Youth with Problematic Sexual Behavior:
Best Practice Documents Overview

Youth with problematic sexual behavior (PSB) are a diverse population of children and adolescents who have, for a variety of reasons, engaged in problematic sexual behavior. A Children's Advocacy Center (CAC) is an ideal institution for screening, assessing, and providing services to these youth in the least restrictive environment possible. Further, CAC's are well positioned to help prevent these youth from falling through the cracks by ensuring access to evidence-based services for the youth and the family. The idea of serving these youth within a CAC may feel outside the scope of a CAC's mission to provide a safe environment for child victims of crime; however, many youth with PSB already are, or are closely related to, existing CAC clients. A large percentage of youth-initiated sexual behavior occurs within a child's social network (nuclear family, close relative, friend network). Given this fact, many child victims are brought to the CAC alongside youth with PSB. In many cases, caregivers require education and support in managing the needs and responses of both children involved. The response of service agencies in the community (such as Child Protective Services, juvenile justice, law enforcement, schools, behavioral health and medical) to cases of PSB of youth is typically inconsistent and fragmented, with multiple agencies believing that response does not fall under their jurisdiction. Without a response grounded in current research, and designated to a specific institution or agency, these youth face punitive and detrimental interventions or a lapse of response at all. In contrast, with guidance of informed CAC's multiple disciplinary teams, both policy and professional responses to PSB of youth can be coordinated through collaboration among agencies.

With this need in mind, the following documents have been compiled by CAC professionals with real world experience collaborating with community partners and creating and maintaining treatment programs for youth with PSB. These documents are not intended to be used word-for-word, but instead are to be used as working examples and starting off points to create materials fitting the local jurisdiction and community. The goal is to empower your CAC to start and/or maintain addressing PSB of youth through your MDT and supporting evidence-based treatment programs within the CAC and in the community. It is important to take these general examples and apply your own agency, MDT, and state-specific protocols in order to ensure that the language accurately reflects the unique services your agency provides.

Below are individual CAC documents and accompanying guidelines that outline why and how the documents are intended to be used. You may find that you have already developed similar documents for your work with other populations. In these cases, it may be appropriate to utilize existing documents for multiple populations. Legal counsel and MDT partners can be consulted for feedback and to address questions about how these documents could be best applied in your setting.

Guidelines for the Use of the "Consent for Evaluation and Treatment" Document

This document is intended to be reviewed with the youth's caregiver and signed prior to assessment and/or treatment of a youth with PSB. This document parallels generic consent forms for assessment and treatment that you may already have in your existing library of forms. Giving caregivers clear

expectations can help reduce anxiety and begin to build a solid foundation upon which healing can begin.

The importance of early caregiver engagement, particularly when youth have PSB, cannot be overstated. Because responses by the different service agencies can feel confusing and unpredictable, caregivers may enter services unsure of what to expect for themselves or their child.

Staff responsible for administering this document should be familiar with state and federal laws regarding mandated reporting so that those laws can be explained to the caregiver if questions arise. Staff should also be familiar with laws regarding HIPPA regulations and regulations for the management of documents once collected.

Guidelines for the Use of the "Consent for the Release/Exchange of Confidential Information" Document

This document is intended to be reviewed with the youth's caregiver and signed prior to releasing and/or exchanging information with outside agencies. This document parallels generic authorizations for the release and/or exchange of information and may also already exist within your library of forms.

Staff responsible for administering this document should be familiar with HIPPA regulations as well as regulations for the management of documents once collected.

Guidelines for the Use of the "Consent for Case Review with the Multidisciplinary Team" Document

This document's intention is similar to the "Consent for the Release/Exchange of Confidential Information" document; however, it is expressly designed to outline the members and functions of a Multidisciplinary Team (MDT) that may be involved in a youth with PSB case.

The staff responsible for administering this document should be familiar with all the parameters of the "Release/Exchange" document, in addition to being familiar with the CAC's MDT process. Staff should be comfortable explaining to caregivers the purpose of the MDT, the role of the CAC in facilitating the MDT, and any risks or advantages to the case review process. The staff should also be able to answer questions caregivers may have about their rights for refusal of services, as well as how the clinical care will be impacted with and without the MDT case review process.

Guidelines for the Use of the "Limits to Confidentiality" Document

Informed consent and confidentiality are critical concepts that should be reviewed with all clients and their caregivers (and legal guardians if different) prior to engagement in any therapeutic service. This document is intended to provide additional information pertinent to consent and confidentiality and about legal issues for youth with PSB whose behavior may be considered illegal in the jurisdiction. It may be particularly pertinent to clients at or above the age of adjudication, and may need to be revisited throughout the course of services as youth are asked to share information about their PSB.

The "Limits to Confidentiality" document may be used with clients who have been adjudicated and/or have agency(ies) involvement related to their sexual behavior. Treatment for older youth with PSB can entail the client's admission/acknowledgement of involvement in a crime. Knowledge of the factors of the case that can impact the legal implications of youth behavior is essential when addressing PSB of youth. Further, when applicable, it is paramount that clients and their caregivers fully understand the

potential implications of the acknowledgement of additional crimes outside of their referral behavior or offense. This document may not be relevant for younger clients whose therapeutic services do not require acknowledgement of involvement in a crime.

Guidelines for the Use of the "Home Safety Plan" Document

Safety planning is a process to implement with families early in services and is addressed when there is a need for establishing and/or clarifying strategies to support the safety of all children. Safety planning is a process to consider with all families; however, in cases that include youth with problematic sexual behavior, there is often a specific need to review safety and establish clear rules to support the safety of children in the home and in the community.

The "Home Safety Plan" includes information regarding restrictions for and responsibilities of the youth with PSB, responsibilities of the caregivers, and activities in which the child and/or children may engage. Commonly, safety is part of the intake assessment, and as a safety plan is developed with the caregivers as part of the intake or initial sessions of treatment. Safety should be reassessed informally and formally throughout the course of treatment and the plan revised accordingly when warranted.

This document is intended to be developed jointly with the caregivers and directly involve the youth. The document is subdivided into two forms, one which is more appropriate to be used with older youth and adolescents, and one for younger children. The content is consistent between the two documents, but the language is carefully selected to be developmentally appropriate for each population. This document is a template, with example guidelines to facilitate the development of a home safety plan that fits the context, strengths, risks, and vulnerabilities of those involved. It should NOT be used strictly as written without working with the caregivers to determine fit and need for the family. Contexts to consider include whether there is a no contact order in place, if there are younger or vulnerable children in the home, or if there is the potential for contact with other children (e.g., frequent visitors, home businesses, and/or child care facilities in the home).

The purpose of this document is to empower caregivers to understand their role as an external control for their child, as well as their responsibility to monitor the safety of their child and others while their child remains in the community. It is further intended to establish and clearly outline expectations that, by following, support the family in achieving positive therapeutic outcomes. The "Home Safety Plan" should be a working document which allows for changes and adaptations through the course of the family's progress in services. Difficulty following the safety plan may raise the level of risk for problematic behavior. In order to work towards safety and protection, there may be discussions with community partners on the MDT to determine if additional supports are needed for the family, as well as if options other than community-based placement and treatment are needed, given the level of PSB, the risk factors, and the vulnerability of children.

This document is not a legally binding contract, but rather a plan developed as a team with the family. This is a clinical tool and not equivalent to a legal document such as a Family Court Order.

In the event that the youth with PSB is removed from the home and restricted from contact with their victim and/or siblings, this document may be part of a reunification plan, but should NOT take the place of a clearly defined reunification plan.

After the safety plan is developed with the caregivers, a family meeting to include the youth with PSB is needed. CAC staff should prepare the caregivers to provide much of the information and messages about what is expected for the safety plan. When appropriate, other children in the home may be included in this family meeting. The presentation and discussion should fit the development of the children involved in the meeting. Allow time during the family meeting to review each item with the clients and allow for questions or discussions to ensure that safety is balanced with cultural sensitivity.

Guidelines to Consider in Creating a Memorandum of Understanding (MOU) to Expand or Improve Services for Youth with Problematic Sexual Behavior

A Memorandum of Understanding (MOU) is a formal agreement between two or more agencies that establishes common goals and defines how a partnership will improve service delivery and/or expand services to children and families being served by your Children's Advocacy Center (CAC).

I. Considerations Regarding Critical Issues Before Entering into an MOU

Needs:

What are your CAC's needs? Does your CAC need to expand treatment services for youth with PSB? Does your CAC need more cooperation between agencies to promote effectiveness or improve efficiencies in service delivery?

Resources:

What community resources are available to improve and/or expand CAC services to children with PSB and their families? Specifically, are there private or community providers that specialize in the evaluation and treatment of children with PSB? Are there private or community providers that have similar mission and vision statements that may be congruent with your CAC's identified needs for youth with PSB? Do the local Department of Social Services and/or Board of Education have any resources that compliment, improve, or expand services to these youth?

Stakeholders:

Who are vital stakeholders that can work cooperatively to improve and/or expand CAC services to children and families and/or identify and overcome barriers to service delivery? Stakeholders may include Child Protective Services, behavioral health specialists, public defenders, local courts or judges, law enforcement, Health Department specialists, pediatricians, and other local and state agency officials in juvenile justice.

II. Considerations for Establishing Clearly Defined Agency Expectations Before Entering into an MOU:

Responsibilities:

How will the CAC and the partnering agency(ies) designate and define responsibilities? Responsibilities should be defined as specific action statements and utilize actionable verbs (e.g., provide, support, refer, develop, participate, maintain, ensure, shall, identify, assess, testify etc.)

Examples of CAC responsibilities may include the following action statements:

- The CAC shall provide a safe environment for children during the investigative process when allegations of child maltreatment arise;
- The CAC will identify youth with problematic sexual behavior and present their findings to the MDT to determine evaluation and treatment needs, or;
- The CAC will ensure that appropriate internal/external referrals are made to providers that can provide evaluation and/or treatment services.

Examples of partnering agency responsibilities may include the following action statements:

- Community partners will monitor and supervise youth with problematic sexual behavior in the community.
- Treatment provider will deliver evaluative and treatment services to youth with problematic sexual behavior.
- Community partners will identify youth with problematic sexual behavior and refer to the CAC for the multidisciplinary coordination of services.

Confidentiality Limits:

How will the CAC and partnering agency(ies) protect client rights to confidentiality? For example, both agencies may agree to share documents within their purview, but not third party records.

How will the CAC and the partnering agency(ies) disclose information? Will CACs share forensic interview reports or rely on verbal or documented information shared within the MDT meetings? For example, agencies may decide that the MDT Coordinator will document information shared and recommendations made by all parties in the MDT meeting and will disseminate this document to involved parties on the case.

How will the CAC and partnering agency(ies) handle unauthorized disclosures of confidential information? CACs should have policies and procedures in place for training staff regarding what, how, and with whom information is able to be shared outside the CAC in order to protect client confidentiality. For example, policies should ensure that CAC staff confidentially dispose of any third party documents provided to them by unauthorized personnel and only disseminate documents created by the CAC with proper authorizations in place. CACs should research and apply what is allowed and mandated by state law and local policy.

Term and Termination Limits:

How long will the MOU be effective? For example, participating agencies may decide that the MOU will be effective for five years starting on the date the MOU is fully executed.

How will the CAC or treatment provider terminate the MOU, and for what reasons? For example, partnering agencies may agree that the MOU may be terminated by the CAC or partnering agency, for any reason and at any time, with 30 days written notice to the other party.

How will the CAC or partnering agency deal with disputes/grievances? For example, partnering agencies may decide that CAC leadership or partner agency leadership will meet to discuss disputes or grievances regarding the MOU in an attempt to rectify problems prior to issuing formal written notice of termination.

Additional Considerations for CACs when Integrating Services for Youth with Problematic Sexual Behavior

I. Considerations for Maintaining Client Safety, Supervision, and Privacy During Service Delivery at the CAC

Proper supervision, safety, and privacy for all youth should be the primary goal within a CAC, and further considerations are required when integrating services for youth with PSB. If caregivers of youth with PSB are asked to supervise their child, staff should prepare caregivers prior to the appointment. This should include clear expectations of the type of supervision required by the agency. If staff is asked to supervise, clear guidelines should be established and education and training may be needed to ensure supervision is provided in a child-friendly manner. The likelihood of problematic sexual behavior occurring within a CAC is incredibly low, and is further reduced with adequate sight and sound supervision.

If instances of PSB are known to the CAC prior to scheduling an appointment or there are no contact orders in place, efforts should be made to ensure that the youth with PSB and the other child(ren) involved in the case are not scheduled for forensic interviews, assessments, or mental health services during overlapping periods of time. This ensures confidentiality is maintained for all clients involved and supports CAC's mandate for providing a child-focused setting that is physically and psychologically safe for all youth served. Some agencies may elect to make adaptations to service delivery to avoid unknown overlap in victim and PSB services. These may include changes in typical business hours, separate service delivery times, or use of separate waiting areas, entrances, or buildings.

When PSB is the reason for the referral, authorizations for the release of information can be made at the forensic interview as part of standard practice to allow for the sharing of information with assessment staff. Caregivers can be informed that, should the youth with PSB be seen at the CAC, this release would give the assessing provider access the victim's disclosure in order to inform the assessment and potential treatment recommendations for the youth with PSB. When youth with PSB are seen for an assessment, similar authorizations for the release of information can be completed to allow the assessing therapist to communicate with the forensic interviewer in the victim's case.

Law enforcement may choose to include information gathered in the forensic interview in their formal report, which may also be requested by the assessment provider of the youth with PSB to inform the assessment and subsequent treatment recommendations.

Sample Consent and Confidentiality Agreements

Examples of these forms are available on following pages. Adding your agency's logo and contact information into the header or footer (or adding the content to your organization's letterhead) is recommended.

Consent for Evaluation and Specialized Treatment

I, _____; _____ of

Name of Legal Guardian Relationship to Child

_____,

Child's Name Date of Birth

do hereby authorize [Your Agency's Name] to conduct the following services (initial each) :

_____ Conduct Specialized Evaluation and Assessment

_____ Provide Specialized Treatment

I understand that my records are protected under the Health Insurance Portability and Accountability Act of 1996 (HIPPA), 45 C.F.R., Parts 160 and 164, and cannot be disclosed without my written consent unless otherwise provided for in the regulations. This agency is a mandated reporter. The information collected during the provision of services can be used anonymously for research related to prevention of childhood trauma and abuse.

_____

Legal Guardian #1 Signature Date:

_____

Legal Guardian #2 Signature Date:

_____

Witness Date:

Consent for the Release/Exchange of Confidential Information

I, _____; _____ of
Name of Legal Guardian Relationship to the Child

_____,
Child's Name Date of Birth

do hereby authorize [Your Agency's Name] to receive and release the following information, verbal and written, concerning the Child:

____ Family History; _____ Verbal Comments by the Provider; _____ Incident Reports;

____ Psychological/Psychiatric/Academic and Mental Health Evaluations; ____ MDT Records;

_____ Clinical Summary; ____ Forensic Interview Content; _____ Forensic Interview Report;

Other: _____

From/To: _____

(Person or organization from/to which disclosure/release is to be made)

The disclosure/release will be used for the purpose of (initial each) :

__Exchange of Information __ Diagnostic Evaluation __ Treatment Planning

I understand that my records are protected under the Health Insurance Portability and Accountability Act of 1996 (HIPPA), 45 C.F.R., Parts 160 and 164, and cannot be disclosed without my written consent unless otherwise provided for in the regulations. This agency is a mandated reporter and assures only limited confidentiality. All information collected during the provision of services can be disclosed to authorities investigating sexual abuse of a minor. All information collected can be used anonymously for research related to prevention of childhood trauma and abuse. I authorize [Your Agency Name] to share information for the purpose of treatment and service coordination with the members of the Multidisciplinary Team (MDT) and the staff of the Children's Advocacy Center.

_____

Legal Guardian #1 Signature Date:

_____

Legal Guardian #2 Signature Date:

_____

Witness Date:

Consent for Case Review with the Multidisciplinary Team

I, _____; _____ of

Name of Legal Guardian Relationship to the Child

_____,

Child's Name Date of Birth

hereby consent to and authorize [Your Agency Name] and its professional staff to conduct a case review as deemed necessary or advisable by appropriate members of the Multidisciplinary Team (MDT). A case review is a meeting of relevant agency members in order to review the information about the Child and help with coordination of care. The following are agencies who are members of the Multidisciplinary Team (MDT), and with whom the Signee(s) authorize(s) [Your Agency Name] to share information for the purpose of treatment and service coordination: Children's Advocacy Center, Primary Care Physician, Child Welfare [Local Name], Therapists, Family Court, Law Enforcement, Public Defender's Office, Prosecution, Department of Juvenile Justice [Local Name], Department of Mental Health [Local Name], Board Of Education, County School District;

Other: _____

I understand that my records are protected under the Health Insurance Portability and Accountability Act of 1996 (HIPPA), 45 C.F.R., Parts 160 and 164, and cannot be disclosed without my written consent unless otherwise provided for in the regulations. This agency is a mandated reporter. All information collected during the provision of services can be disclosed to authorities investigating sexual abuse of a minor and used anonymously for research related to prevention of childhood trauma and abuse.

_____

Legal Guardian #1 Signature Date:

_____

Legal Guardian #2 Signature Date:

_____

Witness Date:

LIMITS OF CONFIDENTIALITY

Treatment for Youth with Problematic Sexual Behavior

I, _____; _____ of

Name of Legal Guardian Relationship to the Child

_____,

Child's Name Date of Birth

understand that there are limits to confidentiality when receiving assessment and treatment services at [location].

I understand that, when applicable, the therapists will discuss my child's treatment with appropriate staff and professionals within the child protective services, juvenile justice, legal, law enforcement, and/or other related agencies. I understand that this may take the form of verbal and/or written reports and may occur on a regular basis to best ensure that my child receives the appropriate care and to ensure the safety of the community.

I understand that if my child or I disclose information of incidents of suspected abuse or neglect that are not currently known to authorities, this information will be reported to the proper authorities, as required by state law.

I understand that if I or my child is in danger of hurting ourselves or others, this information will be reported in order to obtain appropriate protection.

I have been given the opportunity to ask questions about the limits of confidentiality and understand when reports will be necessary.

I understand that the treatment program does not require that the Child or Legal Guardian discuss any behavior or offense for which they have not been charged.

Legal Guardian #1 Signature Date:

_____

Legal Guardian #2 Signature Date:

_____

Witness Signature Date:

_____

Home Safety Plan - Adolescent

This is a basic safety plan with suggested rules. This is a template to be adapted or customized to fit the family's situation. For most adolescents, the safety plan will have basic common-sense rules. In most cases, it should not keep adolescents from "having a life," nor should it impose a heavy burden on caregivers or family members. Although a safety plan will have clear rules against some activities (for example, babysitting or looking at pornography) and will require closer than usual parental supervision, it usually will not prohibit most normal teenage activities that parents might normally approve (e.g., spending time with appropriate peers, having a part-time job, engaging in school activities, playing sports, dating, etc.), and a safety plan normally will not require parents to take on 24/7 supervision. The basic suggested rules may include:

Things Adolescent WILL NOT do:

1. Adolescent will never baby-sit for any amount of time. This includes any and all caretaking activities such as bathing, dressing, undressing, walking a younger child to the bus stop or to school, etc.

2. Adolescent will never go into their younger siblings' bedrooms. If they are invited into their bedrooms, they will say "No."

3. Adolescent will not allow their siblings to come into their bedroom.

4. Adolescent will not enter or remain in the bathroom when their siblings are in the bathroom.

5. Adolescent will keep the bathroom door locked when they are in the bathroom alone.

6. Adolescent will not engage in any "horseplay" or tickling with their siblings or any other young children.

7. Adolescent will not watch movies, TV shows, or internet material or listen to music that their parents have not approved or which contain sexual material.

8. Adolescent will not talk about sexual things or make sexual comments or sexual jokes around their siblings or any other children.

9. Adolescent will not send texts or emails which contain sexual content.

10. Adolescent will not engage in the use of pornography including looking at pictures or drawings of individuals without clothes.

Things Adolescent WILL do:

1. Adolescent will respect the authority of their parents and follow their house rules.

2. If Adolescent is doing something with their siblings or any other younger children, and the sibling or other child says "No," or "Stop," Adolescent will do so.

3. Adolescent will be appropriately dressed when in public areas of the house.

4. If Adolescent's younger siblings, or any other children, bring up sexual topics or ask about sexual things, Adolescent will tell them to go ask their parent or caregiver.

5. If Adolescent feels temptations to engage in illegal sexual behavior, they will talk about it with a parent or caregiver.

Things Adolescent CAN do at home, if OK with siblings and parents while supervised by a responsible adult:

1. Adolescent can watch TV, read, listen to music, play sports or play games with their siblings.

2. Adolescent can talk and joke politely with their siblings.

3. Adolescent can go to house of worship, to the store, or on family outings with their family.

4. Adolescent can ride in the car with their family.

5. Adolescent can eat meals or go to restaurants with their family.

5. Adolescent can show appropriate affection to their siblings if the sibling initiates it and if a parent or caregiver is supervising. No kisses.

Some things Adolescent's Caregivers WILL do:

1. Where supervision is required per this Home Safety Plan, Caregivers will provide line of sight supervision to Adolescent, meaning that they must be able to see and hear Adolescent.

2. Caregivers will supervise interactions between Adolescent and young children and not ask Adolescent to babysit or engage in any care taking roles as mentioned above.

3. If Caregivers are not available to supervise interactions between Adolescent and young children, they will make sure that there is some other informed, responsible adult who will take on this responsibility.

4. Caregivers will supervise TV shows, music, videos, and internet material.

5. Caregivers will monitor Adolescent's activities, such as school work, homework, type of friends, whereabouts, curfew hours, and so forth, and help Adolescent make good choices.

6. Caregivers will help Adolescent follow rules by reminding them when necessary.

7. Caregivers will ensure that all the younger children are clothed unless they are in their own room with the door closed, in the bathroom with the door closed, or in bed.

8. Caregivers will be open and accepting to talking with Adolescent about any sexual questions or temptations.

The family agrees to:

1. Treat each other with respect.

2. Respect the Caregivers' authority and follow their house rules.

3. Listen to each other.

4. Be kind to each other.

5. Dress respectfully/appropriately.

6. Have fun activities with each other.

7. Have time so children and adolescents in the home can talk privately with their Caregivers about important matters, including questions about relationships.

8. Help each other be successful and follow the rules of the family.

Other rules the family may wish to add

1.

2.

3.

Adolescent Signature Date:

_____

Caregiver Signature Date:

_____

Therapist Signature Date:

_____

Home Safety Plan – Child

This is a basic safety plan with suggested rules. This is a template to be adapted or customized to fit the family's situation. For most children in our program, the safety plan will have basic common-sense rules. In most cases, it should not keep children from "having a life," nor should it impose a heavy burden on caregivers or family members. Although a safety plan will have clear rules against some activities (e.g., babysitting or looking at pornography) and will require closer than usual parental supervision, it usually will not prohibit most normal youth activities of which parents might normally approve (for example, spending time with appropriate peers, engaging in school activities, playing sports, etc.), and a safety plan normally will not require parents to take on 24/7 supervision. The basic suggested rules may include:

Things Child WILL NOT do:

1. Child will never baby-sit for any amount of time. This includes any and all caretaking activities such as bathing, dressing, undressing, walking a younger child to the bus stop or to school, etc.

2. Child will never go into their younger siblings' bedrooms. If they are invited into their bedrooms, they will say "No."

3. Child will not allow their siblings to come into their bedroom.

4. Child will not enter or remain in the bathroom when their siblings are in the bathroom.

5. Child will keep the bathroom door locked when they are in the bathroom alone.

6. Child will not engage in any "horseplay" or tickling with their siblings or any other young children.

7. Child will not watch movies, TV shows, or internet material or listen to music that their parents have not approved or which contain sexual material.

8. Child will not talk about sexual things or make sexual comments or sexual jokes around their siblings or any other children.

9. Child will not send texts or emails which contain sexual content.

10. Child will not engage in the use of pornography including looking at pictures or drawings of individuals without clothes.

Things Child WILL do:

1. Child will respect the authority of their parents and follow their house rules.

2. If Child is doing something with their siblings or any other younger children, and the sibling or other child says "No," or "Stop," Child will do so.

3. Child will be appropriately dressed when in public areas of the house.

4. If Child's younger siblings, or any other children, bring up sexual topics or ask about sexual things, Child will tell them to go ask their parent or caregiver.

5. If Child feels temptations to engage in illegal sexual behavior, they will talk about it with a parent or caregiver.

Things Child CAN do at home, if OK with siblings and parents while supervised by a responsible adult:

1. Child can watch TV, read, listen to music, play sports or play games with their siblings.

2. Child can talk and joke politely with their siblings.

3. Child can go to house of worship, to the store, or on family outings with their family.

4. Child can ride in the car with their family.

5. Child can eat meals or go to restaurants with their family.

5. Child can show appropriate affection to their siblings if the sibling initiates it and if a parent or caregiver is supervising. No kisses.

Some things Child's Caregivers WILL do:

1. Where supervision is required per this Home Safety Plan, Caregivers will provide line of sight supervision to Child, meaning that they must be able to see and hear Child.

2. Caregivers will supervise interactions between Child and young children and not ask Child to babysit or engage in any care taking roles as mentioned above.

3. If Caregivers are not available to supervise interactions between Child and young children, they will make sure that there is some other informed, responsible adult who will take on this responsibility.

4. Caregivers will supervise TV shows, music, videos, and internet material.

5. Caregivers will monitor Child's activities, such as school work, homework, type of friends, whereabouts, curfew hours, and so forth, and help Child make good choices.

6. Caregivers will help Child follow rules by reminding them when necessary.

7. Caregivers will ensure that all the younger children are clothed unless they are in their own room with the door closed, in the bathroom with the door closed, or in bed.

8. Caregivers will be open and accepting to talking with Child about any sexual questions or temptations.

The family agrees to:

1. Treat each other with respect.

2. Respect the Caregivers' authority and follow their house rules.

3. Listen to each other.

4. Be kind to each other.

5. Dress respectfully/appropriately.

6. Have fun activities with each other.

7. Have time so children and Childs in the home can talk privately with their Caregivers about important matters, including questions about relationships.

8. Help each other be successful and follow the rules of the family.

Other rules the family may wish to add

1.

2.

3.

Child Signature Date:

_____

Caregiver Signature Date:

_____

Therapist Signature Date:

_____

Sample Memorandum of Understanding Between CAC and Treatment Provider

MEMORANDUM OF UNDERSTANDING BETWEEN (Children's Advocacy Center) AND (Treatment Provider) For Evaluative and Treatment Services for Youth with Problematic Sexual Behavior

(Children's Advocacy Center) partners with outside agencies through Memorandums of Understanding (MOUs) to provide high-quality services for youth with problematic sexual behavior (PSB).

(Children's Advocacy Center) seeks strong partnerships to address safety, management, supervision, and treatment of youth with PSB so that the youth can:

*Be treated on an outpatient basis while living in the community;

*Live safely with other children, and;

*Attend school and participate in school activities without jeopardizing the safety of themselves or other students.

This understanding outlines the collaboration between (Children's Advocacy Center) and (Treatment Provider) to provide evaluative and treatment services to youth with PSB and their families. As both agencies recognize the need for a continuum of services, the following collaborative services are mutually agreed upon:

(Children's Advocacy Center) shall:

1) Host the Multidisciplinary Team (MDT) and generate referrals.

2) Ensure an MDT member is responsible for making the initial referral to (Treatment Provider) for evaluation and treatment of youth with PSB.

3) Obtain a signed, dated, and witnessed release of information (ROI) from the parent or legal guardian, before referral to (Treatment Provider). A referral will include the following information: (specific based on agency) demographic information on the youth exhibiting PSB and their caretaker/guardian, a brief summary of the PSB and any other pertinent psychosocial information obtained during the course of the CAC's involvement.

4) Send referrals to (specific title of individual receiving referral) via (email, phone, etc.)

5) Provide support to (Treatment Provider) around participation in legal processes and re-staffing of cases as needed.

6) (Other specifics for the CAC)

(Treatment Provider) shall:

1) Contact the parent/legal guardian of the youth identified as having PSB within 48 hours of the initial referral, via phone or mail, to schedule an intake or evaluation session.

2) Provide evaluative and treatment services based on Best Practice Standards, that are evidence-based, and ethically sound.

3) Develop a comprehensive treatment plan that includes safety recommendations for managing the youth in the least restrictive setting possible.

4) Participate in (specific to the referring agency)/(CAC) transition meetings with Child Protective Services and/or Family Team Decision Making (FTDM) Meetings.

5) Maintain communication with (CAC) staff including (agency specific) to ensure that referred youth and families receive appropriate follow-up and case coordination services.

6) Ensure that all (Treatment Program) clinicians are appropriately licensed by the State of (specify) and have the knowledge and skills necessary to provide effective interventions to youth with PSB.

7) Ensure that all (Treatment Program) clinicians will remain abreast of current research and apply this accordingly to evaluative and treatment services.

8) Obtain and keep liability insurance policies, throughout the term of this MOU, that are issued by a company or companies authorized to do business in the State of (specify) and licensed by the (specify) with liability coverage provided therein in the amount of at least (specify).

9) (Other specifics for the Treatment Provider)

As both agencies recognize the need to protect mental health records, the following confidentiality provisions are mutually agreed to:

1) Protect their clients' right to confidentiality. (CAC) and (Treatment Provider) agree that any mental health records generated as a result of the CAC program referrals are maintained by (Treatment Provider) staff. Access to these mental health records can only be granted with the appropriate written informed consent of the child/parent/guardian as required by law.

2) Not disclose or use any information concerning a recipient of services provided under this MOU, except in accordance with a court order, for any purposes not directly connected with the administration of such services, except upon written consent of (CAC) or as required by (specify any state-specific regulations or laws governing confidentiality).

3) Acknowledge that any unauthorized disclosure of records and information is a criminal offense punishable by a fine of up to (specify $ and any other possible penalties-incarceration etc.) (Treatment Provider) shall be bound by these confidentiality provisions. Any individuals authorized to access the information maintained by (Treatment Provider) pursuant to this agreement, shall be obligated to sign a Confidentiality Acknowledgement (attached hereto as Addendum A). Only individuals who have a need to know will be provided with confidential information.

Both agencies recognize the term and termination provisions:

1) This MOU will be effective for a period of (specify) starting on the date the MOU is fully executed.

2) Either agency may terminate this MOU for any reason and at any time, upon providing (specify timeframe) written notice to the other agency.

3) In the event of a dispute between (CAC) and (Treatment Provider) involving the interpretation or application of the contents of this MOU, (CAC) and (Treatment Provider) agree to make good faith efforts to resolve grievances informally.

4) (Any further provisions)

_____ _____

CAC Director Treatment Provider Director

DATE:_____ DATE:_____