OU Problematic Sexual Behavior - Cognitive Behavior Therapy Agency Readiness Guide

A Readiness Tool to Assist Your Agency in Planning to Provide Community-Based Services for Youth with Problematic Sexual Behaviors

psbcbt.ouhsc.edu

The University of Oklahoma Health Science Center PSB-CBT Program

Agency Readiness Guide

AGENCY READINESS GUIDE

Thank you for your interest in developing a program to serve children with problematic sexual behaviors and their families with the Problematic Sexual Behaviors – Cognitive-Behavioral Therapy (PSB-CBT) Program. The purpose of this guide is to provide you (and your agency) with a tool that can be used to examine your agency's level of readiness to implement, and more importantly sustain, a treatment program for youth with problematic sexual behaviors.

This guide is designed as an internal document for your agency (i.e., it will not be submitted to the University of Oklahoma). This guide is designed to facilitate discussion of factors that impact success in providing the PSB-CBT Program.

The Agency Readiness Guide provides information about a variety of domains related to success with the program such as referrals, caregiver participation, provider characteristics, and collaboration with community stakeholders. For each domain, a rating scale is intended to be useful as a visual depiction of your agency's strengths and challenges. However, we want to emphasize that training and implementation of the PSB-CBT program does not require agencies to have high (green) ratings across the instrument. In fact, it may be unrealistic to think that any agency would be able to mark green ratings for every topic on the guide.

The guide is designed to help raise awareness of your agency's strengths and challenges, assist with making plans to address challenges, and help complete the application for PSB-CBT training. In order to succeed in the implementation process, and maximize the likelihood of sustainability, this Agency Readiness Guide should be completed as a group with critical members of your agency (e.g., administration, clinical supervisors, and clinicians). Agencies may consider including key stakeholders from the community in these discussions.

If you have questions, please contact our team at the OU Health Sciences Center (OU-YPSB@ouhsc.edu).

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Successful programs start serving children with problematic sexual behavior as quickly as possible after the clinical training. This is most likely to occur when agencies already have existing referrals of children with problematic sexual behavior (or referral sources). Collaborative relationships with child protective services, child advocacy centers, schools, law enforcement, and juvenile justice (particularly if you are serving older youth) are key to sustainable programming. When examining your agency's readiness in the area of referrals, think about how successful your agency has been and your potential for receiving referrals for youth with problematic sexual behaviors.

Key topics/concepts to consider:

- How are youth with problematic sexual behaviors identified in the community?
- When youth are identified, how are they connected to treatment services?
- How often does your agency receive referrals for youth with PSB?
- What could you do as an agency to increase the number of referrals for youth with PSB?
- Would you have inclusion/exclusion criteria for your group services?
    - Important topics to consider include, but are not limited to, the following: age of youth, types of sexual behavior, adjudication status, language barriers, and referral source.

OVERALL RATING: REFERRALS

1	2	3	4	5	6	7	8	9	10
Have to overcome significant referral barriers			Have some barriers to referrals and working on ways to overcome those barriers				Have regular success in receiving referrals for youth with PSB		

Comments:

What are the next steps for your agency (i.e., in what ways could referrals be improved at your agency)?

If your ratings for Referrals fell within the yellow or red category, suggestions include:

- Investigate the individual(s) who are currently connecting youth with problematic sexual behaviors to treatment services within your community.
- Schedule in-person meetings with community leaders who are directly connected with referring children for services, and problem-solve barriers to referrals. Make sure to also develop strategies to overcome identified barriers and include benchmarks for progress and a timeline for reassessing how successfulness of the strategy.
- Meet with potential community collaborators (e.g., child protective services, child advocacy centers, lunch meetings with judges) to discuss your services.
- Present at events hosted by potential referral sources and collaborators (e.g., child protective services annual conference, Court Appointed Special Advocate Meetings).
- Conduct meetings with the referral team at your agency to discuss services for youth with problematic sexual behaviors, and seek their suggestions for increasing referrals.
- Meet with other professionals in the area that currently provide services to youth with problematic sexual behaviors to discuss: (a) the services you provide; (b) their current referral process; (c) lessons they have learned to increase referrals.
- Meet with agency clinical staff to identify if current clients/patients are appropriate for PSB treatment. Determine who referred these families for services at the agency and then reach out to those individuals and/or agencies to establish a referral connection.
- Identify the agencies in the community that serve families of youth with PSB such as, but not limited to, Child Protective Services, child advocacy centers, juvenile justice, local law enforcement, and schools. Contact the senior leaders (e.g., Director, Clinical Supervisor) at these agencies to introduce the PSB Program and attempt to schedule an in-person meeting to discuss how a referral connection could be made.
- Provide community education presentations on the subject of children with problematic sexual behavior that includes information about referring to PSB Program at the agency.
- If the agency or potential referral source agency have internal newsletters or distribution lists, write a short description of the PSB Program and referral process and request it be included in the newsletter or sent via distribution list. Agency staff and community colleagues are excellent sources of information for where to do these presentations.
- Contact the PSB-CBT Team at the OUHSC to discuss current referral challenges.

Agencies that are able to implement and sustain the PSB-CBT model typically have strong working relationships with community partners that already serve children with problematic sexual behaviors, such as child welfare, juvenile justice, child advocacy centers, law enforcement, and the schools. Think about your agency's current relationship with community partners.

Key topics/concepts to consider:

- Who are the major voices for youth with PSB within your community (e.g., judges, prosecutors, probation officers, child protective service leaders)?
- What is your agency's current relationship with the individuals who are the major voices in your community?
- How do you plan to establish/continue regular communication with major voices (e.g., courts, child protective services) and your program?
- What kind of relationship do you have with community agencies that may serve as referral sources? For example, if child welfare is an important referral source in your community – do you have an established relationship with staff at child welfare?
- As a system, what barriers will you face within your community? Examples include: (a) child protective services does not address problematic sexual behavior of youth; (b) youth are commonly sent away to residential treatment; and/or (c) the community is unsure how to manage young children with problematic sexual behavior?
- What are some of the strengths for your agency when working with community partners?
- What are some of the challenges your agency faces when working with community partners?

Resource: NCSBY Fact Sheet: Collaborative, Community Based, Evidence Based Services: Targeting Problematic Sexual Behavior in Children and Youth

OVERALL RATING: COMMUNITY COLLABORATIONS

1	2	3	4	5	6	7	8	9	10
Need to overcome challenges with community partners			**Have some challenges with community partners, but working on ways to overcome these challenges**				**Have regular communication and success with community partners**		

Comments:

What are the next steps for your agency (i.e., in what ways could caregiver participation be improved at your agency)?

If your ratings on Community Collaborations fell within the yellow or red category, suggestions include:

- Meet with agency staff and/or colleagues in the community to identify who in the community would be appropriate partners in working with children with PSB, child victims, and their families. Reach out to these prospective community partners to introduce your agency and PSB Program, and start a dialogue about ways you the agency and community partner could collaborate to enhance services for these families.
- Schedule an agency "open house" or tours for prospective community partners and have flyers about the agency and services ready to give attendees. Make sure to talk about the agency PSB Program and goals for developing and maintain a network of community partners to collaborate regarding treatment for children with PSB, child victims, and their families.
- Identify who within your agency has established relationships with state and local agencies that will be critical partners. Have these identified individuals facilitate communication related to the PSB Program (even if these individuals will not be directly involved with services).
- Host a community meeting to discuss youth with PSB and identify current gaps in the community regarding the accurate understanding of assessment, treatments, and prevention. Invite leadership from child protective services, law enforcement, probation, prosecution, public defenders, other court personnel, schools, child advocacy centers, medical personnel, behavioral health specialists, and other agencies with interest or investment with this population.
- Maintain regular phone, email, and/or in-person contacts with community partners to share successes and challenges of collaborations. Send thank you notes for successes.
- Offer to provide consultation on complex PSB cases and use that relationship to promote interagency relationships to enhance services for children with problematic sexual behaviors, their child victims, and their families.
- Contact the OUHSC PSB-CBT Team to discuss suggestions for establishing or strengthening collaborations within your community.

Caregiver Participation

Agencies that are able to successfully implement and sustain the PSB-CBT model have strong caregiver involvement in the treatment program. In fact, caregivers are required to attend and participate in each group session. Think about how successful your agency is at involving caregivers directly in the services you provide.

Key topics/concepts to consider:

- Currently, how involved are caregivers in treatment sessions with youth at your facility (e.g., are they expected to attend each week, do they actively participate in sessions with youth)?
- How does your agency currently view the importance of having caregivers involved in services for their child?
- Have you been able to successfully address internal barriers, such as parents' lack of motivation, limited self-efficacy, perception that the child is the problem) to caregiver participation in your community?
    - If yes, how were you able to address internal barriers?
    - If no, what kinds of challenges have you encountered?
- Have you been able to address external barriers (transportation, hours of operation, babysitters) to caregiver participation?
    - If yes, how were you able to address external barriers?
    - If no, what kinds of challenges have you encountered?

OVERALL RATING: CAREGIVER PARTICIPATION

1	2	3	4	5	6	7	8	9	10
Have to overcome significant barriers for caregiver participation			Have some barriers to caregiver participation and working on ways to overcome those barriers				Have regular success in engaging caregivers in treatment		

Comments:

What are the next steps for your agency (i.e., in what ways could caregiver participation be improved at your agency)?

If your ratings for Caregiver Participation fell within the yellow or red category, suggestions include:

- Consider reviewing research on engaging caregivers in treatment. Determine what strategies would be good to try and have a plan for how to revise these strategies based on successes and challenges. Example resources include: http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2938751/pdf/ccap19_3p182.pdf. http://lausdsmh.net/wp-content/uploads/2012/03/Mary-McKay-Parent-Engagement-Presentation.pdf
- Talk to caregivers of current or past clients/patients about their experiences in services at your agency to get ideas for engaging caregivers in treatment with their children.
- Consider if the agency has a culture of not including caregivers in treatment and start conversations with staff on how to change that culture.
- For foster parents, connect with the managing agency and get permission to provide foster parents with continuing education for attending treatment services with their foster child.
- Find services in your community that will help aid in transportation services.
- Have a previous graduated parent make a testimonial to show to families, or have a past parent come and speak to the current parents.
- Incorporate Motivational Interviewing (MI) strategies into the curriculum.
- If possible, offer services at times that are most convenient for caregivers (e.g., evenings).
- If possible, offer free childcare during service appointments for other children in the caregiver's home. Consider partnering with volunteer groups to provide this support.
- If possible, provide a small snack to children (and caregivers) if appointments are scheduled near a mealtime.
- During the initial appointment, spend time with the caregiver addressing their concerns, dispelling myths they may have about problematic sexual behaviors of youth, identifying supports and barriers to participation, and discussing ways to overcome any barriers.
- Plan on providing an open-ended group program where caregivers of youth who are about to graduate can provide testimonials to caregivers who are new to the program.
- Contact the OUHSC PSB-CBT Team to discuss strategies for increasing caregiver participation.

The University of Oklahoma Health Science Center
PSB-CBT Program

Previous Success with Evidence-Based Practices

Agencies which are successful in implementing the PSB-CBT model often have experience in and have successfully implemented and sustained other evidence-based treatments for children and their caregivers.

Key topics/concepts to consider:

- Currently, what are the evidence-based models that are regularly utilized at your agency?
- How comfortable are your clinicians with providing evidence-based practices?
- Is Trauma-Focused Cognitive-Behavioral Therapy (TF-CBT) implemented in your agency? What was the process of training?
- How many of your clinicians have been trained in empirically-supported parent behavior management therapies such as Parent-Child Interaction Therapy (PCIT) or Incredible Years?
- What supports does your agency provide to providers and programs to facilitate training in an evidence based model? How do you manage productivity requirements, CEU needs, and other factors that impact time and training? What strategies have been successful to implement evidence-based models in your agency?
- What have been some of the challenges in implementing evidence-based models in your agency?
- If this is the first evidence-based model your agency will implement, would you like to have contact with an agency director who has successfully brought evidence-based treatment programs to their agency for advice?

OVERALL RATING: EVIDENCE-BASED PRACTICES

1	2	3	4	5	6	7	8	9	10
Have experienced limited success implementing evidence-based models in our agency			**Have experienced some challenges when implementing evidence-based models, but have a few models that have been implemented successfully**				**Have regular success in implementing evidence-based practices at our agency**		

Comments:

What are the next steps for your agency (i.e., in what ways could the implementation of evidence-based practices be improved at your agency)?

Previous Success with Evidence-Based Practices

If your ratings on Evidence-Based Practices fell within the yellow or red category, suggestions include:

- If this is the first evidence-based model your agency will implement, contact an agency director who has successfully brought evidence-based treatment programs to their agency for advice.
- Talk to community partners and colleagues with experience in evidence-based models for ideas and support in implementing the PSB Program.
- Reach out to training centers in evidence-based models to request resources on what to consider and try when interested in establishing an evidence-based model.
- If applicable, conduct a meeting with all agency personnel to discuss why certain models have been successfully implemented in your agency, and while other models have not been as successful.
- Regularly collect data on the clients served in your agency to evaluate your strengths and challenges with referrals and treatment programs. Us this data for quality improvement purposes.
- Meet with others who helped successfully implement an evidence-based model and brainstorm what contributed to the success of implementation. Identify how to use that information to support the implementation of the PSB Program.
- Contact the OUHSC PSB-CBT as a resource to connect you with evidence-based training opportunities.

Agencies that are able to sustain the PSB-CBT program utilize empirically-supported assessments throughout services to develop the initial treatment plan, evaluate progress in treatment, improve services, and guide treatment decisions, and treatment outcomes.

Key topics/concepts to consider:

- Currently, what assessment instruments are regularly utilized at your facility for children with problematic sexual behaviors?
- What assessment instruments are regularly utilized at your facility for children who have experienced child abuse and/or neglect (or other traumatic events)?
- How comfortable are your clinicians with routinely using empirically-supported assessments?
- Are your clinicians trained to administer, interpret, and effectively utilize the Child Sexual Behavior Inventory (CSBI)?
- Are your clinicians trained to administer, interpret, and effectively utilize the UCLA PTSD Reaction Index and/or the Trauma Symptoms Checklist for Children (TSCC)?
- Are your clinicians trained to administer, interpret, and effectively utilize the Child Behavior Checklist (CBCL) and/or the Behavior Assessment System for Children (BASC)?
- What strategies have been successful to implement empirically-supported assessments in your agency?
- What have been some of the challenges to implementing empirically-supported assessments in your agency?
- What quality improvement efforts have been implemented in your agency?
- How will your team manage data and summarize important findings from your program (e.g., recidivism rates, family involvement)?

Resources: Assessment Tools Fact Sheet

OVERALL RATING: ASSESSMENTS

1	2	3	4	5	6	7	8	9	10
Have to overcome barriers ro regularly utilizing assessments			**Have some barriers related to assessments and working on ways to overcome those barriers**				**History of successfully utilizing empirically-supported assessments**		

Comments:

What are the next steps for your agency (i.e., in what ways could you improve the use of empirically-supported assessments at your agency)?

If your ratings on Assessments fell within the yellow or red category, suggestions include:

- Consult with local agencies who regularly use assessment tools to discuss their experiences.
- Review information about potential assessments measures online and/or use the fact sheet attached to this packet.
- Meet with the agency clinical team and discuss current procedures for measuring clients' progress on treatment goals. Can the team document progress over time? Can the team identify when treatment is not working and other options need to be considered? Identify what are your agency's strengths/needs regarding assessments to: (a) identify treatment goals, (b) evaluate progress of the child, and (c) examine the program's strengths and areas that need improvement.
- Contact the OUHSC PSB-CBT Team to discuss empirically-supported assessments and ways to receive training within your community.

Agencies that are able to sustain the PSB-CBT program have been able to successfully address logistical concerns associated with providing a group treatment program in the community. This next section is designed to help you consider some of the more common logistical topics.

Key topics/concepts to consider:

- Where would you provide group services for youth with PSB and their families (e.g., within your own agency, partnering agency)? Where would you have enough space to conduct groups?
- When will you conduct the group to maximize family participation?
- Which clinicians at your facility would participate in training and provide services for families?
  - What is it about these clinicians that make them the most qualified?
- In order to meet the certification requirements treatment sessions must be recorded to assess fidelity to the model. What challenges might you experience with recording sessions and what strategies could you use to overcome these challenges?
- Another certification requirement is for your trained clinicians to participate in a one-hour consultation call every other week. These calls are conducted via WebEx, an online system that functions like Skype. What challenges might you experience with consultation attendance and what strategies could you use to overcome these challenges?
- How would your organization cover the time for providers to participate in the training and ongoing consultation?

Resources: Provider Characteristics Fact Sheet; Logistics Fact Sheet

OVERALL RATING: LOGISTICS

1	2	3	4	5	6	7	8	9	10
Have to overcome significant logistical barriers			Have some logistical barriers and working on ways to overcome those barriers				Have a carefully designed plan to address logistical barriers		

Comments:

What are the next steps for your agency (i.e., in what ways could the logistics of conducting a group treatment be improved at your agency)?

If your ratings on Logistics fell within the yellow or red category, suggestions include:

- Review the Logistics Fact Sheet and discuss the best options to address logistical issues.
- If group space is not available at your facility, consider partnering with other agencies for space. Consider locations that reduce barriers to family participation.
- Review Provider Characteristics Fact Sheet. Discuss with the clinical team to identify providers with the best fit for the program.
- Consider partnering with local graduate schools to provide practicum training experiences and have students as co-facilitators of the program.
- Contact the OUHSC PSB-CBT Team to discuss questions and concerns highlighted on the Logistics handout.

Family / Cultural Considerations

Agencies that are able to sustain the PSB-CBT program are generally knowledgeable about the families they will serve in their community and they carefully consider familial and culturally relevant topics prior to implementing a new program.

Key topics/concepts to consider:

- Treating problematic sexual behavior of youth involves two highly sensitive topics for a family: Parenting practices and the sexual behavior of children.
  - Parents typically find it difficult to address sexual behavior with their children. The parents own history can impact their response. We find there are regional and other cultural factors that impact their comfort level addressing sexual behavior and sex education.
  - Parents can feel defensive when parenting behaviors are addressed in treatment. Helping caregivers understand that the parenting information is designed to help their child and not to blame parents for past behavior.
- How successful have your programs been in addressing these sensitive topics with families? What supports does your team have in place for families and clinicians? What educational opportunities do we have for family members?
- How would your agency provide an environment where clinicians could talk about these issues?
- What strategies does your agency use to ensure that families receive culturally informed services?
- Discuss how your agency might address families who present to treatment with additional challenges (e.g., learning problems, developmental delays)?

OVERALL RATING: FAMILY/CULTURAL CONSIDERATIONS

1	2	3	4	5	6	7	8	9	10
Have to overcome significant family/cultural barriers			Have some family/cultural barriers and working on ways to overcome those barriers				Have a history of successfully addressing cultural/ethnic factors in our community		

Comments:

What are the next steps for your agency (i.e., in what ways could you improve services for families and cultures at your agency)?

If your ratings on Family/Cultural Consideration fell within the yellow or red category, suggestions include:

- Discuss community diversity and identify strengths and barriers to addressing sensitive topics, including parenting youth with problematic sexual behaviors.
- Identify team members who have experienced success with engaging caregivers on these sensitive topics. Consider providing in-services training or other strategies that have been successful.
- Invite leadership from the community to discuss the best practices to address these sensitive topics. Leaders may be formal (e.g., church officials, directors of community organizations) or informal (individuals known in the community to be influential).
- Attend online or conference trainings on addressing sensitive topics with diverse communities.
- Contact the OUHSC PSB-CBT Team to discuss ways in which services can be conducted in a manner that is culturally informed and sensitive to diverse groups of families.

Sustaining the PSB-CBT program at your agency will require effort, resources, and a strong commitment to serving children with problematic sexual behaviors in your community. This next section is designed to help you consider sustainability topics. Sustainability includes: (a) funding for the services; (b) funding for outreach and community collaborations; (c) personnel committed to maintaining the program; and (d) within-agency trainers to support sustaining and expanding the program.

Key topics/concepts to consider:

- What are your plans for funding the clinical program? For funding the administration and outreach portions of the program?
- If you will have a multidisciplinary team component to the program, what are your thoughts about funding this portion? [Note: Child Advocacy Centers are key collaborators in this area.]
- How successful has your agency been in sustaining other evidence-based programs?
    - If your program has a history of success, what are the factors that helped your agency be successful?
    - If your program has not had a history of success, what factors have caused the most problems?
- What funding options have you explored?
- How would your organization continue to fund the services after clinicians have been trained in PSB-CBT?
- What are the most important foreseeable challenges your agency may face when trying to sustain the PSB-CBT Program?
- Who within the agency would be best to provide ongoing training on PSB to new personnel?
- What are supports and barriers for the personnel to become within-agency trainers in the PSB-CBT model?

Resources: Funding Considerations Fact Sheet; Provider Characteristics Fact Sheet

OVERALL RATING: SUSTAINABILITY

1	2	3	4	5	6	7	8	9	10
Have to overcome significant barriers in order to achieve long-term sustainability			**Have some sustainability barriers and working on ways to overcome those barriers**				**Have a history of sustaining evidence-based programs at our agency**		

Comments:

What are the next steps for your agency (i.e., in what ways could sustainability be planned for and improved at your agency)?

If your ratings on Sustainability fell within the yellow or red category, suggestions include:

- Review the Funding Considerations Fact Sheet and host a meeting within your agency to explore and identify potential funding sources within your community. Also discuss possible regional, state, and federal funding opportunities.
- Meet with community partners about current and future funding options. Child protective services, probation, and Medicaid officials may be helpful, as well as private organizations such as United Way.
- Talk with leadership from other community agencies who have successfully sustained programs for youth with PSB.
- Contact the OUHSC PSB-CBT Team to discuss potential long-term funding strategies.

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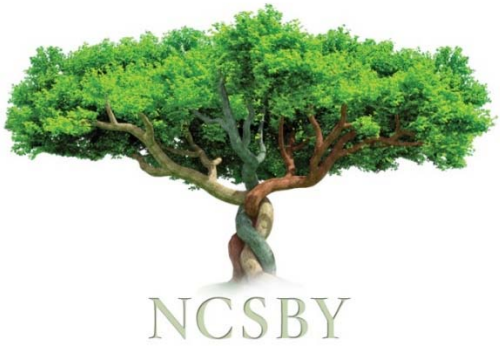
Fact Sheets

1. NCSBY: Collaborative, Community-Based, Evidence-Based Services: Targeting Problematic Sexual Behavior in Children & Youth
2. Assessment Tools
3. Provider Characteristics
4. Logistics
5. Funding Considerations

Collaborative, Community Based, Evidence Based Services: Targeting Problematic Sexual Behavior in Children and Youth



For more information about community based approaches to addressing problematic sexual behavior of youth contact the Center on Child Abuse and Neglect at: OU-YPSB@ouhsc.edu

Problematic Sexual Behavior in Children and Youth

While sexual exploration and play are a natural part of childhood sexual development, some sexual behaviors indicate **more than harmless curiosity.**

In cases where these behaviors pose a risk to the safety or well-being of the child and other children in his or her world, it is imperative for families and communities to step in and mitigate through proper identification, treatment, and intervention.

What are Problematic Sexual Behaviors?

Problematic sexual behaviors (PSB) in youth are defined as child or adolescent initiated behaviors typically involving sexual body parts that are:

- **Developmentally inappropriate**
- **Potentially harmful to self or others and/or**
- **Illegal**

Greater than one-third of sexual offenses against child victims are committed by other youth.
Problematic Sexual Behavior primarily occurs with other children known by the youth, with a quarter of victims being family members. Few sexual offenses of youth involve strangers

Qualities of Effective Community Based Programs

Effective community based treatments for youth with problematic sexual behavior, the child victims, and their families have the following characteristics:

- **Community collaboration.** Juvenile justice, child welfare, treatment services systems, schools, child advocacy centers and others collaborate to identify children with problematic sexual behaviors, assess risk, and engage families in evidence-based treatment;
- **Clinical services teams trained in evidence-based treatment**.
- **Active parent and caregiver involvement**. Helping these children and youth requires active engagement of the family; and
- **Agency and public policies** that are consistent with research outcomes

When accomplished effectively, communities can better sustain the safety, health, and well-being for the children and families in the community.

For more information see the National Center on the Sexual Behavior of Youth: www.ncsby.org

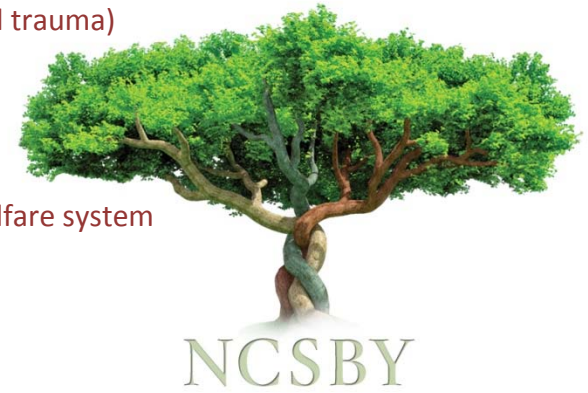
Community Problem Requires Community Response:
The Role of Community Stakeholders

As problematic sexual behavior of youth commonly occur with children within their social network, **lack of community collaboration leads to**:

- Failing to identify youth in need of services
- Families divided, both physically and emotionally
- Fragmented services
- Risk to the community members

In contrast, **community collaboration and implementation of evidence-based services** for youth with problematic sexual behaviors, children impacted, and families can lead to:

- Decreased child symptoms (problematic sexual behavior and trauma)
- Increased pro-social behaviors in children and youth
- Decreased parent / family stress
- Improved safety and well-being for child and family
- Sustainable and safe reunification of family members
- Improved placement stability for youth involved in Child Welfare system
- Decreased recidivism for youth involved in juvenile justice
- Decreased costs for placement, services and interventions



Community Decision Making Process

Historically, no **individual** community-system has responsibility for coordinated care for all youth with problematic sexual behavior. Implementing evidence-based treatment requires service agencies to **effectively plan, develop, and enact** a community decision-making process related to care and treatment of youth and their families.

Individuals and professional involved in this process:

- Caregivers (Bio/Kinship/Foster/Adoptive Parents)
- Child Protective Services
- Law Enforcement
- Juvenile Justice
  - *Judges*
  - *Prosecutors / Defense*
  - *Probation*
- Victim Advocacy
- Behavioral and Mental Health
- School Personnel
- Medical Providers
- Other Professionals
  - Speech Therapists
  - Occupational Therapists
  - Rehab Specialists
- Faith-Based Communities / Agencies

Community Goals and Outcomes

- Effective and consistent identification of youth and families dealing with problematic sexual behavior
- Effective and consistent referral of identified youth to evidence-based services
- Sustainable implementation of evidence-based services
- Family-centered response to all impacted by the problematic sexual behavior of youth
- Coordinated response across agencies and systems

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Parent and Child-Report Assessments

Child Sexual Behavior Inventory-III **(CSBI-III)**. The CSBI-III is a caregiver-completed instrument that assesses the presence and frequency of a range of sexual behaviors (Friedrich, 1997). The CSBI-III yields three standardized scores: (a) CSBI Total, (b) Developmentally Related Sexual Behavior, and (c) Sexual Abuse Specific Items. These items also correspond to nine domains of sexual behavior: (1) Boundary Problems, (2) Showing Private Parts, (3) Gender Role Behavior, (4) Self-stimulation, (5) Sexual Anxiety, (6) Sexual Interest, (7) Sexual Intrusiveness, (8) Sexual Knowledge, and (9) Looking at Others' Private Parts. The manual provides support for the CSBI-III internal consistency (.72 for normative sample and .92 for sexually abused sample), stability (.91), and convergent, discriminant, and construct validity. The CSBI-III has demonstrated sensitivity to treatment effects (e.g., Cohen & Mannarino, 1996a, 1997). Eight items, added since the third revision of this inventory, assess aggressive and/or coercive sexual behaviors (four items), as well as withdrawal and avoidance of sexual content (four items). In a normative sample, none of the items assessing aggressive sexual behaviors were endorsed and can be used as critical items (Friedrich, 2006, page. 179). Friedrich has a related safety assessment provided in his book on assessment of child sexual abuse that can be useful to examine home and environmental risk and protective factors. The CSBI-III is distributed by Psychological Assessment Resources (PAR) and more information about the measure and ordering information can be found at: http://www4.parinc.com/Products/Product.aspx?ProductID=CSBI.

Adolescent Clinical Sexual Behavior Inventory **(ACSBI)**. The ACSBI is designed to assess the sexual behavior of high risk adolescents. The ACSBI has an adolescent self-report and a parent report version. There are five subscales: (1) Sexual knowledge/interest, (2) divergent sexual interests, (3) sexual risk misuse, (4) fear, and (5) concerns about appearance. More information about this measure can be found in the following two resources:

Friedrich, W.N. (2002). Psychological assessment of sexually abused children and their families. Thousand Oaks, CA: Sage.

Friedrich, W.N., Lysne, M., Sim, L., & Shamos, S. (2004). Assessing Sexual Behavior in High-Risk Adolescents with the Adolescent Clinical Sexual Behavior Inventory (ACSBI). *Child Maltreatment, 9(3), 239-250.*

UCLA PTSD Index. Researchers and clinicians at the UCLA Trauma Psychiatry Service have developed this series of self-report instruments to be used to screen both for exposure to traumatic events and for all DSM-V PTSD symptoms in school-age children and adolescents who report traumatic experiences. These instruments are meant to serve as brief self-report screening tools to provide information regarding trauma exposure and PTSD symptoms. The items of the UCLA PTSD indices are keyed to DSM-V criteria and can provide preliminary PTSD diagnostic information. However, these instruments are not intended to be used in place of a structured clinical interview to definitively establish a PTSD diagnosis. Instead, the instruments are meant to be used to quickly and efficiently screen for PTSD symptoms in children and adolescents who have experienced a traumatic event, and to provide information regarding the frequency of those symptoms.

***Trauma Symptom Checklist for Children* (TSCC**; Briere, 1996) and ***Trauma Symptom Checklist for Young Children* (TSCYC).** The TSCC is a 54-item self-report instrument designed to measure post-traumatic distress and related psychological symptomatology in children aged 8 to 16 years. It is used to evaluate children who have experienced traumatic events such as physical and sexual assault, victimization by peers, major losses, witnessing violence, and natural disasters. Reliability analysis of the TSCC scales has demonstrated relatively high internal consistency - ranging from .77 to .89 (Briere, 1996; Lanktree & Briere, 1995; Elliot & Briere, 1994). The validity of the TSCC has also been well established (Briere, 1996; Briere & Lanktree, 1995). The TSCYC is a parent-report version of the TSCC and can be used for children as young as 2 years of age.
The TSCC & TSCYC are distributed by Western Psychological Services and the websites are:
http://www.wpspublish.com/store/p/3065/trauma-symptom-checklist-for-children-tscc.
http://www.wpspublish.com/store/p/3067/trauma-symptom-checklist-for-young-children-tscyc.

***Child Behavior Checklist-Parent Form* (CBCL).** The CBCL (1 ½ - 5; 6-18 years) is a standardized checklist of childhood behavior problems and social competence completed by the caregiver (Achenbach, 1991). The CBCL has been used extensively in clinical research with children and has demonstrated internal consistency (.95), test-retest reliability (one week; Total Problems Scale = .93), and construct validity (Achenbach, 1991). There is a Total Problems Scale, Externalizing Behavior Problems Scale, and Internalizing Problems Scale, as well as relevant subscales. Scores greater than 65 are considered clinically significant.
More information about the CBCL (including ordering information) can be found at: www.aseba.org.

***Behavior Assessment System for Children: Parent Rating Scale* (BASC-PRS) *and Self Report* (BASC-SRP).** The BASC-PRS (Reynolds & Kamphaus, 1992) is completed by the caregiver and has versions for children aged 6-11 years (138 items) and adolescents aged 12-18 years (126 items). Both versions are standardized and provide an assessment of childhood behavior problems and social competence. They measure factors such as anxiety, depression, somatic complaints, hyperactivity, attentional problems, withdrawal, atypical behavior, aggressiveness, delinquent behavior, social skills, and leadership. Additionally, the BASC-PRS yields scores on a child's externalizing and internalizing behaviors and social competence. The BASC-SRP (Reynolds & Kamphaus, 1992) is completed by the child and also has versions for children aged 6-11 years (152 items) and adolescents aged 12-18 years (186 items). Both versions are standardized and provide an assessment of the child's emotions and self-perceptions. They measure factors such as anxiety, depression, atypicality, social stress, school maladjustment, interpersonal relations, and self-esteem. The BASC-PRS and SRP are widely used with established reliability and validity.
The BASC is distributed by Pearson and information can be found at the following website:
http://www.pearsonclinical.com/psychology/products/100000658/behavior-assessment-system-for-children-second-edition-basc-2.html?Pid=PAa30000.

Provider Characteristics

Problematic Sexual Behavior-Cognitive Behavior Treatment (PSB-CBT)

The PSB-CBT model is a family-oriented, cognitive-behavioral, psycho-educational, and supportive treatment group model designed to eliminate problematic sexual behaviors and improve pro-social behavior and adjustment in children, while reducing stress and enhancing skills in parents and other caregivers. Successful and sustainable implementation of the model requires attention to particular factors, or "drivers" that support model fidelity and improved client outcomes. Agencies that have successfully implemented PSB-CBT with fidelity note selection of clinicians to participate in training and implementation of PSB-CBT as a key driver of success.

Through the selection process, agencies have determined that the following characteristics are representative of clinicians effective in their uptake and delivery of PSB-CBT:

- *Cognitive-behavioral and family systems orientations*
- *Comfortable discussing sexual development and sexual content*
- *Ability to effectively engage caregivers, family members, and youth*
- *Comfortable with directive approaches in clinical treatment*
- *New therapists who have a mature approach to families or seasoned therapist who have an approach and conceptual understanding similar to PSB-CBT*
- *Organizational skills (i.e. ability to coordinate, community outreach, and managing referrals)*
- *Good communicating skills with families and referral sources*
- *Prepared to actively and directly collaborate with partnering agencies and community stakeholders such as probation and child welfare*
- *Ability to teach parents behavioral management and relationship building skills*
- *Experience with group treatment models (caregiver and child)*
- *Comfortable managing child/youth behavior in a group setting*
- *Strong presentation and facilitation skills for group training and education sessions*
- *Investment in sustaining the program and in training therapists and community stakeholders in the model*

For more information about treatment for problematic sexual behavior of youth, please contact:
OU-YPSB@ouhsc.edu

PSB-CBT Program Logistics

Treatment Day/Time

It is recommended that the PSB-CBT Program be delivered at a time and day in your community that would maximize caregiver participation. The PSB-CBT group treatment programs are typically 90 minute sessions once a week. Most often, conflicts with school and caregiver employment require group sessions to be delivered in the evening. However, some programs have been able to deliver group services earlier in the day. When planning the specific day of your group, it will be important to carefully consider common scheduling conflicts that occur in the evenings within the community in which you provide services (e.g., religious services, sporting events, etc.).

Supervision Day/Time

The PSB-CBT Program requires weekly staffing and coordination with the treatment team. Weekly staff meetings could be planned in a variety of ways, and the treatment team will need to find days/times that best fit the schedules and needs of the team members and agency. The follow are suggestions that have resulted in the greatest success for programs. PSB-CBT treatment teams meet briefly (minimum of 30 minutes) immediately prior to group therapy sessions to (a) prepare treatment rooms and materials; (b) review the treatment objectives for the session and therapist responsibilities for each portion of the session; (c) discuss any updates, concerns, and/or questions about the families participating in the group, and (d) discuss new referrals and potential inclusion in the group. The treatment team also benefits from meeting after group sessions typically 30-60 minutes to (a) write progress notes; (b) discuss child and caregiver session highlights and challenges, providing feedback as needed; (c) meet briefly with families to address specific concerns (e.g., an immediate school concern), and (d) plan for any follow up and the next session. Teams using this structure report higher levels of satisfaction with program implementation and maintenance.

Number of Therapists

The PSB-CBT Programs rely on the work of multiple therapists to successfully facilitate group sessions.

- The School-Age Group Program: Delivered by an individual, skilled therapist for the children and one for the caregivers. However, two therapists are often ideal to help manage any potential behavioral challenges and provide additional support and perspectives.
- The Preschool Group Program: Delivered by a minimum of two therapists with the children and one with the caregivers. However, depending on your group size, you may want to include additional therapists. When delivering services for 7-8 children, it is often helpful to have three to four therapists in group each week.

Therapy Space

PSB-CBT Programs use a parallel group structure to deliver services for families. That is, caregivers and children meet in simultaneous concurrent groups for the majority of the each session. During the combined sessions (where the children and caregivers are seen together) a larger room is needed. Thus, two rooms (that are ideally close in proximity) are needed for each treatment session.

- Typically, caregiver groups are held in large rooms that are able to accommodate 16-20 adults (and include the children for the combined sessions).
- Children's groups are often held in smaller rooms that are able to accommodate 8-12 children and therapists.

Storage

The PSB-CBT training team will provide a treatment protocol that specifically describes the materials needed for each group session. It is important to consider in advance where you will store these materials. The program runs more efficiently when the handouts and materials are prepared for many weeks in advance. Some programs provide a snack to children in the group, which can also be stored. A cabinet is an ideal storage place, preferably 4' wide by 8' tall or larger. Of course, some teams that use this model do not have a single cabinet that is available and they may store materials in several, smaller locations.

Problematic Sexual Behavior-Cognitive Behavior Treatment (PSB-CBT)
Funding Considerations

The PSB-CBT model is *a family-oriented, cognitive-behavioral, psycho-educational, and supportive treatment group model* designed to eliminate problematic sexual behaviors and improve pro-social behavior and adjustment in children, while reducing stress and enhancing skills in parents and other caregivers. Successful and sustainable implementation of the model requires attention to particular factors, or "drivers" that support model fidelity and improved client outcomes while simultaneously attending to the real needs for **covering costs** of the service in an increasingly constrained public and private funding environment.

In December 2013, early adopters of the model and stakeholders came together to reflect on key measures of agency readiness to implement the model, tasks associated with adoption and active implementation of the model, and key success factors the implementation process. Additionally, participants provided insight into current encountering and billing strategies with Medicaid as well as potential contracting and fundraising strategies to support sustainable implementation of the model with attention to clinical outcomes.

MEDICAID BILLING AND ENCOUNTERING

Funding for PSB-CBT programs is often reliant on reimbursement from public insurance (i.e. Medicaid) to support program operations. As such, establishing a robust clinical assessment protocol within agencies providing PSB-CBT is critical to support service authorization. Typical diagnoses for children with PSB include Disruptive Behavior Disorders (e.g., Oppositional Defiant Disorder, Conduct Disorder), ADD/ADHD, and trauma disorders (e.g., Adjustment Disorder, PTSD).

Costs associated with developing, implementing, and maintaining such a protocol is generally supported through the uses of the following billing codes:

- Initial Assessment: 90791
- Treatment Planning: H0032

As a group model, Medicaid billing codes most often used to support PSB-CBT services include:

- Group Treatment: 90853
- Individual Treatment: 90837
- Family Treatment: 90847
- Rehab Services: H0032
- Weekly Collateral: 90887

DIRECT CONTRACTING FOR PSB-CBT SERVICES

In addition to Medicaid funding for clinical services, agencies successful in implementation of PSB-CBT report close working relationships with community partners / stakeholders including local child welfare and juvenile justice agencies. Often, these stakeholders have access to local, state or national funding streams that can be used to support clinical services for children and families already being served by their system. If these funds are available, working with key stakeholders to establish direct contracting opportunities is a critical component of program sustainability. One such funding stream is juvenile justice block grants. To learn about juvenile justice grant programs in your state and locate local contacts please visit http://www.ojjdp.gov/jabg/ .

PRIVATE FOUNDATION FUNDING

Agencies that have been successful in achieving sustainable PSB-CBT programs report that they rely on multiple streams of funding or "braided" funding streams to fully support their work with attention to both model fidelity and clinical outcome. While each state or region differs in they number, type and focus of philanthropic organizations, it is important to look for funders that support similar work in other areas and that share the philosophy of family focused treatment for youth with problematic sexual behaviors. One such agency that is in many local areas is United Way. Regardless though of the potential funder, once identified agency leadership mush install a coordinated approach to funding that includes the input and support of community stakeholders.

FUNDRAISING STRATEGIES

1. It is often helpful to highlight how working with youth with sexual behavior problems more generally, and using the OU SBP-CBT model more specifically, is in fact *secondary prevention* and that in fact, though implementation of this approach, the agency is acting on behalf of potential victims.
2. The use of stories (incorporating both quantitative and qualitative data) of youth with SBP is powerful and should be included in your approach to funders. In particular, being able to share what happened to bring the youth into contact with the system, the negative effects of inadequate system response, and how this model and family centered approach to treatment helps achieve positive child and family outcomes should be shared. In a sense making these youth "human" to the audience can gain attention and compassion from otherwise distanced or perceivably uninterested audiences.
3. It is important for agencies doing this work to solicit and receive letters of support from key community stakeholders including the judicial system, juvenile justice, schools, law enforcement, and child welfare.
4. Agencies should seek collaborative requests for funding with shared community responsibility to identify, maintain, and monitor funding for these services. This supports capacity building at the community level.
5. It is critical to identify champions within the agency and within the community early in the process of implementation and to work actively throughout to maintain these connections and support these champions.

COST MODELING

In determining costs associated with starting and maintaining a PSB-CBT Program agency leaders should consider the following fixed costs and staff time requirements:

- Training costs for staff (need a minimum of two trained staff in each agency to support the model)
- Costs of standardized clinical assessments
- Treatment space costs (you will need two spaces available for each group session as youth and caregiver groups are run concurrently)
- Materials of treatment sessions (please see the accompanying cost model worksheet for specific requirements)
- Creation of data collection & reporting pathways within your agency (utilization, performance, and outcome data to be collected and reporting monthly)
- Installation of audio visual recoding equipment to support monitoring of clinical performance / fidelity
- Regular meetings with key stakeholders attended by clinical and administrative implementation team members
- Weekly implementation team meetings (administrative and clinical)
- Session planning and documentation
- Execution of weekly youth and caregiver sessions (60-90 minutes in length)
- Clinical consultation with training faculty