Durham
Local Safeguarding Children Board

Assessment, Intervention and Moving On (AIM)

Procedures

Endorsed by the LSCB Policy & Procedures Group on 26 April 2007 – updated September 2010

CONTENTS

		Page No.
1	**Inter-Agency Procedures**	4
	Introduction	
	Principles	
	Sexually Harmful Behaviour by Children & Young People	5
	Information Sharing	
	Child Protection & Public Protection Procedures	6
	The Three Routes to an AIM/Information Sharing Meeting	
	Criminal Justice Route	
	Concern Route	8
	Young Person moving/receiving services within County Durham	9
	Role of Lead Agency/Co-Worker	10
	Appendix 1: Referral Form	11
2	**Criteria for Referral**	13
	Criminal Justice Criteria	
	Concern Route Criteria	
	Young Person moving/receiving services within Co Durham Criteria	15
	Appendix 2: Problematic Sexual Behaviours – Guidance for all Managers	16
3	**Information for Good Practice: The AIM Model**	22
	Roles & Tasks	
	AIM Assessment Framework	
	AIM Process	23
	AIM Assessment Report	
	AIM Four Domains of Assessment	
	Offence Specific	24
	Development	25
	Parenting Capacity	26
	Family and Environmental	27
	Using the Model: Strength Continuum	
	Using the Model: Concern Continuum	
	Outcome Grid	28
	Making Adjustments	
	Outcome Matrix	

Appendix 3: AIM Assessment Consent Form 30
Appendix 4: Ten Steps to Assessment 31
Appendix 5: AIM Assessment Report Format 32
Appendix 6: Continuum of Indicators of Strength 33
Appendix 7: Continuum of Indicators of Concern 34
Appendix 8: Bibliography/Further Reading 36

1. Inter-Agency Procedures

Introduction

1.1 These new procedures are intended to provide workers with a guide to the steps to be taken in dealing with children and young people who sexually harm other children. They incorporate recent changes in the law and in national and local guidance concerning this group of young people.

1.2 The revised edition of *Working Together to Safeguard Children* 2006 states that LSCBs and Youth Offending Teams should ensure that there is a clear operational framework in place within which assessment, decision making and case management take place. It stresses that neither child welfare nor criminal justice agencies should embark upon a course of action that has implications for the other without appropriate consultation.

1.3 The purpose of these procedures is to provide a clear operational framework within which the processes of assessment, decision-making and case management can take place. This requires a collaborative approach between child welfare and criminal justice agencies.

1.4 In order to facilitate this collaborative approach there needs to be some consensus on the philosophy of intervention. Research has shown that work with children and young people who abuse – including those who present with sexually harmful behaviours – should recognise that such children are likely to have considerable needs themselves, and also that they may pose a significant risk of harm to other children. Evidence suggests that children who harm others may have suffered considerable disruption in their lives, been exposed to violence within the family, may have witnessed or been subject to physical or sexual abuse, have problems in their educational development, and may have committed other offences. There is often huge potential for change and thus it is essential that a system is in place that identifies those at highest risk of re-offending in order to target limited resources effectively.

Working Together to Safeguard Children 2006

Principles

1.5 The complex nature of the problem requires a co-ordinated multi-disciplinary approach, which addresses both child protection and criminal justice issues.

1.6 The needs of the children and young people who sexually harm should be considered separately from the needs of their victims.

1.7 Children and young people who sexually harm others are in need of help and are entitled to appropriate services.

1.8 The reasons why young people sexually harm are multi-faceted and to explore this further a full risk assessment and an assessment of need must be carried out in every case.

1.9 The primary objectives of intervention must remain at all times the protection of victims and potential victims and the avoidance of any repetition of the sexually harmful behaviour.

1.10 The young person will be held accountable for his or her behaviour.

1.11 Wherever possible, young people who sexually harm have a right to be consulted and involved in all matters and decisions which affect their lives. Their parents / carers have a right to information, respect and participation in matters that concern their family / children in their care.

Sexually Harmful Behaviour by Children & Young People

1.12 Sexually harmful behaviour by young people includes a wide range of behaviours, in a variety of situations and can be defined as:

"A minor of any age who commits a sexual act with a person of any age:

- against the victim's will;
- without consent;
- in an aggressive/exploitative manner.

Contact behaviours: touching, rubbing, disrobing, frottage, sucking or penetrating – penile or with an object (vaginal or anal), sexual behaviours with animals.

Non-contact behaviours: exhibitionism, voyeurism, obscene communication, verbal or written sexual harassment or denigration" (Ryan, 1991).

1.13 Work with children and young people who sexually abuse requires a co-ordinated, multi-agency response. It is important that all agencies work closely together to enhance communication and ensure consistency of approach. The welfare of children is paramount and the primary objective is the prevention of future victims and perpetrators.

Information Sharing

1.14 Matters of information sharing, confidentiality and data protection are covered in the Information Sharing Arrangements for County Durham Children's Trust (2009).

Child Protection Procedures & Public Protection Procedures

1.15 Nothing in these procedures is intended to replace any requirements of either public protection or child protection procedures. Rather, these procedures are seen as complimentary. It may be that it is possible, in particular cases, to amalgamate some meetings. If this is possible, without being to the detriment of the tasks of any meeting, then this should be encouraged.

The Three Routes to an AIM Assessment/Information Sharing Meeting

1.16 The need to develop multi-agency risk management and care plans is not just restricted to those who have committed criminal offences. Rather, there is often a need to intervene before the young person's behaviour requires the intervention of the criminal justice system or when the criminal justice system is not seen as the most appropriate method of dealing with sexually harmful behaviour. Many young people with histories of sexually harmful behaviour are placed, by other Local Authorities, within County Durham or they may receive services from agencies within County Durham. It is equally important that these young people receive the same level of multi-agency response as any other young person and that risk management plans are as equally robust.

1.17 Consequently, there are three routes which would lead to the convening of an AIM Assessment/Information Sharing Meeting. These are the "Criminal Justice Route", the "Concern Route" and the "Young Person Moving into/Receiving Services Within County Durham Route".

Criminal Justice Route

1.18 When a child or young person (over the age of 10) is interviewed by the Police for an alleged offence of sexually harmful behaviour and a decision taken as to the progress of the case (Reprimand/Final Warning or Charge only. A referral will be made by the Police to Social Care Direct (SCD) using the PROSEC 83 referral form then SCD will take full details and contact the relevant CDYOS office within 24 hours of receipt of the referral.

1.19 This does not apply to a decision to take No Further Action. If a Police Officer has concerns about a young person for whom the decision is to take no further action, then they should refer the case via the "Concern Route".

1.20 Social Care Direct will check SSID and formally refer the concern to the locality Children in Need team. The Children in Need team manager will liaise with locality CDYOS. Where available the manager to ensure that information is gathered from SaSSMT records to share at the AIM meeting.

1.21 The relevant CDYOS Service Manager North/South will call, administer and chair an AIM/Information Exchange meeting. This meeting will be held within five working days of the referral being received from the Police. The agencies to be invited to this meeting **must** include:

- CDYOS relevant staff including Complex Case Manager for PPU (Public Protection Unit).
- Safeguarding & Specialist Services (Team Manager/Senior Practitioner).
- Representative of Access and Inclusion Service
- Representative from School / College (college if over 16 and in attendance)
- Police (Usually Officer in Charge of the case).
- Senior Nurse Child Protection.
- CAMHS / STEPS. (Full Circle)
- Other agencies should be invited if appropriate.

1.22 The purpose of this meeting will be for all agencies to share relevant information and to develop an interim risk management plan/care plan. In addition, the meeting will decide whether an AIM assessment is considered appropriate. An assessment can still be undertaken if the young person is denying the offence(s) or refusing to co-operate. In these circumstances, the assessment will gather the best available information from all agencies/professionals.

1.23 If a full AIM assessment is considered appropriate, then the lead agency for production of the assessment will be CDYOS, unless the young person is already an active case to the Safeguarding & Specialist Services This will be undertaken jointly with a social worker appointed by Safeguarding & Specialist Services or CDYOS if Safeguarding & Specialist Services are the lead agency. The assessment will be completed within 20 working days and will report back to a reconvened meeting of the group. Again, this meeting will be chaired and administered by CDYOS. The child and their parent(s)/carer(s) **must** be invited to this meeting.

1.24 The purpose of the second meeting will be to agree the assessment and to develop a multi-agency risk management/care plan for the young person. Thereafter, the process will follow the normal CDYOS and Safeguarding & Specialist Services case review processes.

1.25 Consideration must always be given at both meeting of the following:

- referral to MAPPA / potentially dangerous persons procedure, via MAPPA co-ordinator

1.26 If the young person is attending school or other education resource, information must be shared with the High Risk of Harm Panel. The Access & Inclusion will take responsibility for this.

Concern Route

1.27 If any worker from any agency considers that the behaviour of any young person (of any age) is cause for concern (in terms of sexually harmful behaviour) then they must make a referral to Social Care Direct following the appropriate referral process. This is subject to existing local protocols in relation to gaining consent to sharing information. Social Care Direct will take full details and if the child or young person is (a) **not** currently receiving a service from Safeguarding & Specialist Services and (b) meets the criteria for an AIM/Information Exchange meeting they will inform CDYOS ensuring that the referrer is made aware of the process. If the referred young person is receiving a service from Safeguarding & Specialist Services then Social Care Direct will inform the allocated worker from Safeguarding & Specialist Services and CDYOS within 24 hours.

1.28 The CDYOS Service Manager North/South will discuss the case with the referrer and, using the "Criteria for Referral" agree whether the case is appropriate for an AIM/Information Exchange Meeting to be called. If it is considered appropriate, then the CDYOS Service Manager North South will call, administer and chair the meeting. The AIM/Information Exchange Meeting will be held within five working days of the referral being received.

1.29 The role of the meeting is as described above. Should an AIM assessment be considered appropriate then the lead agency for completion of the assessment will be Safeguarding & Specialist Services, unless the young person is an active case to CDYOS. CDYOS will appoint a co-worker to assist the assessment or vice versa if the lead agency is CDYOS. The assessment will be completed according to timescales set out for specific circumstances, and will report back to a reconvened meeting of the group. The CDYOS should be consulted in each case for timescales. This second meeting will be administered and chaired by Safeguarding & Specialist Services (Team Manager). The role of this second meeting is as above. The young person and their parent(s)/carer(s) **must** be invited to this meeting. The AIM Assessment is not to be viewed as additional to Children In Need Core Assessment or ASSET assessment and should not be seen as separate to child protection procedures. It should not be necessary to convene separate meetings.

Young Person moving into/receiving services within County Durham Route

1.30 If any agency receives information or becomes aware that a young person with a history of sexually harmful behaviour has moved to an address within County Durham, or is receiving services from agencies within County Durham, they must make a referral to the relevant CDYOS office using the appropriate referral form (Appendix 1). The CDYOS Service Manager North/South for that office will discuss the case with the referrer and, using the "Criteria for Referral" will agree whether the case is appropriate for an AIM/Information Exchange Meeting to be called. If it is considered appropriate for such a meeting to be called, then it will be called, administered and chaired by CDYOS. The meeting must take place within five working days of the referral being received.

1.31The agencies to be invited to this meeting **must** include:

- CDYOS relevant staff including Complex Case Manager for PPU (Public Protection Unit).
- Safeguarding & Specialist Services (Team Manager/Senior Practitioner).
- Representative of Access and Inclusion Service: (Access Service Manager or Pupil Casework Officer)
- Representative from School / College.
- Police (usually Officer in Charge of the case).
- Senior Nurse Child Protection.
- CAMHS / STEPS.
- Representatives from "Home" Safeguarding & Specialist Services.
- Care Provider / Independent Fostering Agency.
- Other agencies should be invited if appropriate.

1.32 The purpose of the AIM/Information Exchange Meeting in these circumstances will be to exchange relevant information between all agencies, develop an interim risk management/care plan, and to decide on the appropriateness of a full AIM assessment. The decision as to whether or not a full AIM assessment will be undertaken should be informed by other assessments (if available) that may have been undertaken by the "Home" agencies. If an AIM assessment is considered appropriate, then the meeting will need to decide which agency will be the lead agency for the assessment and the chairing/administering of future meetings. It will be normal for one of the "Home" agencies to take the lead role in the assessment. The meeting will also need to decide which agency will take the supporting role in the assessment.

1.33 Consideration should always be given to referral to MAPPA / Potential Dangerous Persons Procedure.

1.34 The assessment will be completed within 20 working days and will report back to a reconvened meeting (as above).

Role of Lead Agency/Co-worker

1.35 The 'Lead Agency' is responsible for:

- obtaining consent from the young person and family/carers to complete the AIM assessment;
- gathering and collating relevant information;
- liaising with other professionals;
- interviewing the young person and family/carers;
- completing the AIM assessment and ensuring its distribution.

1.36 The co-worker assists with the all of the above apart from obtaining consent and with distribution of the assessment.

1.37 For contact details of relevant agencies/officers refer to the LSCB Child Protection Procedures Appendix 4.

Appendix 1

Website http://www.cdves.org.uk

AIM Referral

Name of person causing concern:

D.O.B:

Current Address:

Referring Agency and Title:

Contact Number:

Reason for Referral
(Outline concerns and risk issues and include and other relevant information).

Please provide names and addresses of people from agencies you feel would have relevant knowledge regarding the young person:

Name	Full Address	Contact No:

Managers decision and action to be taken:

(Detail even if no action is to be taken and note reasons why)

2. Criteria for Referral

2.1 The three routes to an AIM assessment/Information Sharing meeting are:

(a) Criminal Justice Route
(b) Concern Route
(c) Young Person Moving Into/Receiving Services Within County Durham

2.2 The following criteria should be considered for each route prior to a referral being made:

<u>Criminal Justice Route Criteria</u>

2.3 A child or young person under the age of 18 years who has committed sexual abuse against children, adolescents and adults, within the family, outside the family or against a stranger.

2.4 An AIM referral and assessment will apply to:

- young people who admit the abuse but whose behaviour is deemed so serious at the onset that the Police make an immediate decision to charge.

- young people who admit the offence but have previous offences and are therefore not eligible for the Final Warning and Reprimand Scheme and are immediately charged.

- young people who admit the offence and are likely to receive a Reprimand or Final Warning. The AIM assessment will form part of the Final Warning assessment that is undertaken before the warning is formally delivered.

- young people who have been subject to no further action following an allegation of sexually harmful behaviour may be considered as appropriate for referral via the concern route.

<u>Concern Route Criteria</u>

2.5 These behaviours tend to go beyond normal exploration and experimentation generating concern that indicates a referral. The list is not exhaustive and any sexual behaviour that is considered inappropriate, after discussion with line manager should be considered for referral.

2.6 Behaviour which would cause concern may include:

- pre-occupation with sexual matters.
- use of sexually explicit language and jokes with a theme of humiliation and targeting of a specific person.
- young person tending to be socially involved with younger children (requires judgement).
- repeated and explicit sexual conversations especially with younger children.
- pre-occupation with pornography especially with violent or sadistic theme.
- pre-occupation with masturbation.
- excessive masturbation either in private or in public.
- non-contact behaviours such as obscene communication.

2.7 **There should be a number of repeated incidents, however minor as opposed to a single incident**. It must also be remembered that concerns must be regarding behaviour that is considered to be sexually harmful to others.

2.8 The young person may present with inappropriate behaviour/s in a variety of settings including:

- school
- hospital
- home
- youth clubs
- after-school club
- residential care
- foster care
- external service providers

2.9 For Operational Managers, further guidance to assist with the decision making process in respect of appropriate and inappropriate sexual behaviour can be located in Appendix 2.

Young person moving into/receiving services within County Durham

2.10 The placement may be within:

- private foster care placements.
- private residential placements.
- Durham Local Authority residential homes.
- extended family or friends.

2.11 Young people with the following need to be referred to CDYES:

- If the young person has received a Final Warning or Reprimand for sexual offence/s. The offences can be either current or historical.
- If the young person has been charged and convicted of a sexual offence/s. The offences can be either current or historical.
- If the young person is subject to Police Bail (section 47.3 under The Bail Act) following an allegation of sexually harmful behaviour perpetrated against an adult or child.
- If a young person's sexual behaviour has caused concern by other professionals or carers but has not resulted in any criminal proceedings taking place.

Appendix 2

PROBLEMATIC SEXUAL BEHAVIOURS

Guidance for all Managers

This information should be considered by all managers on receipt of a referral under the concern route criteria of the AIM protocol.

1. AGE APPROPRIATE SEXUAL BEHAVIOURS

Sexuality is a part of every human regardless of age. Below is a partial list of healthy sexual behaviours in children (Wurtele & Miller-Perrin 1992, Johnson 1993):

Preschool age (0-5 yrs)

Common features include: Sexual language relating to differences in body parts, bathroom talk, pregnancy and birth. Infants may touch their genitals as it achieves a pleasurable sensation. This behaviour can be random and sporadic. They tend to be disinhibited where they show their genitals to others or are interested in other's bodies. They begin to imitate life around them and this can lead to copying adult behaviour either out of curiosity or because of the reactions they get from those around them. Games such as 'mummies and daddies' and 'doctors and nurses' are prevalent at this stage.

School age children (5-7 yrs)

These children have more access to peers and more inter-active sexual exploration can take place both with the same gender and opposite gender peers. This is the questioning stage and children will be fascinated with bodies and sexual behaviour. Overt displays of affection such as kissing can cause great hilarity and expressions of disgust. Children may also find great pleasure in telling 'rude' jokes some of which they do not understand but they like the reactions particularly of the adults around them. Some sexual questions begin and concepts of love and affection begin to develop, evolving into behaviours and questions that continue into later childhood.

Pre-adolescent children (10-12 yrs) through to adolescence

10-12 yrs: This age group tends to be more focussed on social relationships and expect and begin to experience clearer sexual feelings. They may become more absorbed with masturbation that will develop clearer patterns in adolescence. More information sharing takes place comparing bodies. At this stage their bodies are entering puberty and hormonal changes are creating a range of physical and emotional sensations.

12 years onwards: By puberty sexual organs are clearly developing and more routine masturbation takes place for girls and especially for boys. As children move deeper into adolescence, romance, intimacy and sexual issues are driven by physical feelings, emotions and social expectations. Dating and more intense sexual relationships begin moving from thinking about and discussing romance to kissing, petting and in many cases sexual intercourse.

2. PROBLEMATIC SEXUAL BEHAVIOURS

Johnson (1999) offers the following characteristics of problematic sexual behaviour in children that will alert us to possible problems with their sexual development and merit further assessment. The characteristics at the beginning of the list are less worrying than those towards the end.

- The children engaged in the sexual behaviours do not have an ongoing mutual play relationship.

- Sexual behaviours that are engaged in by different ages or developmental levels.

- Sexual behaviours that are out of balance with other aspects of the child's life and interests.

- Children who seem to have too much knowledge about sexuality and behave in ways more consistent with adult sexual expression.

- Sexual behaviours that are significantly different than those of other children the same age.

- Sexual behaviours that continue despite consistent and clear messages to stop.

- Children who appear unable to stop themselves from participating in sexual activities.

- Children's sexual behaviours that elicit complaints from other and /or adversely affect other children.

- Children's behaviours that are directed at adults who feel uncomfortable receiving them.

- Children (over the age of 4) who do not understand their rights or the rights of others in relation to sexual contact.

- Sexual behaviours that progress in frequency, intensity, or intrusiveness over time.

- When fear, anxiety, deep shame, or intense guilt is associated with the sexual behaviours.

- Children who engage in extensive, persistent mutually agreed upon adult-type behaviours with other children.

- Children who manually stimulate or have oral or oral genital contact with animals.

- Children who sexualise non-sexual things or interactions with others, or relationships.

- Sexual behaviour that causes physical and /or emotional pain or discomfort to self or others.

- Children who use sex to hurt others.

- When verbal and /or physical expressions of anger precede, follow or accompany the sexual behaviour.

- Children who use distorted logic to justify their sexual actions.

- When coercion, force, bribery, manipulation or threats are associated with sexual behaviours.

Johnson (Gil and Johnson, 1993) identifies definable groups of children based on a continuum of the level of sexual disturbance. Each group includes a wide range of children, with some borderline between groups, or those who move between groups over a period of time.

In summary these groups are:

- **Group One - Normal sexual exploration (See 1: Normal sexual behaviours).**

- **Group Two - Children who are sexually reactive**

This group of children display more sexual behaviour than children with healthy sexual development. Their focus on sexual behaviour is out of balance. Most of the children in this group will have been sexually, physically and/or emotionally abused and those who haven't been directly abused will have been exposed to sexually overwhelming environments. These children are likely to be confused and overwhelmed by sex and sexuality and this confusion leads to more frequent and visible sexual behaviours as they are unable to absorb or fit their experiences into their developing sexuality.

Behaviours that characterise this group of children are solitary sexual behaviours such as excessive masturbation and sexual behaviour with other children and sometimes adults. This type of behaviour is often not in the child's control and is a response to overwhelming feelings that the child cannot control. The child does not use coercion or force or attempt to maintain secrecy and any harm or discomfort to others is not intentional. The sexual behaviours of these children appear compulsive and are often linked with deep shame, guilt and a pervasive anxiety. Many children in this group may be suffering Post Traumatic Stress Disorder caused by their own abuse.

- **Group Three - Extensive Mutual Sexual Behaviours**

Children in this group are typically children who have suffered physical, sexual and emotional abuse and neglect. Many will have been physically and emotionally abandoned and many will be in substitute care. They have learnt that adults hurt them and are distrustful of relationships with adults. They frequently associate sex with love and caring and they look to other children to help meet their emotional needs through sexual behaviour. These children do not use force or coercion but find other similar lonely and abused children to engage in a full range of sexual behaviours with. The behaviour gives them, if only momentarily, a sense of being close to someone and to relieve their feelings of despair.

Children in this group do not show emotion about their sexual behaviour unlike children in group two who feel shame and guilt and those in group three show anger and aggression. They seem to have a matter of fact attitude towards acting sexually with other children. These children will have started in group two as sexually reactive children and have begun to use sex as a coping mechanism. They may move into group four.

- **Group Four - Children Who Sexually Molest**

Children in this group show sexual behaviours, which are beyond developmentally appropriate behaviours. They may engage in a full range of adult type behaviours. In a similar way to children in group two they are pre occupied with sex and sexual behaviour and there is an impulsive and aggressive quality to their behaviour. Anger, rage, loneliness and fear often characterise their feelings around sexual behaviour.

These children sometimes use physical aggression toward their victims and will always use coercion to seek out children who are vulnerable to bribes, being fooled or to force or threats. These children will always be in a position of power over their victims whether through size, age, status, intellectual ability etc. Theses children often display behavioural problems, have few friends and few interests. They have difficulties with impulse control and few coping skills. Their sexual behaviour increases over time to form a pattern. They rarely ever show any empathy for their victims.

Children who molest may have been sexually abused. Virtually all will have sexual abuse in their families, will have suffered emotional abuse and probably physical abuse and will have witnessed extreme physical violence between their primary care givers. These children are at a high risk for continuing and escalating their sexual behaviours.

The following are definitions frequently related to sexually harmful behaviour.

COERCION

- Use of nurture, care, love and friendship followed by threat of rejection
- Victim groomed to expect nurture then threatened with withdrawal if not compliant
- Threats of force or violence even if the threats are not carried out.
- Victim is offered gifts, favours or friendship as incentive to behave as requested.
- Desensitisation to touch and overcoming physical boundaries via use of games, tickling and 'accidental' intimate touches during games.
- Use of force e.g. restraining and holding.

CONSENT

Consent is:

- Based upon informed choice.
- Active not passive
- Possible only where there is equal power.
- Based on knowledge of what is socially acceptable, the right to say "No", what alternatives exist, the right not to consent.
- Responding to changes in the behaviour and language of partner i.e. partner says 'No'.

EQUALITY

- Equality refers to aspects such as size, age, intelligence, status, knowledge and emotional maturity.
- The victim is five years or younger than the alleged perpetrator. (In some circumstances 2 years younger).
- There are marked or noticeable differences between the individuals physical development e.g. one is much smaller.
- One person is in a position of authority over the other i.e. baby-sitting.
- One person may have learning difficulty or other form of disability.
- One person may have much more sexual knowledge or experience.

CONSENT

Consent is:

- based upon informed choice.
- active not passive.
- possible only where there is equal power.
- based on knowledge of what is socially acceptable, the right to say “no”, what alternatives exist, the right not to consent.
- responding to changes in the behaviour and language of partner, i.e. partner says “no”.

3. Information for Good Practice: The AIM Model

Roles and Tasks (YES and Safeguarding & Specialist Services)

3.1 It is essential that only people trained in the use of the AIM model undertake assessments, or at least one co-worker should be trained in its use.

3.2 If a YESO acts as the 'appropriate adult' in a PACE (Police and Criminal Evidence) interview of a child or young person, it is not appropriate for that worker to subsequently undertake the assessment.

3.3 Where there is an immediate decision to charge the child or young person, the YESO who undertakes the AIM assessment will also complete the pre-sentence report.

3.4 If the victim has a Social Worker, s/he must not be directly involved in the assessment.

AIM Assessment Framework

3.5 The AIM assessment framework and procedures are designed to assist professionals in assessing children and young people who have committed a sexual assault or undertaken sexually harmful behaviour.

3.6 The framework adopts a partnership approach, which is essential for the development of effective practice. It incorporates the concepts of the DoH 'Framework for the Assessment of Children in Need and their Families' used by Safeguarding & Specialist Services and other agencies, as well as the 'ASSET' framework used by Youth Engagement Service Teams. Its use is intended to fit within the timescales agreed by the criminal justice and child welfare systems.

3.7 The AIM initial assessment model is the first stage in gathering and analysing Information, which will assist practitioners to consider what further assessments and interventions might be required to support the young person and their parents/carers. It recognises the importance of parents and family support for the child or young person throughout, therefore adopts a holistic approach to assessing the young person and their family.

3.8 The framework provides a model to assist all professionals within Safeguarding & Specialist Services, YES teams and other agencies or services, who have contact with children and young people, to conduct an initial assessment in order to:

- identify potential risk of re-offending;
- in child protection terms, identify risk to either the young person or their actual/potential victim(s);
- identify the young person's needs;
- assess the young person's motivation and capacity to engage in services and plans;

- identify the capacity of the parents/carers to support the young person;
- suggest priorities for initial response;
- consider referral into the Public Protection system.

3.9 In assessing the distinction between behaviour that is experimental in nature and behaviour that is abusive, the notions of consent, power, equality and authority need to be considered by the assessors.

3.10 It may be that the child or young person cannot remain living with their family during the assessment and/or treatment process as they may be considered a risk to other children in the household.

3.11 The model does not make decisions for assessors but will support decision-making by focusing on strengths and concerns.

AIM Process

3.12 Where the young person and/or their families have a different preferred language from the assessors, or there are mental health issues, learning disabilities or physical health issues, arrangements must be made to ensure equal access to service provision, e.g. interpretation or advocacy services.

3.13 The young person and their parent/carers must be asked by the assessors to sign a consent form agreeing to participate in the process. If consent is not given, but concern remains, the assessment must continue drawing on any existing information and involving the same relevant professionals.

AIM Assessment Report

3.14 The assessment report will comment upon whether the child or young person poses a risk, either to children currently identified, or to others, whether children or adults and consider whether referral into the Public Protection system is necessary.

3.15 The assessors will share the report with the young person and their parents and note any areas of disagreement before sharing it with other professionals.

AIM Four Domains of Assessment

3.16 The AIM model is based on four domains of assessment.

3.17 The questions presented are not exhaustive or to be used as a checklist. They are suggestions for gathering the information needed by the assessors in order to inform the model's continuum indicators of strengths and concerns. These will inform where the young person should be placed in the matrix.

Offence Specific

- **Offending History**

  - Has the young person committed previous offences (sexual or non-sexual)?
  - If yes, did this result in a conviction, caution, reprimand or final warning?
  - If no further action, state the reason why?

- **Nature of the sexual offence/s**

  - Was the offence an isolated incident or part of a series of offending?
  - Did the behaviour escalate over time?
  - Did the offence involve penetration?
  - Was the offence of experimental or peer influenced nature?

- **Attitude to victim**

  - Did the young person know their victim?
  - Does the young person show any feelings of remorse or guilt?
  - Does the young person accept any responsibility for the offence?

- **Offence planning**

  - Did the offence involve detailed and careful planning?
  - Did the young person prepare ("groom") the victims over time?
  - Did the young person have persistent thoughts about the offence before it occurred?

- **Violence**

  - Has the young person a history of violence or aggressive behaviours?
  - Did the offence involve violence or sadistic behaviours?

- **Previous professional involvement**

  - Has the young person received help for previous sexual behaviour in the past?
  - If yes what were the outcomes of previous assessments /treatment?
  - Did the young person complete or drop out of treatment?
  - If they dropped out of treatment, at what stage and for what reason?

- **Motivation to engage with professionals**

  - Does the young person consider that their behaviour is problematic / unacceptable ?
  - Is the young person worried that the problem may impact on their future?
  - Does the young person believe that they might benefit from professional intervention?
  - Is the young person willing to accept professional help?
  - Does the young person have a history of absconding, failing appointments or non-compliance?

Developmental

- **Resilience factors**

  - How isolated/sociable is the young person?
  - Does the young person have goals and ambitions?
  - Is the young person involved in social activities and hobbies?
  - Can the young person express their feelings adequately?
  - Does the young person communicate reasonably?
  - Does the young person have positive reports from school or employers?
  - Is the young person able to understand the possible consequences of their behaviour?

- **Health Issues**

  - Does the young person have any history of serious physical ill-health?
  - Has the young person ever suffered depression or any other form of mental ill-health?
  - Have they ever been diagnosed as suffering a psychiatric illness?
  - Does the young person have any difficulties in concentration, learning or communication?
  - Any support systems in place to address health issues?

- **Experienced physical/sexual/emotional abuse or neglect**

  - Has the young person been subjected to any form of abuse?
  - If yes, what was the nature of the abuse?
  - How long did it continue?
  - Who perpetrated the abuse?
  - How old was the young person when the abuse began?
  - What impact did the abuse appear to have on the young person?
  - Has the young person suffered abuse due to racial, cultural, religious reasons or because of disability?

- **Witnessed domestic abuse**

  - If the young person has witnessed domestic abuse within the home:
  - Who was involved?
  - What was the nature of the domestic abuse?
  - How long did it continue?
  - How frequently did it occur?
  - How old was the young person when the domestic abuse commenced?
  - Does the domestic abuse still occur?

- **Quality of the young person's early life experiences**

  - What attachments did the young person form with carers?
  - Has the young person experienced consistent 'good enough' care?
  - Has the young person experienced harsh or inconsistent care?
  - Has the young person been in substitute care? If so, why, when and for how long?
  - Has the young person experienced a supportive community environment?

➢ **Behaviour problems**

- Does the young person exhibit a range of problem behaviours?
- What was/is the nature of the behaviours?
- When did they commence/stop?
- Where did they occur?
- How were they dealt with?
- Has the young person ever been diagnosed with a conduct disorder or impulsive or compulsive behaviour traits?
- Does the young person regularly engage in substance abuse?

➢ **Sexuality**

- Has the young person's sexual development been appropriate (including sexual education, puberty and sexual experiences)?
- Is the young person confused about their sexual identity?
- Does the young person have persistent thoughts about abusive sexual behaviours?

Parenting Capacity

➢ **Level of functioning**

- Does family function in a positive/caring manner or is it chaotic with high levels of dysfunction?
- Is there a history of abuse in the family/extended family?
- Can parents/carers demonstrate appropriate support for the young person?
- Do the parents have a positive social network?

➢ **Attitudes and beliefs**

- Do parents/carers accept that the offence occurred?
- Do they accept that the young person was responsible for the offence?
- Do they express a degree of concern for the victim?
- Do they have positive protective attitudes?
- Do they believe that professional intervention may benefit the young person?
- Do they accept they have a role to play in further intervention?

➢ **Sexual boundaries**

- Are parental/carers attitudes towards sexual abuse reasonable?
- Do they employ appropriate boundaries in the home, e.g. regarding privacy?
- Can they communicate positively about sexual matters?
- Are there additional or frequent periods of crisis or trauma in the family?

Family and Environmental

- **Opportunity for further offending**

    - How easily will the young person gain access to the victim or other potential victims?
    - Are plans for the supervision of the young person reasonable and responsible?
    - Are those who will act in a supervisory capacity able to appropriately exercise this role?
    - Is the young person willing to comply with supervision/management plans?

- **Community support**

    - Are those in the community who 'need to know' aware of the offence and management plans? E.g. teachers
    - Is there support for the young person in the community? E.g. teachers, friends etc
    - Is there support for the parents in the community?
    - Is the young person or family likely to be at risk of aggressive or retributive actions?

Using the Model: Strength Continuum

3.18 If two or more items in medium strength column (B) are identified then the total for the high strength column should be increased by one. See Appendix 6

3.19 Once the above adjustments have been made the total number of factors in the high and low columns are plotted on the outcome grid and the quadrant into which most of the factors fall is identified.

Using the Model: Concern Continuum

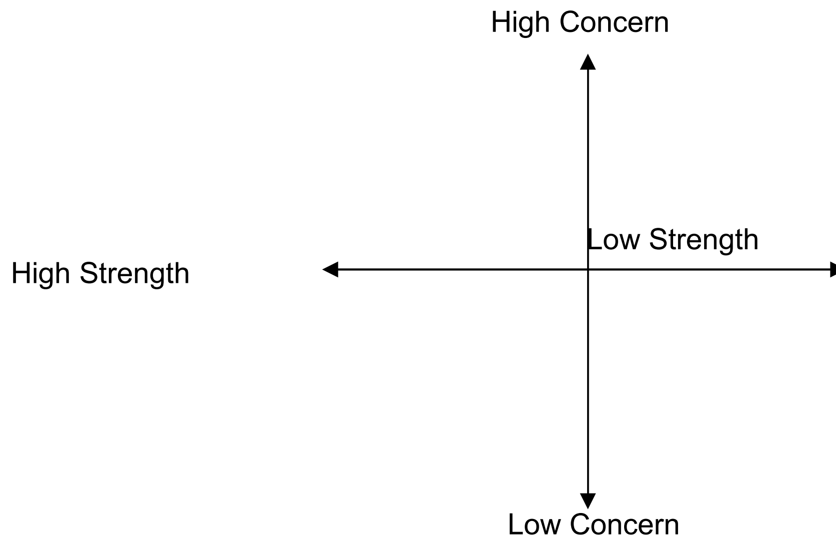
3.20 Any factors that apply to the abusive behaviour, the young person, his/her family or environment should be checked on the continuum and the number of factors in each column calculated. If items 1, 2 or 3 in the high concern column (A) are identified then the young person should be considered high concern regardless of other items that are checked. See Appendix 7.

3.21 If two are more items in medium concern column (B) are identified then the total for the high concern column should be increased by one. Similarly if more than three items in the medium column (C) are identified then the total of the high concern column should be further increased by one.

3.22 Once the above adjustments have been made, consideration is given to whether the young person's overall scores fall predominantly in the high or low concern columns.

Outcome Grid

3.23 Plot the outcomes of the continuums on the grid below



Making Adjustments

3.24 The result of this process will give an indication as to whether the young person concerned has high concerns/high strengths; high concerns/low strengths; low concerns/high strengths or low concerns/low strengths low strengths/low concerns. The initial outcome must then be adjusted according to:

3.25 The outcome of the parent/carer initial assessment outcome that – An overall high score result would increase the strength outcome for the young person and vice versa. So that for example in cases where the young person's outcome suggests a balance or almost a balance between high and low strength the result of the parents carer assessment would be the factor tips the balance.

3.26 The nature of the abusive behaviour – It must be acknowledged that risk = the likelihood of further abusive behaviour + the dangerousness of the behaviour. The risk assessment so far has focussed primarily on the former element and some adjustment may be necessary regarding the nature of the abusive behaviour exhibited. If, for example, the abuse committed by the young person involved violence or activities that resulted in severe emotional or physical harm to his victim/s then the level of concern must be increased.

The Outcome Matrix

3.27 The following matrix provides an indication of the needs of the young person and the type of further interventions that may be helpful. The matrix is the third stage of analysis in which the picture gained by use of the continuums and the necessary adjustments is further refined by using the outcome matrix to consider case management options.

3.28 The grid identifies the most likely recommendation for those young people in the criminal justice system, although each case should be viewed individually and recommendation made primarily on the basis of the needs of the individual, known victims and concerns for community safety.

Individuals in this category are likely to include the most worrying of young people. They are likely to have significant needs across a range of areas. They are likely to need high levels of specialist intensive treatment and high needs for management and supervision

These young people are likely to need a more detailed specialist, comprehensive assessment

Young people in this category may have high levels of need but may be managed safely in the community. They may require placement away from home. Their needs are likely to require the involvement of a range of disciplines, including specialist workers, carers, family workers, teachers and other support staff

High concern **Low strengths** (Prosecution)	**High concern** **High strengths** (Prosecution/ Final Warning)
Low concern **Low strengths** (Final Warning)	**High strengths** **Low concern** (Reprimand)

Young people in this category are likely to require help in meeting a range of needs and may require a full needs led assessment. Interventions may include involvement in a brief programme of education regarding healthy sexual behaviours. Parents/carers are likely to require support. Emphasis may need to be placed on increasing resilience factors, family work, and family support

Young people in this category may require limited intervention. They can usually remain at home and parents/carers are often the best people to help the young person with any information, advice or behavioural change required. Parents may need professional support and information. Review after three months

APPENDIX 3

AIM ASSESSMENT CONSENT FORM

You will have received information explaining to you what an AIM assessment is and why we want to do one.

The assessment is a way of gathering and understanding information which will assist us to help you in the best possible way.

We request your permission to contact other agencies and professionals to seek information from them about you and your family.

By signing the form you are giving us your consent to contact them for the purpose of the assessment. Your consent will not be used for any other purpose.

In the event of no consent it might still be necessary for us to contact other professionals. The decision do this will be based on whether the circumstances justify this, taking into account what is being sort or disclosed, and for what purposes. The law recognises that the sharing of information without consent may be justified in the public interest to prevent harm to others.

I / we agree to Safeguarding & Specialist Services and Youth Engagement Service workers contacting other agencies and professionals to seek and share information to enable them to complete an AIM assessment.

Signed___________________________ Young person __________date

Signed___________________________ Parents/carers _________ date

APPENDIX 4

TEN STEPS TO ASSESSMENT

1. The lead agency will identify the assessors.

2. Watch the video recorded interview or read the victim statement where they exist.

3. Listen to the PACE interview or any account given by the young person regarding their behaviour.

4. Read files and collate any information held by other professionals.

5. Use the AIM assessment model to identify at this stage what is known/not known.

6. Plan the interview with the young person and the parents/carers. Engage them in a process that prepares them for a helping service to be received.

7. Interview the young person but not prior to any Police interview.

8. Interview the parents/carers.

9. Use the Assessment Framework to draw conclusions around the young person's risk, strengths, needs, capacity to change and the degree of support parents/carers can provide.

10. Take the completed report to the multi-agency meeting where roles, tasks and resources can be identified and agreed. Set a review date.

APPENDIX 5

AIM ASSESSMENT REPORT SUGGESTED FORMAT

In writing your findings into a report format it is suggested that the headings below be used to organise your thinking and analysis. They should be preceded by the young person's personal details and concluded with a summary and recommendation section.

Title - AIM Assessment Report

1. Child/young person's basic details e.g. Name, date of birth, address, parents/carers, siblings, ethnicity

2. School/college/employer

3. Offence specific issues

4. Child/young person developmental issues

5. Parenting capacity

6. Family and environmental issues

7. Consideration for referral into the public protection system

8. Conclusion and analysis (ref: outcome grid)

9. Recommendations

10. Parents/carers and young person views of the assessment and recommendations

11. Title and signature of report author

12. Endorsement by line manager

APPENDIX 6

CONTINUUM OF INDICATORS OF STRENGTH

	High strengths		**Medium Strengths**		**Low Strengths (High Need)**
	A		**B**		**C**
1	Young person has the ability to reflect and understand consequences of offence behaviour	1	Young person has at least one parent/carer who supports and is able to supervise	1	Young person appears not to care what happens
2	Young person is willing to engage in treatment to address abusive behaviour	2	Young person demonstrates remorse for offence (even if not accepting responsibility	2	Young person has poor communication skills
3	Young person has positive plans/goals	3	Parents/carers are healthy and there is no other family trauma or crisis	3	Young person has no support/is rejected by parents/carers
4	Young person has positive talents and interests	4	Parents demonstrate responsible attitudes and skills in family management	4	Young person has been excluded from school/unemployed
5	Young person has good problem solving and negotiation skills	5	Parents/carers have no history of own abuse or abusive experiences are resolved	5	Isolated family
6	Young person has at least one emotional confidant	6	Family has positive social network	6	Absence of supportive/structured living environment
7	Young person has positive relationships with school or employers	7	Community is neutral towards young person/family	7	Parents/carers unable to supervise
8	Young person has experienced consistent positive care			8	Family is enmeshed in unhealthy social network
9	Parents demonstrate good protective attitudes and behaviours			9	Family has high levels of stress
10	Family has clear, positive boundaries in place			10	History of unresolved significant abuse in family
11	Family demonstrate good communications			11	Family refuses engage with professionals
12	Family demonstrate ability to positively process emotional issues			12	Domestic abuse in family
13	Family is positive about receiving help			13	Community is hostile to young person/family
14	Young person lives in supportive environment				
15	Network of support and supervision available to young person				

APPENDIX 7

CONTINUUM OF INDICATORS OF CONCERNS

	High Concerns		**Medium Concerns**				**Low Concerns**
	A		B		C		D
1	Young person has previous convictions for sexual offences or evidence of previous sexual offending	1	Young person has been suspected of previous sexual assaults	1	Young person has poor capacity for empathy	1	First known assault/one off assault
2	Formal diagnosis of Conduct Disorder or a history of interpersonal aggression	2	Early onset of severe behavioural problems	2	Young person denies responsibility for assault	2	Non-penetrative (including attempts) assaults
3	Very poor social skills/a reluctance to become intimate	3	Young person diagnosed with ADHD	3	Has difficulties in coping with negative feelings	3	No history of significant trauma or abuse
4	Use of violence or threats of violence during assault	4	Cold callous attitude in commission of assault	4	Has poor sexual boundaries	4	Demonstrates remorse/empathy
5	Self-reported sexual interest in children	5	Young person diagnosed with depression or other significant mental health problems	5	Parents express anger or no empathic concern towards victim	5	Assault appears to be experimental or peer influenced
6	Young person blames victim	6	Young person has significant distorted thoughts about sexual behaviours	6	High level of parental/carer together with family denial	6	No significant history of non-sexual assaults
7	Persistently threatens to commit abusive acts	7	Obsessive/pre-occupation with sexual thoughts/pornography	7	Social group is predominantly pro-criminal	7	Healthy peer relationships
8	Has persistent aggressive/sadistic sexual thoughts about others	8	Copes with negative emotions by use of sexual thoughts, behaviours or use of pornography/graffiti	8	Family members include people subject to “At Risk to Children” registration	8	No documented school problems
9	Has history of cruelty towards animals	9	Targets specific victims because of perceived vulnerability			9	No history of behavioural/emotional problems
10	Little concern about being caught	10	Pattern of discontinuity of care/poor attachments				

APPENDIX 7

11	High levels of trauma e.g. physical, emotional, sexual abuse or neglect or witnessing domestic abuse	11	Unsupervised access to potential victims				
12	High levels of family dysfunction/abusive or harsh child rearing regime	12	Young person regularly engaged in significant substance abuse				
13	Evidence of detailed planning						
14	Early drop out from treatment programme						
15	Highly compulsive/impulsive behaviours						

APPENDIX 8

BIBLIOGRAPHY/FURTHER READING

Araii S. 1997 'Sexually Aggressive Children - Coming To Understand Them' Sage Publications

Calder M. (Ed) 1998 'Working With Children And Young People Who Sexually Abuse: New Pieces Of The Jigsaw' Russell House Publishing

Calder M. (Ed) 2002 'Young People Who Sexually Abuse – Building The Evidence Base For Your Practice'

Department of Health 1999 'Working Together to Safeguard Children'
www.dh.gov.uk

Department of Health 2000 'Framework for the Assessment of Children in Need and their Families'
www.dh.gov.uk

Department of Health 2003 'What to do if you're worried a child is being abused'
www.dh.gov.uk

Erooga M. and Masson H. (Eds) 1999 'Children and Young People Who Sexually Abuse Others: Challenges And Responses' Routledge

Gill E. and Cavanagh E. 1991 'Assessment And Treatment Of Sexualised Children and Children Who Molest Children' Launch Press

Hacket S. 2001 'Facing the Future' Russell House Publishing

Home Office 2000 'Achieving Best Evidence in Criminal Proceedings: Guidance for vulnerable or intimidated witnesses including children'
www.homeoffice.gov.uk

Laming H. 2003 'The Victoria Climbie Inquiry Report'
www.victoria-climbie-inquiry.org.uk

Lewis A. 1999 'Cultural Diversity' in Sexual Abuser Treatment – Issues And Approaches, Safer Society Press

United Nations 1989 'Convention on the Rights of the Child'