidity of development, less sophisticated grooming patterns, and patterns of sexual interests which were less entrenched than their adult counterparts (Calder, 2001). Concerns around the language relating to sexual offences were also of concern, as referring to CYP as 'sexual offenders' rather than CYP with HSB may have turned out to be developmentally harmful, leading to CYP over-identifying with the label. The original AIM model was developed to assess both the strengths, and risks of the young person, giving them a score based upon the levels of concern that the clinician determined. It was designed to be completed within the timescales set by criminal justice and child protection systems, as well as to help the professionals identify the young person's risks and strengths, and to be able to assist multidisciplinary teams in co-working relationships (Griffin et Al, 2008).

The original AIM underwent small scale evaluation by Griffin & Beech (2004) who recommended several changes such as including 'medium' rated concerns, to avoid things being scored either too highly or too lowly; removing ambiguity; distinguishing more clearly the overlap between strengths and concerns; and adding an explicit theoretical model to underpin the framework, among other recommendations. (Griffin et Al, 2008). In response to the proposed feedback, the AIM2 was produced and released in 2007, incorporating much of the feedback provided by Griffin & Beech (2004). In addition, the Beech & Ward (2004) risk-aetiology model was also adopted as the theoretical underpinning, to help clinicians adequately determine the risk factors of the HSB from CYP. In the development of the AIM2 assessment model, it was noticed

that one of the most significant factors for HSB recidivism was having parents, or most significant caregivers in their life, who had not addressed their own trauma, or past problematic behaviour (Griffin et al. 2008).

The most recent iteration of the AIM model, the AIM3, was released in 2019 (Leonard & Hackett, 2019). It rapidly became the dominant assessment model, and was widely adopted in the United Kingdom, Australia and New Zealand. It has also been translated into foreign languages and used in countries such as Norway (Jensen et al., 2022). Due to its relatively recent development and distribution, relatively few studies have been done upon it. Which forms part of the rationale for this dissertation, as there are gaps in the literature which this study aims to fill.

Gaps in the Literature

The AIM3 is the new standard assessment model for the treatment of HSB throughout New Zealand. As it was released in 2019, we now have a few years of it having been used in the field. This gives enough time for clinicians to have become familiar with the model. As of writing, the AIM3 has not yet been researched very widely, and there is very limited data on the experiences of the clinicians who have worked with it. This research aims to fill that gap in the literature by discovering the lived experiences of those who work with the model in a New Zealand context. Of particular interest to this study are the perspectives of clinicians, who are tasked with working with these YP. The interest in the clinicians views can be twofold 1) they are the individuals with the most hands-on knowledge of the subject matter at hand, in this case HSB, and 2) they are the individuals tasked with using the particular assessment tool in their work.

Summary

The purpose of this review was to discover gaps in the literature which would give a theoretical basis for undertaking this study. It has been shown that the causes of HSB can be numerous, and that the seriousness of the harm resulting from this behaviour necessitates interventions so that those young people may go on to lead safe lives. As a result of what has been found here, including the numerous different ways in which HSB can arise, the impact of said behaviour, and various ways of assessing and treating it, the research question has been formed. Recognizing that there was a gap in the literature around the lived experiences of these clinicians and their use of the AIM3, gave the impetus for this study. There are few ways of gaining insight into the suitability of a tool developed for this purpose than to interview those who are both experienced in the field, and who are also familiar with the assessment model itself. Therefore this study will explore the lived experiences of clinician's use of the AIM3 to both assess and treat HSB in young people.

Chapter 3 - METHOD

The purpose of this study was to explore the lived experiences of clinicians' use of the AIM3 clinical tool that is used to assess and guide interventions for young people with HSB. This chapter gives the reasoning for the chosen approach to the research question. It explains the process of designing the research, choosing the method of analysis, ethical considerations, reflexivity, finding participants and collection and analysis of the data.

Methodology

A qualitative approach was used for this study. Qualitative research is utilised for its ability to interpret and understand the data that is collected, searching for meaning in the intersection of understanding between the participants and the researcher. This allows for emergent aspects in the data to arise during the analysis, rather than being limited to the initial outlook which was identified during the initial research design (Creswell, 2003). This emergent aspect allows for flexibility throughout the whole research process, because as data is collected it can further influence and refine the questions asked as new pieces of information comes to light. This occurs as the researcher becomes more practiced in understanding what is important for the study, and from items which are deemed important by the participants themselves. Self-reflection is also another key-feature of qualitative research. The researcher must recognize that they are deeply involved in the process and acknowledge the way in which their own personal values and opinions may also affect the interpretation of the data gathered, whilst also being aware of how that may influence the research outcomes (Creswell, 2003).

Reflexivity

The concept of reflexivity refers to the ability of the researcher to critically reflect on their own subjectivity, and the way in which that may affect the research outcomes. In more positivist points of view, the thoughts, feelings and opinions of the researcher are often omitted, and accurately or not, there is an impression that within those quantitative methods, a researcher is able to stay 'objective'. Within qualitative methods however, it is more apparent that the researcher plays a more dynamic and engaged role, both in the collection of the data, and in the final analysis. Reflexivity here then, invites the researcher to engage in an active process of reflection and self-examination throughout the entirety of the research process, to account for the researcher's own biases and ways in which one's own views influence the research outcomes. In addition, engaging in reflective practices enables the researcher to gain more knowledge and skills along the way, growing in their capacity as a researcher (Renganathan, 2009).

Wilkinson & Kitzinger, (2013) elaborate further on this idea, in a way which is particularly pertinent to this research. Namely with their exploration of 'Insider' research, by which they mean when a researcher is looking at a group of people to which they too belong. In this way then, the lines can become somewhat blurred between researcher and participant, requiring ongoing reflexivity to understand the ways in which this similarity impacts the entire research process.

Part of the rationale for the researcher choosing to engage in this research project was to do with my own involvement in this type of work. I am a clinician who works with YP who present with HSB. In the course of my work, I also use the AIM3 to assess my clients, and design interventions for them. As I knew that the AIM3 had not had many articles written about it since its release, I was curious to discover what other

professionals who used it in their practice thought about it. Reflecting on my own values, opinions, and perceptions, coupled with my relationships to both the subject matter and the participants themselves therefore was vital to understanding the ways in which I impacted and influenced the research. I shared professional characteristics with the participants in this study as a way of building rapport and credibility, and have insider knowledge of the work and of them personally. I work in the same field, and in the same organisation, and was in this instance interviewing colleagues of mine that I knew well in a professional setting. My own professional experience helped to inform the design of the research, facilitate the connection to the participants, as well as to interpret the data and the final analysis. All of these factors contributed to a strong need to understand and reflect upon my own position as an insider in this research (Wilkinson & Kitzinger, 2013).

All of this combined in ways that I had to consider carefully. In interviewing participants, I needed to ensure that they were taking part of their own volition, and not just because of my own positioning as their colleague. I did this by ensuring that I did not broach the topic with any of my colleagues, ensuring that the only way they became aware of the study was through the participant request email that was sent by the manager. I then waited for any interested parties to make first contact with me of their own accord. This meant that I never personally invited anyone to participate. Interviewing the participants was also impacted by our professional relationship, as because we already knew one another, they seemed to have been more comfortable talking to me than they may have been with an interviewer who was a stranger to them. To inspire frank, open and honest conversations, I requested that they respond honestly, and gave assurance that no identifying information would be present in the final report. I had to make sure that I did not let my own views on the AIM3 influence the what the participants were telling me as well, so made conscious efforts to be non-

reactive in my lines of questioning. In general, I believe the AIM3 to be a very good tool for assessing HSB in young people and find it to have many strengths. I wanted to mitigate my generally favourable views on the tool to be able to really focus on collecting the views of the participants. Later, when analysing the data that was collected, I had to try and separate the personal knowledge I had of the participants and avoid trying to interpret their words based on my knowledge of them personally. To do this I tried not to think of the participants during the analysis, focusing only on the specific meanings of the words and language used. This helped me to create a sense of separation between my knowledge of the participants and myself, allowing the data collected to stand on its own merits, rather than the meaning which I could have attributed to it.

Ethical considerations

For this study to be carried it, it was necessary to have ethical oversight to ensure that this research would not disadvantage the participants in any way. The important considerations for ethics were the right to confidentiality and fully informed consent. I also needed to be aware of my dual relationships, as both colleague and researcher towards my participants. Ethical approval was sought from the Auckland University of Technology Ethics Committee and was granted on 22/06/2022 (AUTEC reference number 22/126). This approval was valid for three years, until the 21st of June 2025.

Organisational consent was granted by emailing the Stop chief executive officer for a discussion about the research that I wished to carry out, in which they were given the organisational information sheet (Appendix D) and the chance to ask any questions. Informed consent for the participants was gained by sending them the information sheet (Appendix E) after they had expressed interest in participating. This was originally sent by email, and in case they had not read it before the interview, a

paper copy was also provided at the interview. Participants were encouraged to ask any questions that they may have had, and were then provided with a consent form for them to sign (Appendix G). Participants were informed that the interview would be audio-recorded, and later transcribed for analysis. The data would then be stored securely for a period of six years, before being destroyed.

Participants were assured of full privacy and confidentiality to help them feel comfortable in speaking openly. As they were being interviewed in a small workplace, it was decided to not collect any statistical data which could have been used to identify them, and participants were instead assigned numerical identities. Participants were discouraged from talking to others about their choice to participate in the study, to help them maintain their confidentiality. Due to an organisational norm of regular private meetings for various reasons, it was relatively simple to organise meeting times for semi-structured interviews without other colleagues knowing that that was their purpose.

Recruitment

To find clinicians who used the AIM3 in their work, it was necessary to contact the organisations who used it in their work. Four organisations in New Zealand were found which treated HSB in youth with the AIM3 model of assessment. These were Stop (Christchurch), Safe Network (Auckland), WellStop (Wellington), and Barnardos (Auckland). For research of this kind, 5-8 participants were estimated to have been enough to reach theoretical saturation. As the primary researcher was based in Christchurch and invitations were planned to take place face-to-face, an invitation to participate (Appendix C) was first sent to the Stop chief executive officer (CEO). If enough participants were not able to be recruited from Stop, then the invitation to participate would have been sent to the other organisations. As enough participants were found from Stop to achieve theoretical saturation, this step was unnecessary. An

affirmative response was received from Stop, with the consent form signed by the chief executive officer on 2/8/2022.

Once organisational consent was obtained, the Stop clinical manager emailed the clinicians who fit the selection criteria an invitation to participate. The selection criteria for the participants were they must be currently working professionals who use the AIM3 in their assessment of young people with HSB. The exclusion criteria was that they must not be supervised by the primary researcher. Those who wished to participate were then able to email the primary researcher directly to organise a time to be interviewed. In doing things in this sequence, it meant that neither the CEO nor the clinical manager would know who had chosen to participate in the research process. Upon receipt of an expression of an interest, participants were emailed an information sheet, and a consent form. Seven clinicians responded, although one was unable to be interviewed. Six participants took part in the semi-structured interviews.

Participants

The participants that were recruited for this study were six clinicians from Stop, a counselling service based in Christchurch, New Zealand. Ten clinicians were invited in total, with one responding, but being unable to find time, and three others that did not respond. They were all from a charity organisation that specialises in working with HSB. The participants were a diverse group of members, both male and female, senior clinicians and new clinicians, with a range of different ages and ethnicities. In order to protect the participants privacy, it was decided to collect only a very limited amount of demographic data that could be used to identify them, given that Stop is a small organisation. These protections were deemed necessary in order to reassure the participants that they could speak openly without fear of recriminations should they have been critical of any aspects of their work.

Table 1. Demographics of participants

Name	Gender	Ethnicity	Role
Participant one	Male	Māori	Clinician
Participant two	Female	Unknown	Senior Clinician
Participant three	Female	Māori	Clinician
Participant four	Female	NZ European	Clinician
Participant five	Male	NZ European	Senior Clinician
Participant six	Female	European	Senior Clinician

Data collection

Data was collected through semi-structured interviews at the Stop counselling service's offices in Christchurch, New Zealand. All but one of the participants were interviewed at the Stop offices themselves, with one interview being conducted through a Microsoft Teams video call. Interviews took place between the 16th of August, and the 22nd of September. Before commencing the interviews, participants were welcomed by the researcher, and given the chance to say karakia to open the space. Participants were given the opportunity to read the participant information sheet again, in case they had not done so when they received the email confirming the interview time. Each participant was given the chance to ask any questions and it was made clear that they could terminate the interview at any time without penalty. All participants who were interviewed in person then signed the consent form. The participant who was interviewed through a video call was taken through the oral consent protocol (Appendix H) and gave recorded verbal consent. The interviews were recorded through an audio-recording device. Interview lengths ranged from 20 to 30 minutes. As the interviews were semi-structured, there were some interview questions which guided the interview process, although the interviews were able to flow into other areas, allowing for emergent aspects to be discussed as they naturally arose. The interview questions which were used as a general guide were as follows:

1. What is the AIM3 and how is it used in your practice of working with Adolescents with Harmful Sexual Behaviour?
2. What do you see are the main strengths and weaknesses of the AIM3?

3. How well do you find that the AIM3 is able to fairly assess the severity of the HSB, and provide enough guidance for how to help in the intervention stage?
4. What (if any) are the workarounds, or ways you use the AIM3 which may be different to the authors intentions; Or other things you do to make up for its perceived deficiencies?
5. If you were teaching another clinician how to use the AIM3, what do you think would be the most important things for them to learn?
6. If you know of any other assessment models which have been used in a similar way to the AIM3, how do they compare to it in your view?

Data analysis

Transcription

Following the interviews, the data was transferred by the primary researcher onto a password protected device which was only accessed by the primary researcher. A voice-to-text transcription software called otter.ai was used to make an initial transcription of the audio-recordings. The recording that was made through the video call on Microsoft teams used the inbuilt transcription software to create the text. The primary researcher then went through the text files, while listening carefully to the audio-recordings, ensuring that they had been accurately transcribed, correcting any mistakes, and adding punctuation. Any possibly identifying information was omitted to ensure privacy. This process helped the primary researcher to familiarise themselves with the data in preparation for thematic analysis.

Thematic Analysis

As this study was a qualitative study it was necessary to choose an appropriate method to interpret the data that was collected. This study used thematic analysis, from a critical realist position in order to examine the data that emerged from the semi-structured interviews. Thematic analysis is a common method for identifying and analysing key themes from interviews. This is done by looking at the words and phrases, and examining them for both implicit and explicit meaning contained within the data (Braun & Clark, 2006). There is no one way to proceed with a thematic analysis,

and it is often considered to be “data driven” whereas themes arise, they are discovered and interpreted by the researcher. This means that the process of qualitative research is not proscriptive, it does not follow fixed rules. As such the theoretical processes are applied with flexibility by the researcher to fit appropriately with the data as it emerges (Patton, 1990).

Braun and Clarke (2006) identified six steps vital for a process for carrying out a thematic analysis on data gathered through interviews. The six steps, and the way in which they were utilised in order to analyse the data in this study are as follows.

Step 1: *Familiarity with the data:* The process began in the initial interview, and the subsequent transcription. After transcribing the interviews, they were read and re-read to detect themes that emerged and detect similarities across participants. As these common ideas became apparent, that led into the next step.

Step 2: *Generating codes*: The key ideas that had begun to become apparent were made more explicit and began to be sorted into codes. In the text of each interview, sentences and phrases were highlighted in different colours which shared common themes amongst the participants. Comments were added to help expand upon various ideas.

Step 3: *Searching for themes:* Quotes relevant to one another were then placed onto a virtual whiteboard programme named www.Miro.com, which enabled the easy grouping of relevant quotes together. As broader themes became apparent, quotes were moved around the whiteboard, and categorised. Smaller sub-themes with less importance were removed, and more significant or common ones were grouped together.

Step 4: *Reviewing the themes:* In this step the codes that had been generated, and the quotes that had been selected were placed into a mind map using the Miro whiteboard software. This provided an easy visual way of grouping them together and creating a flow that led from one theme to the next. This made a thematic map that was easy to understand from all the data.

Step 5: *Defining the themes:* By this point the thematic map and the grouping of key codes and quotes was beginning to tell a story from the data. The key themes were now clearly emerging from the data. The ideas that each of them represented became very apparent to the analysis. The data at this point was generating clear names and definitions for each key theme.

Step 6: *Producing the report:* The final step of the analysis was about the selection of the most vivid and compelling extracts which illustrated in rich detail the themes that had emerged from the data. These key themes referenced back to the literature review, and the research question. At this point all these steps came together to produce the report of the analysis.

Chapter 4 - Results and Findings

This study aimed to explore the lived experiences of participants who use the AIM3 model of assessment in their work. The data collected from the participants in this study generated six key themes.

Table 2. Summary of key themes

Key Theme	Sub-Themes
Categorising the AIM3	Psychometric or assessment tool AIM3 as a guided interview
Culture is important and may be overlooked	Lack of Cultural contexts Participants addition of Cultural relevance Māori Context
Simplicity	Colour coded graphs Easy to understand
Holistic nature of the AIM3	Wider areas Trauma and Attachment
Scoring	Nuances in the scoring process Double-Scoring Subjectivity Bias
Co-working	Collaborative Working with the young person Reviewing as a team

Theme 1 – Categorising the AIM3.

The way in which the participants reported using the AIM3 varied. Some of the participants had an impression of the AIM3 being a psychometric (therefore being used as part of an assessment but not a comprehensive tool), while others referred to the AIM3 as an assessment model. All participants commented on the AIM3 being holistic,

looking at different aspects of a young person's life. Some participants used the AIM3 for setting goals for an intervention, while there was also clear messaging around the AIM3 being thought of as a way of structuring guided interviews. Therefore, the AIM3 was involved in both the assessment and intervention for some participants.

Psychometric or assessment Tool

All participants were able to identify the AIM3 as an assessment model, with many commenting that it looked at various aspects of a young person's life. Some participants had an impression of it being a psychometric, which may imply a perception of objectivity and of measuring or testing. The following excerpts describe the views of the participants on the AIM3 being used for assessing HSB.

> *"I perceive the AIM 3 As a psychometric, that our organization uses to assess the harmful sexualized behaviour a client may have engaged in, in particular adolescent clients. I know that the AIM3 is used, also, as a treatment guide."*
> *- Participant one*

> *"AIM3 is a tool that we use as a part of our assessment and intervention with young people who have engaged in harmful sexual behaviour."*
> *- Participant three*

> *"The aim three is an assessment model and helps to break down different aspects of a young person's harmful sexual behaviour, but also it looks holistically at their lives, and looks at all the areas of their lives that might have impacted on their choice to engage in harmful sexual behaviour."*
> *- Participant six*

Using the AIM3 to aid in the assessment of HSB, while also looking at wider aspects of a young person's life seems to be well understood by the participants in their use of it in their work. Most of the participants still seemed to use the AIM3 in the manner that it was intended, regardless of whether they considered it to be a psychometric, or an assessment tool.

AIM3 as a guided interview

Many of the participants also identified the AIM3 as an interview guide. In this sense it allows the participants to be able to remember useful areas to find out more information from the young person being assessed. The participants also noted that in thinking of the AIM3 as interview guide, it enabled them to think and plan for the intervention goals that the young person may have in the treatment process. Some participants also mentioned using the AIM3 in the intervention stage as well, to try and track the young person's progress in treatment.

> *"It also provides quite a thorough, and in depth, you might say, ethnographic, interviewing guide, for getting to know a person, and the various life experiences that they've had, that have led to an event of HSB occurring."*
> *- Participant one*

> *"It's a way to measure certain domains and elements within their life, which would then inform whether they need to come into intervention, if they are in intervention, have any of those areas in their life have improved or gotten worse?"*
> *- Participant three*

Participant one illustrates their perception of the AIM3 filling the role of an interview guide, helping them to learn about the wider experiences that a young person may have had, and how this could have led the HSB which precipitated their engagement in the assessment process. The holistic nature of the AIM3 exploring multiple aspects of a young person's life is immediately apparent.

Participant three discusses the AIM3 in terms of both assessment and intervention. Using it as a guide for them to look at different areas of a young person's life to see how they may be helped by going through an intervention process. Participant three commenting on how the AIM3 can be used beyond just assessment however, by referring to it as something that can still be used throughout the entirety of treatment, as a tool which can help to evaluate whether the goals set for intervention have been met. In this way, Participant three points to the ongoing utility of the AIM3

beyond just an initial scoring, but also in terms of seeing how one is tracking according to the initial goals.

> *"it's an assessment tool for being able to understand the young person's harmful sexual behaviour, and also to guide your intervention with them as well. And, yeah, doing it when, you know, the completion of assessment, after having gotten to know the young person and their family for several weeks, and then being able to revisit the aim, periodically during intervention, also as a way to help keep you on track as well make sure you're doing the right thing."*
> *- Participant four*

> *"I think of the AIM3 as like a guided interview. All right, more than anything as rarefied as a psychometric."*
> *- Participant five*

Participant four makes similar comments to Participant three about the ongoing utility of the AIM3 throughout the entire treatment process. While this clinician finds it initially helpful in helping to understand the young person's HSB, they are also making sure to think of the future aspects of their work. The AIM3, to Participant four is useful for the future goal setting in the intervention process. It can also be useful to review it periodically, for both tracking the persons progress according to the original therapeutic goals which have been set, as well as updating the goals, if further things have been found to work on.

Participant five makes a clearer distinction on how to properly categorise the AIM3, which the impression that it is more properly considered a guided interview, and not psychometric. This may be helpful for participants to understand, as considering something to be a psychometric, may lead people to overestimate the AIM3's external validity, by giving an impression of an objective measuring of the client's behaviour, rather than a measuring of the clinician's level of concern around the various factors.

> *"I think it's a good guide, there's good, field knowledge and research backing up what's in it, ultimately, it's a guide for intervention goals, which I also quite like, rather than risks."*
> *- Participant five*

As participants elaborated further on their view of the AIM3 model, their views emphasise the solid research basis that underlines the AIM3. The impression of it being an interview guide, which is backed up by field knowledge and research is important, as well as the participants' general feeling of it being a good guide and having value for their clinical work. At least one participant felt as though it was helpful in setting intervention goals for a young person and contrasted the utility of this approach with other models which have more a risk-focus. For the participant that explicitly stated this, setting goals was seen as having more utility in their work than trying to assess a young person's risk to the community.

> *"I also think it also relies, still quite a bit on the clinician's knowledge. An obvious one is where they say, 'you have to think about cultural concerns for every single item' and they throw it to you to do that. I think that's actually relevant for every item based on how much you know, in the field. You know, why would you be worried about this thing? Why am I concerned about that? reflects how much you generally know. Well, you and your colleague. So I, I yeah, I think that it's like a, yeah, it's a guided interview more than anything else."*
> *- Participant five*

Participant five touches on some themes which will be elaborated on subsequently, making references both to cultural aspects of the work, as well as the subjectivity of the clinician's assessment. Participant five's paragraph is explaining how the success of the AIM3 is attached to the individual skill and experience of the person carrying out the assessment. By noting that the scoring of the AIM3 will reflect the level of knowledge the clinician has, this strengthens this participants perception of the AIM3 being properly thought of as a guided interview, rather than psychometric. This may have implications for relatively new or inexperienced people in the field using the AIM3 in their work with young people who present with HSB.

Theme 2 - Culture is important and may be overlooked

Culture was mentioned by most participants as something that was important to their work. Most of the participants noted that there was no explicit mention of a place to put cultural aspects into their assessment of the client, and some of them considered

this to be a weakness. As the AIM3 was developed in the United Kingdom, such aspects of cultural sensitivity may not have been considered to have a very large impact on most of their clients. New Zealand, like the United Kingdom, is also known to be a multicultural society, however it also has bicultural aspects of governance stemming from the signing of the treaty of Waitangi, between Māori and the Crown. As a result of the treaty, and the inclusion of Māori culture, it is very important in a New Zealand context to be responsive to the unique cultural aspects of Maoridom. With a large proportion of the clients coming from diverse backgrounds, the impacts of culture became greatly important to the participants assessment and intervention targets. Fortunately, a great strength of the AIM3 is its flexibility in being able to allow the clinician to incorporate their own professional judgement to account for different cultural aspects. The impacts of colonisation, diverse living arrangements and differing cultural beliefs may not have been explicitly considered by the AIM3's authors but were still able to be properly accounted for within the framework of the AIM3.

Lack of Cultural contexts

It was apparent to many of the participants that the AIM3 had been developed in a different cultural environment to New Zealand's. This was likely much more noticeable to participants because of the importance placed on Māori mental health models, and principles of the treaty of Waitangi. The AIM3, being developed in another part of the world, doesn't reflect the partnership between tangata whenua and the crown, which is important to a New Zealand context. Participants reflected on their feeling of cultural invisibility in the AIM3.

> *"I haven't looked into detail around just where it was developed and whatnot. But that's, as far as I'm aware, it's not like Made in New Zealand, not a New Zealand tool. That's not reflective of, of the context in which we have in New Zealand."*
> *- Participant four*

> *Culturally, it feels like culture is pretty invisible in terms of constructs around harm, around whakapapa, around wairua, around place. It's what feels like it's missing.*
> *-Participant two*

“I wonder about.. How it captures culture?
“If there's a domain. You know, maybe there should be another domain, I don't know, but like I wonder about that particular one, especially around some of the nuances of refugees or, those who have just moved to Aotearoa, but also the fact that it's based on American averages [sic].
I think, I could be wrong, but I'm pretty sure it's based on, persons that are based overseas rather than in a specific New Zealand context. So, I think, does it translate that context to a Te Ao Māori world?”
- Participant one

The above participants all reflected upon the differing contexts between where the AIM3 was developed, and where they currently used and applied it, in New Zealand. They spoke of being aware that due to it being developed in another countries, it was likely normed in a different culture. The cultural concerns extend to the experiences of new immigrants and refugees to New Zealand, by being cognisant of the fact that some of the therapeutic work may need to be spent on helping them to adapt to life in New Zealand. They are implying here that perhaps an entire other domain to do with cultural contexts could be helpful, as there could be differing experiences of Refugees, immigrants, Pasifika and those who are embedded in te Ao Māori. Te Ao Māori is also referenced by Participant two, who feels that Māori terms and concepts, such as whakapapa, wairua, and their own perception of harm, may be missing or at least somewhat invisible, as it is not made explicit in the relevant domains.

“I may be wrong, but there doesn't, doesn't seem to be something around culture, and particularly, the clients that we're working with as well, range and the ethnicities that we see, and so yeah, I don't know, there's not really consideration there that we're scoring or taking into account. Like if you think about Māori and you know, like, pacific Islander. Yeah, and all of that impact of colonisation, you know, I guess I suppose that's, that's not taken into account”
- Participant four

“there's something lacking, but I know, it doesn't have that cultural spin on it. And it's kind of done with young people in a different part of the world. So, it's about kind of shaping it or using it in a way that makes sense for the young people of New Zealand, and then also if they're Māori or Polynesian, or any ethnicity kind of taking that into consideration when you're assessing things like environmental and developmental because it's different for all cultures.”
- Participant three

Participant four elaborated further on their view that culture is not explicitly mentioned, nor given an obvious place to be scored within the AIM3. This is apparent in their work and is brought to the participants attention due to the wide range of different ethnicities amongst their clients, giving it an immediate relevance. Participant four perceives the unique needs of their Māori and Pacifica clients, as well as acknowledging the impact of colonisation upon that cohort. What is left unsaid, or perhaps not made entirely explicit, is that the impacts of colonisation can be further extended to Māori clients by imposing upon them western therapeutic models without considering their unique cultural needs.

While Participant three acknowledges that there may not be an explicitly mentioned place for culture, and that the main development of the AIM3 occurred with young people in other parts of the world, they show the ease with which clinicians can adapt the AIM3 to account for this. Participant three spoke about shaping the AIM3 so that it can be made to fit the unique cultural aspects of Māori, Polynesian or other ethnic contexts. Participant three identified that they would be taking cultural considerations into account in the environmental and developmental domains, which could include unique aspects in their living environments, as well as the cultural messaging and other scripts they may have developed over their lifetimes. Recognising that these aspects would be different for all cultures and may not necessarily be normative to a western context. The participants' own personal experience and flexibility then may be vital to properly taking this into account.

Participants addition of Cultural relevance

One of the great strengths of the AIM3 is the flexibility it affords each clinician to work according to the appropriate context, based upon their own best clinical judgement. This theme explores some of the participants' accounts of incorporating

wider cultural aspects into their clinical work. This was mentioned by Participant five in a discussion on an earlier theme where they mentioned:

> *"also it relies, still quite a bit on the person's knowledge. An obvious one is where they say, you have to think about cultural concerns for every single item, and they throw it to you to do that."*
> *- Participant five*

> *"we take into account culture, whereas the AIM wouldn't. Yeah, for example, there's not really, it doesn't actually say, Oh, this person's really disconnected from their culture, focus on this in intervention. That's something that we as an organization would know, we really need to look at that. So, I guess that's where we would veer off."*
> *-Participant four*

> *"I think probably I augment it if I'm working with a client who's not Pākehā So I would look it culturally, a cultural lens, depending what the client brings into this space. So for example, you know, someone's from a Latino culture, I might look at concepts of gender or, or machismo, marianismo, or if from the Middle East, we might be looking at concepts of religion and Islamic themes around relationships. If I'm working with a Māori client I'm wanting to use Te Whare Tapa Wha or just trying to contextualize some of the aim and a lens that's maybe more familiar or that's more inclusive of the person's culture."*
> *- Participant two*

The flexibility within the model of the AIM3 allows the participants to bring their own values and experience into the therapeutic process. Clinicians may feel more comfortable bringing their own values and expertise into treatment depending on how confident they are, meaning the likelihood of them contributing in this way may vary between beginner, and more experienced workers. This aspect of allowing the participants to take responsibility for other unique aspects and characteristics to do with the cultural aspects of the assessment and intervention process within the AIM3 is discussed further by the following participants.

Participant four draws a distinction between the way their clinical organisation works, with what is explicitly mentioned in the AIM3 around culture. They note that the AIM3 isn't going to make someone consider the cultural disconnection a client may be experiencing. However, they feel that their organisation can make up for this, by ensuring that the participants that work for them take it into account. This is one of the

ways in which organisations may be able to add to the AIM3, by ensuring that further aspects are considered according to their needs.

In this comment Participant two talks about the multitude of different ways they may work with individuals from a variety of different cultural contexts. Here they are able to discuss how their extensive experience of working within this field can lead them to branch out far beyond what may prescribed. This shows how the AIM3 isn't limited and allows personal experience to greatly augment its use. Within the context of what is said here is the recognition that this augmentation or extra cultural work is done primarily for clients who are not of a western or European descent, which is expected, as the AIM3 is developed predominately within that particular cultural context. This participant though can branch out widely, in this instance, by considering different gender roles in a latino culture, or Islamic concepts for a middle eastern client. For their Māori clients, users of the AIM3 are able to incorporate Māori health models such as Te Whare Tapa Whā or bring their own personal lived experience.

Māori Context

Part of working with the AIM3 in a New Zealand context means engaging meaningfully with Māori clients, in a way that is culturally relevant to them. Some of the participants interviewed noted the things that may be overlooked, or the underlying assumptions from systems developed in a western cultural context. Western science can sometimes choose to ignore certain values such as spirituality, which may be important to the clients, and help to contextualise their lives and experiences. This was noticed by some of the participants and was deemed to be of greater significance when working with Māori clients and the families.

> *"I don't think it captures spirituality. I don't think it captures Mauri Ora, an understanding of mana. I think it misses the mark on being appropriate for a lot of our Māori clients, in terms of a holistic[sic]... yeah, I just wonder about, what's absent. And whether or not that has an impact on the sort of work that we do."*
> *- Participant one*

"I suppose environmental was somewhere that would often be, you'd look at it differently from a cultural aspect, because what's normal for probably Pākehā living environments and expectations, is kind of different to a Te Ao Māori whānau. And knowing that and having lived that myself, it's just giving understanding and that might be considered not okay. You know, lots of people sharing a room or whatever, or communal living, knowing that when you're scoring and understanding the Māori whānau or I suppose shape, how you would maybe score that different region if you were scoring a non-Māori whānau, is that what you're meaning? Then I suppose moving forward, you might not think that you need to, you might know that that's not an area for this specific family to do too much work on, because that's just their communal way of living."
- Participant three

Western therapeutic models often have an emphasis on objectivity and measuring tangible items as much as possible. This reflects the dominance of these philosophical values in the development of the models used predominately in the west. It can be hard to place abstract concepts of spirituality within them in a meaningful way. The AIM3 is impacted too by this tendency by not explicitly placing culture or spirituality as a distinct factor, however it responds to this problem by allowing the participants to account for it through their addition of their own values and personal experience. Participant one comments on this apparent lack and extends it to the Māori concepts of Mauri Ora and Mana. A concern exists in this participants perception about the AIM3 being able to cater to all their needs holistically. Participant one shows curiosity, or a kind of wondering, around the potential blind spots of both the AIM3 model itself, as well as the participants who use it, attempting to consider the potential unseen impacts on the work with Māori clients.

Participant three recognised the environmental domain as somewhere culture also has an effect. The distinction between the ways of living of a Māori whānau, compared to a typically pākehā/western family living environment. Having multiple people living or sleeping in the same room may be less common in pākehā living environments, and in some instances may be a safety concern for young people with HSB. However extra consideration may need to be given for Māori whānau, where it is

more common to have communal living and sleeping arrangements. A participant's cultural knowledge may be more important here when reflecting on intervention targets, by knowing that some atypical living arrangements, may not be areas of concern.

> *"The intervention goals could be about like, they could come and [the young person], like disconnected from their Whakapapa, or their Marae. And that within Te Ao Māori is seen as something that's, you know, like, no one should have to go through that. So, a part of that intervention plan would be about linking them into someone within their iwi and hapu, or even just starting them down the pathway of learning what their pepeha is, and how that could then you know, assist in them feeling like they're a part of something bigger than themselves, and they're not alone and they're connected. So yeah, definitely. That's another cultural aspect that you would look at."*
> *-Participant three*

Participant three talked more deeply about how cultural safety can be incorporated into the goals for intervention with a Māori client. A key aspect of health, or "hauora" for a client could well be about their own personal connection to Te Ao Māori. This is a vital difference compared to a pākehā client, as a pākehā client likely already feels as though they are adapted to western norms. A Māori client however may be experiencing an unknown emotional distress which could be related to a sense of isolation, or disconnection from their culture as a result of the colonisation process. Knowing this, Participant three rates some aspects of this work into the intervention process, by assisting the young person to reconnect with Te Ao Māori, by helping them to connect to a Marae, to their iwi. Something as simple as learning their pepeha, a way if introducing themselves in a traditional Māori context, can greatly help disaffected young Māori have a sense of cultural belonging – leading to a greater sense of holistic wellness and connection.

Theme 3 – Simplicity

Many of the participants in this study mentioned different aspects of simplicity in the design of the AIM3. This was considered a strength of the model, that it was able to be easily applied by users of various backgrounds. Participants also reported the AIM3 to be easy to understand and explain to parents after the assessment process had

been completed, enabling parents to easily grasp the clinician's findings, and understand the goals for interventions. Having an assessment model be easy to understand, means that there can be greater input from family, and even in some instances clients themselves. It does a good job of de-mystifying results, which other psychometrics can suffer from when it comes to interpreting their results for clients.

Colour-coded graphs

Upon the completion of assessment, a graph is created which scores each of the five main domains. The domains then will come up with different colours in the scoring process, with red being high concern, amber being medium concern and green for low concern. This provides an easy to understand snapshot, which can help clinicians know where they will need to focus their efforts during intervention. This also helps clients and their families to understand what has been found in the assessment process.

> *"I think it offers... it offers tangible ways of understanding the information from completing an AIM assessment, through a graph which is important, and it's color-coded, you know? With traffic lights,. I think it's quite a good way to see it, tangibly. I think that's important. Because often within the psychology world you're dealing with numbers and stats and figures and It's particularly easy to utilize for those that aren't versed in statistical knowledges, and so I think it has a particular value, in an organization like [organisational name] because of its, ease of utility by persons of all sorts of backgrounds."*
> *- Participant one*

At the completion of an AIM3 assessment, a colour-coded graph is created, which can show at a glance the areas of high or low concern for a client. Participant one found that having this graph was a good way of presenting the findings, which are immediately apparent to anyone who views it. A snapshot at a glance. Having the colours be in the traffic light form also makes it simple and easy to read for experts and lay-people alike. Participant one further expanded on this idea by contrasting it with other psychological measuring tools, which can be very complex, requiring specialist knowledge and understanding to interpret. This can put the results outside of easy understanding for parents and clients. But can also serve as a barrier for other users

from different professional backgrounds. The AIM3's ease of utility, combined with simple presentation of results, greatly increases its accessibility.

> *"I like the fact that there are colours and I think that's very client friendly as well. And yeah, and, you know, where its showing red and orange, that helps guide your intervention and you know, okay, so in the family domain, we really need to focus our resources there, like, maybe the family worker needs to be seeing them more often or it's really identified some attachment issues there. So, yeah, I find it quite good, in that it points you in the direction that you need to go."*
> *- Participant four*

> *"I think it's a good structure. And it's a good guide. I think clients like, and their parents like, the simplicity of coming out at the end with a graph and some colours and stuff like that. But in my practice, I guess it's the handy reminder of, you know, do you know about this? What do you know about that? To do with your client. Yes, so it's a good, like checklist for your assessment, so you're not sort of weak in any kind of area."*
> *- Participant five*

The colour-coded graph had some utility for Participant four, who personally liked it, while also acknowledging the utility for presentation for their clients. They also found that having the graphs produced at the end can help them specifically with the development of their intervention plans. This gives them ongoing guidance, and more ideas for future work, including the allocation of future resources to help the client achieve their goals. Participant five confirmed the utility of the graphs to present information to both clients and their parents. In this participant's view this has been something that they have liked and appreciated. In addition to that aspect of the AIM3, Participant five found the graphs to be useful for them in their own work. The graph helped them to reflect on the information that they had gathered so far, while also helping them to make sure that they had considered all the key areas for a comprehensive analysis.

Easy to understand

Participants felt that the AIM3 was easy to understand, and that it generally felt as though it was approachable for the both the clients and their families. Using tools that were both comprehensive in their assessment, while also approachable and easy

to understand for people was noted to be a significant strength in the model. Having a recent tool to work with, and one that could be discussed easily with both clients and their parents helped the participants feel more confident in their work.

> *“it's recent, you know 2019. I think is a recent a recent edition which is good, considering some of the other psychometrics could do with updates.”*
> *- Participant one*

Part of the reason for the general utility and approachability of the AIM3 may be due to it being relatively recent in comparison to other assessment models. Many of the psychometric tools that are currently in use have been around for quite some time, and may be less suited to modern contexts. Participant one feels as though the recent development of the AIM3 is a strength in comparison to some of the older psychometric tools than can be used in assessments.

> *“You can talk to a young person, and I think, generally, you'll come to an agreement that "oh yeah, that one is a bit of a concern". So the language around concern, I think, is another real positive. So we're not like saying, "Oh, we all agree that's a big risk, don't we?" So we're not doing that we're saying, "oh, you know, it makes sense to you that we're a bit worried about that". And they're like "Yeah". So it's, it's not, you know, so that's, I don't know if I can use the word, It's approachable. Its easy to connect with.”*
> *- Participant five*

The ability for an assessment tool to be simple and easy to understand for the clients themselves can be seen as another significant strength for the model. In this instance the participant can talk about the way in which the approachability of the model helps their work with the young person by having them come to an agreement easily about why they may be concerned about certain aspects of their behaviour. This language of concern is being seen as a strength in comparison to past models which looked predominately at “risk”. Clients can find it easier, and perhaps less intimidating, to relate to an idea of concern, rather than framing their behaviour as potentially risky or dangerous.

> *“it's handy for clients, parents to... it's an easy thing to grasp onto. I think it's also... I think it has some good logic, that we, that we have the sexual concerns, but then we look at the other areas as well. And I*

think, I think parents in particular, are kind of happy. You know, either way, like, you know, we are saying, Oh, we're also concerned about their behaviour. Because the parents are like nodding, like "yeah yeah, we are too", or, we get a chance to say, "oh, there's not much concern there. And actually, it looks like you're son is generally a well behaved young man". and they like that too. So, either way, I think the breadth of it, I think is received well, So that's a big positive."
- Participant five

The approachability of the AIM3 is further extended upon here when talking about the young person's behaviour with their parents. Participant five has discovered that parents too find it easy to understand. This can be of great importance as parents may have varying levels of education or may in some instances come from widely variable cultural backgrounds. The strength focused aspect of the AIM3 leads it to an ability to help reassuring parents, by talking about concerns that they likely share with the clinician, or an ability to point out the strengths that a client may be and talk about how they are generally doing well. This enables the collaborative nature of the AIM3 to come to the foreground, giving a sense of 'working with' the clinician, the parents, and the young person. Another strength of the AIM3 touched on here is around its holistic nature, and that being reassuring to parents, as the young person is not reduced merely to the HSB they may have engaged in, but also looks at the wider aspects of things that may be going on in this young person's life.

Theme 4 - Holistic nature of the AIM3

A significant strength of the AIM3 was noted in the earlier section. That being that the tool is holistic in nature, and looks at much wider aspects of the young person's life rather than just focussing on the HSB. This was picked up on by numerous participants, such as Participant three below:

"it focuses on just not just the Harmful Sexual Behaviour, it focuses on other areas like the criminal side, environmental, developmental, all of that stuff. So I think it kind of wraps around the whole of the person's life."
- Participant three

Broader views

The AIM3 can take a broad view of a client and their behaviour. By looking at the wider aspects of their life, it is more able to help clients in any areas in which they may be weak. HSB can be symptomatic of other wider issues, so by looking at other domains such as their environment or developmental aspects, then clinicians may be able to provide better therapeutic outcomes than if they focused purely on the referral behaviour.

> *"it certainly feels like it's a methodical, considered, measured way of assessing, you know, it gives us a rubric, if you like, to look at the different factors in each domain around the nature of the sexual harm, if there's other criminal behaviours, how they're fitting with their peer group, you know, it's quite robust and thorough. So I guess I like that aspect of it."*
> *- Participant two*

> *"I think what I like about it is it's not just looking at the HSB. It's also looking at the other factors, so you might actually be highly concerned about a young person. But the sexual behaviour might be within, not in a red, it might be an orange. But other factors might be red. So it looks not just at the harmful sexual behaviour, but the context of that harmful sexual behaviour within a person a young person's life."*
> *- Participant six*

The structure of the AIM3, and in particular the way the model looks at wider factors that may be contributing to their referral behaviour is appreciated by Participant two. As wider factors could potentially be quite extensive, it may be difficult to know which are the important areas to focus on. The AIM3 is able to help this participant know what the important things are to look for. They feel as though the assessment model provides a robust and methodical framework for considering these aspects beyond the HSB.

This participant also likes the broader context that is given through the AIM3. In this instance they are speaking about an individual who may not have scored particularly highly in terms of the HSB, however, is still a young person that the clinician may have a high level of concern around. This can be revealed by measuring the other domains, and in doing so it may be found that the young person has an unsafe living

environment, or a history of developmental trauma that may need more work done on, which could be missed if one only looked at the HSB in isolation.

Trauma and attachment

Many clients may have a trauma background which could potentially be related to their choice to engage in HSB. Helping a client to process that trauma may be key then to helping them move on from that behaviour. Other factors that may impact on treatment could be their level of attachment to parental figures or other significant people. The AIM3 is useful in facilitating work around both of these factors.

> *"Strength of the model is that I like that looks across all areas of the young person's life. Yeah. So, it's not just focusing on the incident that brought them to stop, but it's looking at. Yeah, like family and upbringing and looking at trauma. And that's sort of it as well. So, like, balanced."*
> *- Participant four*

> *"It gives us a construct to work with and it kind of helps to identify certain areas of inquiry. And I like the fact that it's inclusive around the child and the trauma and attachment lens. So, it's not just about the event that's happened, but it looks into the whole of young person's life, their current situation, their current strengths."*
> *- Participant two*

In the wider context of what is measured by the AIM3, Participant four was able to identify some of the developmental issues that may arise in clients with HSB. In particular they identified that trauma may be something that needs to be looked at and acknowledged. Trauma is often co-occurring with HSB, and the AIM3 provides a space to place their own history of being harmed or having poor attachment.

The way that the AIM3 is able to take a wide perspective on what may be going on for the young person was also apparent here for Participant two. This participant spoke about being particularly pleased with the way that AIM3 is able to include the child's wider needs. They noted that there is a way to score the trauma that a child may have experienced, and place that into the context of their decision to engage in HSB. The ability to look at attachment is also of importance to Participant two, as this can

often be another overlooked factor. Poor attachment to parents or the family can be an important area to work upon in the intervention process in order to help heal some of the bonds that may have been strained by the young person's HSB. In some cases, it may be that the young person's poor attachment to others has led to their decision to engage in HSB as a means of connecting or being close to others and lacking an appropriate means of doing so. The AIM3 allows for this aspect to be considered in both assessment and intervention.

> *"I think by looking holistically at that young person, not just assessing the harmful sexual behaviour and the risk, you're assessing the dysregulation, the emotional needs, the social needs, the developmental needs, so by looking holistically you're looking at all the factors that might have influenced that young person's choice. But it doesn't mean that that's the only thing going on in their lives. They might have had poor attachment and there might be some jealousy there. And that might have impacted the choice to engage in harmful sexual behaviour. But the work needs to be on the attachment, not on whether they've learned about consent or not. So, it helps you, I think, by looking holistically at your concerns, it helps you identify the areas where you need to focus your intervention. Because if I suppose if I'm looking at harmful sexual behaviours as the tip of the iceberg, you need to focus on what's underneath. So, I think the AIM does a good job of looking at what's underneath and what else is going on for this young person? What are the dysregulation, things going wrong in their lives, with the hard things in their lives that we're actually, if we focus on the underneath stuff, that would have a positive impact on that young person and on their sexual safety."*
> *- Participant six*

The holistic nature of the AIM3 was once again noted as a considerable strength of the model by Participant six. They spoke about how all of the other aspects of a young person could be assessed at the same time. These wider factors could then be looked at, and considered in the ways in which they may have contributed to their decision to engage in HSB. Attachment is also seen as a potentially contributing factor by this participant, who has said that they may have had poor attachment or jealousy that led to their decision to engage in HSB. What they have recognised is that this may actually become an important intervention target, which could have otherwise been missed if the AIM3 didn't have the means to look at factors beyond the HSB itself. In this instance they have made the comment that the work done in intervention then

needs to be on the attachment itself, and not necessarily on the rules around consent, although they may make up another component. Participant six thought the AIM3 did a good job at looking at the underlying factors and providing a means to help to respond to them.

Theme 5 - Scoring

The scoring of the AIM3 is something that can be relatively straightforward, yet also complex. In this theme participants spoke of their experiences around the scoring of the AIM3. They spoke of some of the challenges that can arise during assessments, in particular of the risks of scoring too low (underscoring) or scoring too high (overscoring). A common pitfall which is warned against, known as "double-scoring" was also mentioned, which is when the same behaviour gets scored in two different domains was also discussed. Some discussions around participants personality and their levels of bias were also touched on by the participants.

Nuances in the scoring process

The scoring process in the AIM3 is quite simple and straightforward, although due to it being numerical it may be seen to be more objective than it actually is. Understanding that there may be variability between clinicians is important to being able to properly work with this tool.

> *"I think I would make a point of that before starting as like a disclosure that it doesn't capture everything right. But I also think I would say that it's quite easy to underscore, right? Because I think that generally a statement can be made that it's easier to underscore than overscore. That's probably a risk, so I'd front load that, and then I'd probably front load it with the fact that it - the way it's set up is that it privileges the victim's account."*
> *- Participant one*

> *"The clinician has to bear in mind that the number, isn't that... Isn't that relevant. You know, it was kind of like what's behind the number? Fours there for horrific kind of stuff, and the four's there to say you definitely need to get onto this stuff. But you can't score it a six. So, it's like the quality of that four, around that, might be quite different to the quality of a four for self-regulation domain later on, or developmental*

domain, and you got a four in there, that you know, the movability of this first four is possibly less than the others. So there's that stuff. I think the discipline has to keep that in mind, that the fours... It looks quantitative, but its still qualitative."
- Participant five

"I think overall it is really good. I think it needs to be, we need to make sure that it's used in a way that is, as an assessment tool, not as a psychometric. So I do wonder if having scores of twos and fours, are slightly distracting for people, whether it's, that's another way to indicate concern without a number, it could be a letter or it could be a symbol or something like that, or just color coded. I do feel like sometimes, as sort of humans and clinicians, it's easy for us to get hung up on is this a two? Or is this a four? as opposed to how concerned am I about this person?"
- Participant six

In this instance, Participant one talked about the way that they would communicate to a new clinician in the beginning of the assessment process about what they will be scoring. Participant one perceived that the AIM3 is not necessarily going to capture all of the nuances of what has occurred, and to try and prepare them for that reality. They feel as though there is more of a risk of under-scoring for a client, and so they feel that it is important that a new clinician keeps that in mind, as a sort of protective factor against that possibility. Another area of nuance that can occur while scoring is understanding that in some instances there may be conflicting accounts between the client, and the person who was harmed. When that that occurs, Participant one would bring it to the new clinician's attention that it is important to privilege the account of the person harmed, over the client's view.

The nuances in the scoring process were further elaborated upon by Participant five. In this instance they communicated that there can be different weight ascribed to the number that is given to represent the clinicians level of concern for any particular factor. A score of four which measured an aspect of the HSB for one client, could still be a four in the same domain for another client who may have exhibited far more serious HSB than the first. This is because what is actually measured by the four is that the clinician is highly concerned, but a clinician may be highly concerned by a very broad range of behaviours. Participant five also pointed out that the scores of the

behaviour could have various layers of meaning depending on the different domains that they are placed into. Ultimately the message that Participant five feels is the most important to convey is the subjective nature of the scoring, and to be aware that even though numbers are used, those numbers are in fact a subjective measure of a clinician's level concern.

As discussed earlier in the analysis, the importance of treating the AIM3 as an assessment tool, rather than a psychometric is something that participant six feels is important to keep in mind. They gives voice to some of her concern that perhaps newer clinicians may be misled by the attributing of numerical scores to their level of concern around various factors.

Double-scoring

Double-scoring can sometimes occur when a clinician may end up scoring the same concern under two different factors or domains. This is a known pitfall for clinicians, and it is discussed in the manual and training programs. Even so, it can be difficult for clinicians to be able to properly protect against this tendency.

> *"There is always risk for double scoring. Which I think is something that, arguably can't be avoided because of like the nature of the problems that people come with to see us because they're so intertwined and inter-tangled. And it's like a web of, yeah, everything is just not in a vacuum. And so, to separate them out, it's difficult and I don't think... like, it probably takes years and years of clinical experience to know actually which category to put something into."*
> *- Participant one*

> *"it's important not to double score. But I suppose sometimes you forget, and then it can fit in so many other areas. So that's probably something that, I don't know if its a weakness, but it's certainly something that catches me out."*
> *- Participant three*

> *"I find myself double scoring a bit. That's probably not intended. But it's hard not to, because certain things fall into several categories. So that probably wasn't intended, I don't think it's a helpful thing for me. But at the same time, it's also helpful to think of. So for example, you've got a kid, a young person who might have poor social skills, he might come up as having poor social skills and needing to learn about that, but then he also might come up in emotion regulation as feeling lonely and*

isolated."
- Participant six

Participant Six discussed some of the difficulties associated with the risks of double-scoring, as client's problems in their real experience are inter-twined and may appear to belong to two or more categories in the AIM3.

Double-scoring was a commonly referenced difficulty with both the more experienced clinicians, as well as the newer ones. Participant three was hesitant to consider the risk of double-scoring a weakness in the AIM3 model herself, although she did notice that it was something that she struggled with. The AIM3 may benefit from providing some more clear guidelines around areas where double-scoring is likely to occur in order to help clinicians check that they have not inadvertently done so. Participant six also found it difficult to avoid double-scoring, and was able to elaborate on this, by making reference to specific examples of challenges in the categorisation of a young person's problems, in this instance the relation between poor social skills and emotional loneliness.

Subjectivity

Due to the nature of the assessment process, and the relationship building process with the clients, there can be a risk of the clinicians personal feelings coming into the scoring process. Some clinicians may have a high or a low tolerance for certain behaviours, and this could potentially change the outcomes.

"I also find it quite subjective. And also, we use it sometimes, in a way that's very subjective. And it's based on the information that we have at the time when new information can come to light later. And that's not, you know, a quantitative picture. Yeah. It's not always factual."
- Participant four

"people's inclination can come into it. Yeah, so "Oh, not really concerned about this young person". And this is one of those things where you know, generally in the field, it's understood that clinicians estimate of a client's recidivism, Isn't that great. You know, there's all sorts of things that come into it. There's is this kid likable? and if he's likable, that he's probably not going to do it again surely not."
- Participant five

The subjectivity in the scoring process was also commented on by several of the participants. Most participants seemed to be aware that there was an aspect of their own personal views that would come across in their work. Being aware that they were in fact measuring their own opinions then was important to these participants to ensure that they did not mistake their scoring for an objective measure of the client's behaviour. Participant five also makes the comment that sometimes in the therapeutic relationship, a clinician's personal feelings towards a client could potentially be a subjective blind spot or risk. Noting that if the client is likable, then the clinician may be more inclined to feel that they have a lower risk of recidivism.

> *"I think that can when clinicians are so used to scoring psychometrics, which are all very quantifiable. But actually, there's no right and wrong. It's around our gut instinct and around our clinical expertise. So yeah. It's hard to put a, it's hard to describe a sense of, because you're judging it on your clinical expertise, but your relationship with this person that you're assessing, your opinion is quite opinionated. But those opinions need to be based on something. Yeah. Which I think that does give a good framework to base that around. Yeah, and guide you. So it's not just around your gut instinct, or you're feeling around concern. There is some specific guides."*
> *- Participant six*

The subjectivity in the scoring of the AIM3 can be a challenge for clinicians, and it is important for them to keep in mind that it is their opinions which are being measured. Participant six spoke about their gut instinct, opinions, clinical expertise and their own developed relationship with the client. Participant six doesn't consider this to be a weakness of the model however, rather she considers it something to be aware of, noting that it is in fact the purpose of the AIM3 to rely on the clinician's level of expertise in assessing the client. The AIM3 when it is thought of as an interviewing guide, and a way for clinicians to ensure that they are asking the right questions and being aware of the various factors that are important to consider in a young person's intervention. Participant six felt as though the AIM3 provided a good framework and guide for ensuring that those concerns are considered.

Bias

As the clinicians work with clients their own, or organisational biases could possibly become apparent. Some may feel as though they need to show results, leading to them possible scoring the clients lower later on to show that their interventions have worked. In a similar sense, they may score a client too highly initially, to either justify bringing them into intervention, or to make it look as though they have done really well by the end.

> *"I think it can be really helpful to show the clients the graphs. I think that's a really helpful use of the tool because you can then rescore it in several months and show that development. That's probably one thing that we do do. We try and make sure that there is a shift. So maybe if you're umming and ahhing, whether you think it's a two and a four and where it fits, you might be tempted when you're first scoring it as a clinician to score a bit higher, that concern, because you know that you can reduce it and then sort of show some positive growth."*
> *- Participant six*

> *"that's sometimes where I think we might not use it, in the way that it should be used, and that sometimes we might think, be on the fence about two or three and think, "Oh, well, we want it to go down". And it'll be nice. It'll look good, and so we'd bump it up, and I'd, and you'd, think, "well... is that actually a true representation of where they're at?"*
> *- Participant four*

Participants mentioned that in some instances there may have been a slight bias in their scoring process, and that this is most commonly seen in the initial scoring that they may do of a client. Participant six spoke about how if there was some uncertainty over the way that they wanted to score a particular client then they may want to consider scoring it a little higher (over-scoring), as that may then mean that at a later date, they may be able to show a greater reduction in the level of concern. Participant four also looked at this tendency towards an initial bias of over-scoring. In the above comment she reflected on how if she wasn't sure on what score she wanted to give, then she too would probably score it more highly initially, knowing that she would be likely to be able to reduce it a later date. Participant four also showed a certain degree of concern however towards this particular bias in her practice,

wondering if by doing this she may have not actually been accurately recording the clients scores for the AIM3.

> *"I think it's definitely a bias to be aware of, especially if you're working for an organization that wants to see positive change in their clients. And that's a probably an organizational bias, which might be a bit a bit kind of concerning…*
>
> *and you don't want to be seeing the concerns higher because then it might invalidate your work? Or there might be some concern that your work isn't working.*
> *- Participant six*
>
> *"It is subjective to the clinician's bias. I guess the other thing there is, you know, being real. you are rescoring the aim, and you want it to go down. Yeah. So, there's a kind of like, there's a kind of like, that bias that you've been working with this kid for a few months now. and you want something to show for it. And so, there is this kind of like looking 'for', a kind of like, "oh, I can get that down to a two now, I reckon?" And just because he's been coming in for three months? Yeah, so there's a little bit of pressure, that people probably put on themselves."*
> *- Participant five*

Biases were also apparent in the rescoring process and were mentioned by participants 5 and 6 as well. There was an idea that came across from both participants that there was an interest for the clinician, and perhaps as well for the organisation that they worked for to see positive improvement in the clients. Both participants felt that this was an important bias for clinicians to be aware of, and in some ways, it was a difficult one to avoid. Participant six mentioned that a clinician could feel as though they weren't doing well at their job if they weren't able to record positive results. Participant five also touched on this theme, by suggesting that clinicians, may end up looking more closely for positive effects if they have been working with their client for some time. This could translate to pressure put on the clinician themselves to show that their work had been successful. Clinicians will need to be aware of these biases in their scoring and re-scoring processes in order to ensure that they are actually creating accurate representations of the client's behaviour, rather than a reflection of the clinicians preferred outcomes.

Theme 6 - Co-working

Co-working was an important theme that came across from all of the participants in the study. The AIM3 allows for collaborative working processes, both with colleagues, and even with the clients themselves. This is a significant strength of the AIM3, as it can mean that having more people involved can help protect against clinicians' biases or different levels of experience. Co-working was the norm at the organisation at which the participants worked, so it may have been an organisational norm for them to co-work, rather than a recommendation from the authors of the AIM3. Even so, the flexibility to allow for co-working can be considered to be a significant strength of the AIM3.

Collaborative

Clinicians felt as though it was easy to use the AIM3 with their colleagues and sometimes the clients themselves. This lead to feeling supported, and as though there was shared responsibility. This may have been an organisational norm, although it was recommended too by the AIM3 authors.

> *"I don't know if it's specific to the AIM3, but it's that you don't do it in isolation. It's done with a co-worker. So, you're sharing your guys' thoughts and the information you both gathered, both with the family and individual."*
> ---
> *"knowing that I didn't have to do alone, it's not something you have to do alone. And there's not that pressure of you having to do it alone, and (you can) use the supports that you have within your guys' system or Stop's."*
> ---
> *"we have an individual worker and a family worker and together, you guys, we would score the AIM and it's a good way to share differing views, you know, agree on things. Get information that the other person collected that you may not have known. Make the plan together instead of you just working in isolation"*
> *- Participant three*
>
> *"We work collegially with each other. And we work as a pair, often with the family and the individual. But I'm assuming not everyone who's working with the aim will be scoring it with a colleague necessarily, that's just the way our organization works."*
> *- Participant six*

"... Scoring of the aim alongside with the outcomes of the interview and the interview content from the assessment, all come together, I suppose, on the end of assessment process. And because at Stop we have the review as a team I think then it's a really good solid look at what the information that's come out of the assessment and where do we need to go in intervention. So, it helps. I think what I like about it, too, that we're not, we're not just applying a program. You know, we're actually looking at the actual context of the harm and the young person and then designing the intervention as a specialised, you know, process."
- Participant two

The above participants considered the ability to co-work throughout the AIM3 assessment and intervention process to be a significant strength in their work. Participants found that working in that way allowed them to feel as though there was more security for them in being able to work with others, as the pressure of needing to take significant decisions about the treatment of a young person was not theirs alone. Participants reflected that co-working allowed them bounce ideas of each other, and to have another clinician check over their work. Sharing the information that had been gathered with other members of their team meant that when it came to the end of the assessment, they were able to fully reflect on the information gathered and create a strong and focused plan for intervention. Participant two spoke of that being a feature of the AIM3 process that they really liked and appreciated, as it enabled a comprehensive custom designed intervention taking into account the young person's unique circumstances, as opposed to simply applying a pre-formed programme.

Working with the young person

Some clinicians felt as though it was helpful to include the young person themselves in the scoring process, and that that could help them understand the process, while also engaging meaningfully with the treatment.

"Doing it with the young person. And also, getting their input into it as well, rather than doing it separate to them. Yeah, I feel like the answers would be different depending on that as well. Because I guess I'm aware that another colleague does that. And thinking actually, oh, that might be kind of helpful tool."

"When I've worked a case, on my own, I am scoring the AIM based on the information that I've gathered, I suppose it doesn't count really. I

don't do it with the young person, and I know that's been a recommendation, to do it with the young person."
- Participant four
"I guess it guides my practice, also, in that, I think it's quite handy to give to a client and talk them through it, get their point of view on it, and then go away and find your co-worker. Have our opinions about their opinions? See whether we agree. So I mean, yeah, it can be used in a collaborative way, I Think, and I quite like that about it."

"It's pretty easy to follow. I think, the fundamental thing where, where just, each item, you're thinking, why are we concerned about them? Like I said, before, it's not too hard to gain agreement on. Even if they're thinking "I'm fine. I'm never going to do it again". You know, the young person goes, "Yeah, I can see why people worry about that, I shouldn't have done that"."
- Participant five

Participants 4 and 5 both spoke about using the AIM3 collaboratively with the young person themselves. Participant four felt as though she thought that working with the young person could be a possibility, mentioning that other colleagues of hers had suggested it, although she had not yet had tried. She still felt as though it could work, and seemed to feel as though the AIM3 was flexible enough to be able to include the young person in the scoring process. She reflected too that having the young person involved in that way could perhaps augment the process, or even change the final scoring. Participant five reported that he does in fact use the AIM3 with the young persons themselves and reflected on finding that to be quite helpful. He extended that collaborative perspective as well to his co-worker, in jointly considering the opinions of the young person. Earlier themes of the AIM3's simplicity and accessibility were also apparent in Participant five's perspective when it came to including the young person's view, as he felt as though it was quite easy for them to follow along, and relatively straight-forward to get their agreement upon level of concern for particular domains.

Reviewing as a team

Participants felt as though coming together afterwards, and sharing with one another helped them to protect against bias and blind-spots, while also enabling them to profit from the experience and perspectives of others with expertise.

"Co-score it with someone who's been here a bit longer than you. So you like, you train yourself into, you know have those conversations about why would you be concerned about this? And not that? What differences does it make if they've got autism, you know? So yeah, I think for me, that's the fundamental thing is to have that, you know, the general understanding, that it's a guide, but it's not going to spell it out for you. And so, yeah, that message is, I think really important."
- Participant five

"I suppose that's where I find the importance of not doing it in isolation and doing it with other people, because then you've got other colleagues experience of having done the aim for a number of years. And their scoring would look probably quite different for someone who's got like a low tolerance or high tolerance for things."
- Participant four

"So at the end of assessment, Yeah, we will read the report and show the aim graph and kind of give our rationale as to why we've scored it like that. And then they'll give feedback, whether they think we've been too harsh or not harsh enough. And then, you know, it just creates this dialogue that can give further, kind of support and insight into this young person's needs going forward."
- Participant three

Many participants spoke on the importance of having their team with them to help in reflection on their assessment. Their team could share their experience, and help them in the scoring process and review the case with them. The assistance of their team was essential in helping them feel as though they were supported and helped them by training them to ask important questions and reflect on the responses. Participants four and three mentioned that they found the support of their colleagues invaluable as it helped them to reflect on their own scoring, enabling them to account for their own personal views that may come across in scoring. This is important to them, as the concern of some clinicians may be more or less for some domains depending on their own personal tolerances for certain behaviours. As Participant five noted in the above quote, the AIM3 is a guide, and so it requires conversations and reflections based upon clinical expertise to ensure that it can give proper results, and good guidance for a therapeutic intervention. The AIM3 allows for this, and is greatly strengthened by the capacity to be used in a collaborative process.

Summary

In summarising the research that has been undertaken, and the results that have been produced, six key themes emerged from the data. The first of these key themes was about categorising the AIM3, and included discussions about whether it was most appropriately considered to be a psychometric or an interview guide. The second key theme that emerged was to do with how culture may be a blind spot in the AIM3 and led to discussions around how clinicians incorporated clients' cultural needs into their work. Thirdly was to do with the simplicity of the AIM3, and how this was of benefit to both clinicians and clients, as it increased its accessibility, and allowed easy presentation of the data to clients and their families. The fourth theme was around the holistic nature of the AIM3, clinicians found it valuable in that it looked at the wider context of the young person's life who was being assessed and wasn't limited by only looking at the nature of their HSB. The fifth theme to emerge was related to the scoring of the AIM3, in which aspects of uncertainty around double-scoring, and the possible impacts of bias and subjectivity were raised. Finally, in the sixth key theme to emerge were discussions around the collaborative nature of the AIM3, and the way it facilitated co-working amongst colleagues, which could even be extended to include the clients and their parents themselves. Overall, clinicians felt as though the AIM3 was a very good tool, and helpful in their work.

Chapter 5 - Discussion and Conclusion

The aim of this study was to explore and understand the lived experience of clinicians' using the AIM3 model of assessment to assess and treat HSB in CYP. Six clinicians took part in this study. Thematic analysis yielded 6 key themes being: categorising the AIM3; culture is important and may be overlooked; simplicity; holistic nature of the AIM3; scoring and co-working. Generally speaking, the participants all had a favourable view of the AIM3, and appreciated the flexibility it allowed for experienced clinicians to work with CYP in ways that they felt were most appropriate. Some concerns were raised from the clinicians about cultural issues being overlooked, and a risk of bias or subjectivity in the scoring process, although they felt as though that was balanced out by the AIM3's comprehensive analysis of the whole of the young person's life. This study has highlighted the lack of studies around the AIM3, and its use in the field, and suggests that a more in depth look at the way other clinicians and organisations use it in their work would be of value in the field. To fill this gap, this study has attempted to begin to contribute to the literature, by joining some of the quantitative data gathered about the AIM3's reliability from the study by Jensen et al. (2022), and deepening it with a piece of qualitative research, that uncovers more rich detail of the participants' personal experiences. This research also contributes to the literature around the perspectives of professionals who work with CYP with HSB such as that found in the study by Pelech et al. (2021), although only from the perspective of those who use the AIM3 in their work. This research too aims to increase the visibility and importance of culture within the assessment and intervention treatment processes, and extend that work to incorporating more Māori mental health models, as suggested by Bush et al. (2019), in their research.

Limitations and future research

A limitation of this study was to do with the six participants themselves. They were all from the same organisation, and as a result had the same organisational

culture. This made for a relatively small, homogenized sample size. There may have been greater agreement amongst the participants as a result of this. A more diverse sampling of clinicians, including clinicians from multiple different organisations could have led to more diverse viewpoints and observations being shared. Future research could be benefited by expanding the scope of this study to include the other New Zealand based organisations that use the AIM3 in their work.

Another limitation of the research included my own presence in the research process. I was a colleague of the participants, and therefore was part of the cohort myself. This impacted on the research in diverse ways, in spite of my best efforts to minimise this effect. Participants knew me already, and so were quite comfortable in speaking with me, whereas it may have taken more time for an unknown interviewer to develop rapport. Although I tried to ensure confidentiality, it is also possible that the participants may have felt uncomfortable expressing all of their true feelings, due to my positioning as their colleague as well. There was therefore a dual-relationship between us, of both colleague and researcher/participant that may have impacted the study. Any future research carried out on this topic may benefit from a researcher unknown to the participants.

This study was only interested in the views of the clinicians who use the AIM3 in their work, however there are more viewpoints that could be considered in the use of the AIM3. It would be interesting to know about the experiences of the people being assessed by the AIM3, and whether they felt that they could participate in the process, whether or not they felt the assessment was fair, and if at the end of their treatment the AIM3 had helped guide their intervention towards beneficial outcomes.

Implications and recommendations

The results of this study lead to several implications for practice in a New Zealand context for clinicians who work with the AIM3 to help CYP with HSB. The key

implications and recommendations that have arisen as a result of this research are as follows.

Firstly, this study has implications for clinicians working in a New Zealand context to be aware that they may need to augment certain aspects of the AIM3 in order to ensure that the cultural needs of clients are being met. For those who are working with Māori clients, this will have an added layer of importance in light of the obligations under the principle of partnership enshrined in the treaty of Waitangi. However, working in a way which is culturally sensitive will be important for any clients who are not from the dominant western paradigm. The AIM3 may not explicitly mention cultural influences as something to be aware of, and therefore it is strongly recommended that any clinicians working in this field incorporate wider cultural knowledge into their work with their clients.

Secondly, clinicians should be aware of the subjectivity that is inherent in the scoring process. This does not mean that the scoring is not going to be an accurate representation of the client, but that there are some pitfalls that a clinician should be aware of. Clinicians need to be aware that what they are scoring is their level of concern, and that this could potentially vary from clinician to clinician. This leads to a risk of bias or subjectivity that may come through in their scoring. This can be mitigated by taking note of the domains where they may be at risk of double-scoring, and to also understand that the scoring should be helping them to set their intervention targets for the treatment process.

Thirdly,many of the clinicians spoke of the perceived value in using the AIM3 to facilitate co-working. The graphs are able to be viewed for clinical reviews which can quickly inform others, and provide space for them to give feedback. The AIM3 can be used by individuals, although as noted in the previous section that can increase the risk of bias, which can be lessened through the sharing of expertise. Clinicians are recommended to use the AIM3 in conjunction with their colleagues, in order to reduce

bias and subjectivity, while also allowing a greater amount of experience to be brought into the process. Furthermore, the AIM3 should not be limited to just co-working with ones colleagues, but on a case-by-case basis could also be extended to allowing the input of the young person, and even their family members into the scoring process.

Fourthly, clinicians should be made aware of the potential problems arising from mischaracterisation of the AIM3. Due to the numerical values assigned to the scoring of a clinician's level of concern, one may be tempted to assign it quantitative validity. However, it is qualitative data that is being collected. If a clinician considers it to be a psychometric, then they may over-state the value of the scoring. A clinician should properly think of the AIM3 as an interview guide, that helps them to set goals for their intervention. Understanding that the scoring in the different domains are there only as guideposts, rather than fixed results with high external validity.

Conclusion

This project has attempted to give a critical analysis of the experiences of clinicians who use the AIM3 in their work with young people who have presented with HSB. Clinicians were invited to share their experiences and provide feedback on the assessment model. Their responses were then subjected to a thematic analysis to search for meaning that emerged from the data in rich detail. Through the sharing of their thoughts, feelings and experiences, participants responses helped to inform the research, showing that generally they felt as though the AIM3 was a tool that very useful for them in their work, and that any weaknesses in the model were able to be mitigated through either the individual clinicians personal experience, or through co-working with their colleagues. This research has provided a unique look into the personal insight and experiences of professionals who work in the realm of HSB, and has aimed to contribute to the professional literature, as well as provide a basis for future research in this field.

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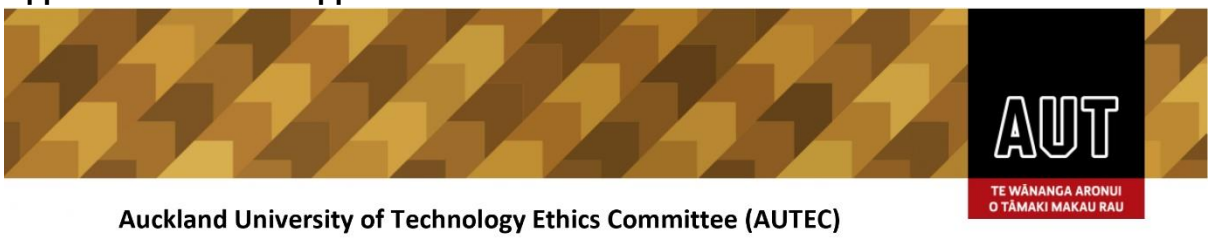
Appendices

Appendix A – Ethics Approval



Auckland University of Technology Ethics Committee (AUTEC)

Auckland University of Technology
D-88, Private Bag 92006, Auckland 1142, NZ
T: +64 9 921 9999 ext. 8316
E: ethics@aut.ac.nz
www.aut.ac.nz/researchethics

22 June 2022

Liesje Donkin
Faculty of Health and Environmental Sciences

Dear Liesje

Re Ethics Application: **22/126 Clinicians lived experience of using the AIM3 Assessment Model to assess harmful sexual behaviour in adolescents.**

Thank you for providing evidence as requested, which satisfies the points raised by the Auckland University of Technology Ethics Committee (AUTEC).

Your ethics application has been approved for three years until 21 June 2025.

Non-Standard Conditions of Approval

1. Provision of an assurance that the data will be stored with the primary supervisor post analysis.

Non-standard conditions must be completed before commencing your study. Non-standard conditions do not need to be reviewed by AUTEC before commencing your study.

Standard Conditions of Approval

1. The research is to be undertaken in accordance with the Auckland University of Technology Code of Conduct for Research and as approved by AUTEC in this application.
2. A progress report is due annually on the anniversary of the approval date, using the EA2 form.
3. A final report is due at the expiration of the approval period, or, upon completion of project, using the EA3 form.
4. Any amendments to the project must be approved by AUTEC prior to being implemented. Amendments can be requested using the EA2 form.
5. Any serious or unexpected adverse events must be reported to AUTEC Secretariat as a matter of priority.
6. Any unforeseen events that might affect continued ethical acceptability of the project should also be reported to the AUTEC Secretariat as a matter of priority.
7. It is your responsibility to ensure that the spelling and grammar of documents being provided to participants or external organisations is of a high standard and that all the dates on the documents are updated.
8. AUTEC grants ethical approval only. You are responsible for obtaining management approval for access for your research from any institution or organisation at which your research is being conducted and you need to meet all ethical, legal, public health, and locality obligations or requirements for the jurisdictions in which the research is being undertaken.

Please quote the application number and title on all future correspondence related to this project.

For any enquiries please contact ethics@aut.ac.nz. The forms mentioned above are available online through http://www.aut.ac.nz/research/researchethics

(This is a computer-generated letter for which no signature is required)

The AUTEC Secretariat
Auckland University of Technology Ethics Committee

Cc: nwc8661@autuni.ac.nz

Appendix B – Recruitment Protocol

AIM3 STUDY RECRUITMENT PROTOCOL

Inclusion Criteria:

- Participants must be currently working professionals, who work with adolescents who present with harmful sexual behaviour (HSB).
- Participants must utilise the AIM3 model of assessment to assess HSB in adolescents.
- Participants are willing to answer questions about their experiences of using the AIM3 in their work.

Exclusion Criteria:

- Participants must not have the researcher as their supervisor.

Recruitment for this study is as follows:

1. An email requesting the participation of an organisation will be sent to the Chief Executive or Clinical director.
2. An email will be sent to the clinical manager, asking to invite those clinicians who meet the inclusion criteria to contact the student researcher directly to express their interest in participating.
3. Participants who express interest will email the student researcher directly.
4. The student researcher will respond to the participants, sending the participant Information Sheet, and the Consent Forms, as well as inviting them to ask any questions.
5. A mutually agreed upon time for the interview to take place will be arranged.
6. In person interviews will have the first 10 minutes set aside to sign consent forms, and ask any questions. Participants will be informed that they may withdraw at any times.
7. Video-conferencing interviews will have the first 10 minutes set aside to orally confirm consent, ask any questions, and be informed that they may withdraw at any time.

Appendix C – Organisational Participation Request Email

Dear Chief Executive

I am an honours student at AUT university, who is currently working on a dissertation.

I am looking for participants in a study I am carrying out. The research question for this particular topic is *What are the lived experiences of clinicians who use the AIM3 Assessment model?* This research will be aiming to explore the perspectives of those professionals who use the AIM3 to assess harmful sexual behaviour in adolescents. It is hoped that this research will expand knowledge in this particular setting, and may be of benefit to other professionals who work in this space. Knowledge gathered from this research may potentially help with training of other clinicians, provide feedback to the AIM3 creators, and further the understanding of the relationships between clients, clinicians and assessment models.

If this research interests you or your organisation, and you have clinicians who currently work with the AIM3 who may be able to take part, then I would like to invite you to contact me.

Yours sincerely,

Tom Hume.

Appendix D – Organisational Participant Information Sheet

Organisational Participant Information Sheet

Date Information Sheet Produced:

09 June 2022

Project Title

Clinicians lived experience of using the AIM3 Assessment Model to assess harmful sexual behaviour in adolescents.

An Invitation

I am Tom Hume, and I am carrying out this research as part of my qualifications for the honours year of a psychology degree. This requires me to design and carry out a study which can contribute to the scientific literature on a chosen topic. I am interested in discovering how clinicians experience using the AIM3 assessment model in their work. As someone who employs clinicians who work in a professional setting with the AIM3, I would like to invite you to contribute to this research, by allowing your employees to choose to participate in this research if they so wish. It is expected that the information gathered in this study will help to further inform clinicians' use of this tool, and may contribute to future developments of the AIM Assessment Model. Please know that participation in this study is entirely voluntary, and your choice to take part will neither advantage, nor disadvantage, yourself in any way.

What is the purpose of this research?

This research will satisfy in part, the requirements for an honours degree in psychology. In addition, I wish to discover the opinions of the professionals who use this assessment tool in their work. The findings of this research may be used for academic publications and presentations.

How was I identified and why am I being invited to participate in this research?

This research project requires the participation of clinicians who utilise the AIM3 Assessment Model in their work with adolescents who have presented with harmful sexual behaviour. In searching for organisations that met this criteria, I learned of the work that your organisation does in this particular field, and reached out to see if you would like to participate.

How do I agree to participate in this research?

Your participation in this research is voluntary (it is your choice) and whether or not you choose to participate will neither advantage nor disadvantage you. You are able to withdraw from the study at any time. If you choose to withdraw from the study, then you will be offered the choice between having any data that is identifiable as belonging to you removed or allowing it to continue to be used. However, once the findings have been produced, removal of your data may not be possible.

If you would like to participate in this research, then please complete the online consent form at the end of this information sheet or email me to express your interest. I will then contact you to find a time that will be suitable for us to meet, where you will be able to ask any questions. Should you then decide you wish to proceed, I will provide you with the necessary consent forms and arrange a way to contact potential participants in your organisation.

What will happen in this research?

This research will take the form of a semi-structured interview in which some questions will be asked around your experiences of using the AIM3 to assess and treat harmful sexual behaviour in adolescents. Interviews are estimated to take between 30-60 minutes. Questions will explore the different aspects of the AIM3 and its functionality and how it could be improved.

Following the completion of the interview, the interview will be transcribed an analysed. The participants will be able to review the transcription. Following that the data will be analysed for key themes.

What are the discomforts and risks?

There are no anticipated discomforts nor risk to the participants of this study.

What are the benefits?

This research will benefit myself by fulfilling the requirements of an honours qualification in psychology from AUT university.

It is hoped that this research will have wider benefits as well. There is currently a lack of information around the lived experiences of clinicians' use of the AIM3 assessment model. This research aims to fill that particular gap, and to widen the available literature on this topic. The information gathered will be able to inform those clinicians who work in this field by comparing their experiences with those of their colleagues. Findings from this research may also inform future updates of the AIM Assessment models, and further increase its usability for future practitioners.

How will my organisations privacy be protected?

With your consent, your organisation will be acknowledged as having assisted in this research project. Should you wish for your organisation to remain anonymous, then no mention of its name will be made.

What are the costs of participating in this research?

The cost to you will be the time taken from employees to participate in the interviews. It is estimated that the time for the entire interview process, including signing of consent forms will not exceed one hour.

What opportunity do I have to consider this invitation?

After being invited to participate in this research, you will have one month to reply and to express your interest in taking part.

Will I receive feedback on the results of this research?

Yes, you will receive feedback on this report. At the culmination of this process a brief summary of the findings will be created and sent to you. Once the dissertation itself has been completed, you will also be given the opportunity to request a copy if you so wish.

What do I do if I have concerns about this research?

Any concerns regarding the nature of this project should be notified in the first instance to the Project Supervisor, Dr Liesje Donkin, liesje.donkin@aut.ac.nz, (+649) 921 9999 ext 8164.

Concerns regarding the conduct of the research should be notified to the Executive Secretary of AUTEC, *ethics@aut.ac.nz* , (+649) 921 9999 ext 6038.

Whom do I contact for further information about this research?

Please keep this Information Sheet and a copy of the Consent Form for your future reference. You are also able to contact the research team as follows:

Researcher Contact Details:

Tom Hume, tom.hume@stop.org.nz, 021 2371 306

Project Supervisor Contact Details:

Dr Liesje Donkin

Senior Lecturer/Clinical Psychologists

Liesje.Donkin@aut.ac.nz

(+649) 921 9999 ext 8164

Approved by the Auckland University of Technology Ethics Committee on *22/06/2022*, AUTEC Reference number *22/126*.

Appendix E - Participant Information Sheet

Participant Information Sheet

Date Information Sheet Produced:

09 June 2022.

Project Title

Clinicians lived experience of using the AIM3 Assessment Model to assess harmful sexual behaviour in adolescents.

An Invitation

Kia ora. I am Tom Hume, and I am carrying out this research as part of my qualifications for the honours year of a psychology degree. This requires me to design and carry out a study which can contribute to the scientific literature on a chosen topic. I am interested in discovering how clinicians experience using the AIM3 assessment model in their work. As someone who uses the AIM3 in the course of their work, I would like to invite you take part in this research and to share your views. It is expected that the information gathered in this study will help to further inform clinicians' use of this tool and may contribute to future developments of the AIM Assessment Model. Please know that participation in this study is entirely voluntary, and your choice to take part will neither advantage, nor disadvantage, yourself in any way.

What is the purpose of this research?

This research will satisfy in part, the requirements for an honours degree in psychology. In addition, I wish to discover the opinions of the professionals who use this assessment tool in their work. The findings of this research may be used for academic publications and presentations.

How was I identified and why am I being invited to participate in this research?

This research project requires the participation of clinicians who utilise the AIM3 Assessment Model in their work with adolescents who have presented with harmful sexual behaviour. In order to find clinicians who fit this criteria, permission was sought from agencies that work in this field to invite their staff to participate in interviews for this study.

The clinical manager of these services was then asked to email the invitations to participate to those clinicians who fit the inclusion criteria, along with an instruction to email the researcher if they were ready and willing to participate in this research.

As one of the clinicians identified who works both with the AIM3 and adolescents with harmful sexual behaviour, your experiences are of interest to this research project, and as such you are cordially invited to participate.

How do I agree to participate in this research?

Your participation in this research is voluntary (it is your choice) and whether or not you choose to participate will neither advantage nor disadvantage you and will not impact your employment. You can withdraw from the study at any time. If you choose to withdraw from the study, then you will be offered the choice between having any data that is identifiable as belonging to you removed or allowing it to continue to be used. However, once the findings have been produced, removal of your data may not be possible.

If you would like to participate in this research, then please complete the online consent form at the end of this information sheet or email me to express your interest. I will then contact you to find a time that will be suitable for us to meet, where you will be able to ask any questions. Should you then decide you wish to proceed, I will provide you with the necessary consent forms and arrange a time for us to carry out the interview.

What will happen in this research?

This research will take the form of a semi-structured interview in which some questions will be asked around your experiences of using the AIM3 to assess and treat harmful sexual behaviour in adolescents. Interviews are estimated to take 60 minutes. Questions will explore the different aspects of the AIM3 and its functionality and how it could be improved.

Following the completion of the interview, the interview will be transcribed an analysed. You can review your transcript prior to analysis if you wish to and have two weeks to indicate if any corrections need to be made.

What are the discomforts and risks?

There are no anticipated discomforts nor risk to the participants of this study.

What are the benefits?

This research will benefit myself by fulfilling the requirements of an honours qualification in psychology from AUT university.

It is hoped that this research will have wider benefits as well. There is currently a lack of information around the lived experiences of clinicians' use of the AIM3 assessment model. This research aims to fill that gap, and to widen the available literature on this topic. The information gathered will be able to inform those clinicians who work in this field by comparing their experiences with those of their colleagues. Findings from this research may also inform future updates of the AIM Assessment models, and further increase its usability for future practitioners.

How will my privacy be protected?

Your privacy will be protected by ensuring that no identifiable information is included in the final report. The final data that is produced by yourself will be given either a pseudonym or an interview number in order to protect your identity.

Some demographic information such as gender and ethnicity will be retained for the purpose of statistical analysis.

Your choice to participate is also kept in confidence. No other person will be informed that you have chosen to participate in this study. While it is possible that some other people may discover that you have chosen to participate in this study if you compete the interview at your workplace, no-one else will be aware of the content of the interview, or what you have said in the interview process.

Should you have any further concerns around the degree of privacy that is able to be offered, you are invited to raise those concerns with myself at a time of your choosing.

What are the costs of participating in this research?

The only cost to yourself will be in terms of time required for the interview itself. The amount of time required for the interview is anticipated to be no more than 60 minutes.

What opportunity do I have to consider this invitation?

After being invited to participate in this research, you will have one month to reply and to express your interest in taking part.

Will I receive feedback on the results of this research?

Yes, you will receive feedback on this report. At the culmination of this process a brief summary of the findings will be created and sent to you. Once the dissertation itself has been completed, you will also be given the opportunity to request a copy if you so wish.

What do I do if I have concerns about this research?

Any concerns regarding the nature of this project should be notified in the first instance to the Project Supervisor, Dr Liesje Donkin, liesje.donkin@aut.ac.nz, (+649) 921 9999 ext 8164.

Concerns regarding the conduct of the research should be notified to the Executive Secretary of AUTEC, *ethics@aut.ac.nz* , (+649) 921 9999 ext 6038.

Whom do I contact for further information about this research?

Please keep this Information Sheet and a copy of the Consent Form for your future reference. You are also able to contact the research team as follows:

Researcher Contact Details:

Tom Hume, tom.hume@stop.org.nz, 021 2371 306

Project Supervisor Contact Details:

Dr Liesje Donkin

Senior Lecturer/Clinical Psychologists

Liesje.Donkin@aut.ac.nz

(+649) 921 9999 ext 8164

Approved by the Auckland University of Technology Ethics Committee on *22/06/2022*, AUTEC Reference number *22/126*.

Appendix F – Participant Wanted Advertisement

Participants Wanted

For research study on clinicians' experience of the AIM3

Researchers from AUT university are interested in learning about the lived experiences of clinicians who use the AIM3 Assessment model in their work with adolescents who present with harmful sexual behaviour.

We wish to discover how it is that clinicians find using this tool, and any feedback that they may have on it. Of particular interest is discovering how the AIM3 meets the needs of the professionals who use it, and in what ways it is able to help the adolescents who are assessed and treated with it.

Who do we need?

- Working professionals who use the AIM3 in their practice.
- Experience working with adolescents with harmful sexual behaviour.
- Participants who are willing to be interviewed about their experiences.
- Participants who are not supervised by any of the researchers.

Should you wish to be included as a participant, please contact the researcher Tom Hume, via email at tom.hume@stop.org.nz, or via cellphone on 021 2371 306, to express your interest.

This research is taking place under the supervision of Dr Liesje Donkin, who may be contacted via email at liesje.donkin@aut.ac.nz.

Appendix G – Participant Consent Form

Consent Form

Project title: **Clinicians lived experience of using the AIM3 Assessment Model to assess harmful sexual behaviour in adolescents.**

Project Supervisor: **Dr Liesje Donkin**

Researcher: **Tom Hume**

- O I have read and understood the information provided about this research project in the Information Sheet dated 09 June 2022.
- O I have had an opportunity to ask questions and to have them answered.
- O I understand that notes will be taken during the interviews and that they will also be audio-taped and transcribed.
- O I understand that I will have the opportunity to review my transcript and have two weeks from the date that the transcript was sent to me to correct any errors
- O I understand that taking part in this study is voluntary (my choice) and that I may withdraw from the study at any time without being disadvantaged in any way.
- O I understand that if I withdraw from the study then I will be offered the choice between having any data that is identifiable as belonging to me removed or allowing it to continue to be used. However, once the findings have been produced, removal of my data may not be possible.
- O I agree to take part in this research.
- O I wish to receive a summary of the research findings (please tick one): YesO NoO

Participant's signature: .....

Participant's name: .....

Participant's Contact Details (if appropriate):

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Date:

Approved by the Auckland University of Technology Ethics Committee on 22/06/2022 AUTEC Reference number 22/126.

Note: The Participant should retain a copy of this form.

Appendix H – Oral Consent Protocol

Oral Consent Protocol

Project title: **Clinicians lived experience of using the AIM3 Assessment Model to assess harmful sexual behaviour in adolescents.**

Project Supervisor: **Dr Liesje Donkin**

Researcher: **Tom Hume**

The participant joins the videoconference

O Do you agree to my recording your consent to participate?

If they agree, then the record function will be activated and they will be asked the following:

O Have you read and understood the information provided about this research project in the Information Sheet dated 09 June 2022?

O Do you have any questions about the research?

O Do you understand that notes will be taken during the interviews and that the interview will also be audio-recorded and transcribed?

O Do you understand that taking part in this study is voluntary (your choice) and that you may withdraw from the study at any time without being disadvantaged in any way.?

O Do you understand that if you withdraw from the study then you will be offered the choice between having any data that is identifiable as belonging to you removed or allowing it to continue to be used? However, once the findings have been produced, removal of your data may not be possible.

O Do you agree to take part in this research?

O Do you wish to receive a summary of the research findings? (please tick one): YesO NoO

O Do you want me to send you a copy of the audio recording for this consent? YesO NoO

O Please confirm you name and contact details

Participant's name: .....

Participant's Contact Details (if appropriate):

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I will now turn off the recording of the Consent and then will start a separate recording for the interview.

Approved by the Auckland University of Technology Ethics Committee on 22/06/2022 AUTEC Reference number 22/126.

Note: The Participant should retain a copy of this form.

Appendix I – Organisation Consent Form

Permission for researchers to access organisation school staff / students.

Project title: ***Clinicians lived experience of using the AIM3 Assessment Model to assess harmful sexual behaviour in adolescents.***

Project Supervisor: **Dr Liesje Donkin**

Researcher: **Tom Hume**

- O I have read and understood the information provided about this research project in the Information Sheet dated 09 June 2022.
- O I give permission for the researcher to undertake research within _____
- O I give permission for the researcher to access the employees of _____

Chief Executive's signature: .....

Chief Executive's name: .....

Chief Executive's Contact Details (if appropriate):

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Date:

Approved by the Auckland University of Technology Ethics Committee on 22/06/2022 AUTEC Reference number 22/126.

Note: The head of the organisation should retain a copy of this form.