DEPARTMENT OF HUMAN SERVICES
OFFICE OF CHILD WELFARE PROGRAMS

CHAPTER 413
DIVISION 60

COUNSELING AND TREATMENT SERVICES

Effective 12/29/95

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Family Planning Services

413-060-0000
Purpose
(Adopted 12/29/95)

These rules define eligibility criteria for family planning services, describe the services to be provided, and the responsibilities SOSCF has to provide these services.

Stat. Auth.: HB 2004
Stats. Implemented: ORS 435.205 - 435.235

413-060-0010
Eligibility
(Adopted 12/29/95)

The following persons or families are eligible to receive family planning services:

(1) Families who request family planning information.

(2) Children who are in the legal custody and care of the State Office for Services to Children and Families.

(3) Minor children who are 15 years of age and older who request family planning information.

Stat. Auth.: ORS HB 2004
Stats. Implemented: ORS 435.205-235

413-060-0020
Family Planning Services
(Adopted 12/29/95)

Family planning services provided by the State Office for Services to Children and Families include:

(1) Referrals to appropriate family planning resource for consultation and treatment, or

(2) Counseling and information regarding avoiding unwanted pregnancy, termination of pregnancy, maintaining the desired family size and the spacing of children.

Stat. Auth.: HB 2004
Stats. Implemented: ORS 435.205-235

413-060-0030
Service Responsibility
(Adopted 12/29/95)

The State Office for Services to Children and Families will be responsible to:

(1) Explore the need for and interest in family planning services of children who are in the legal custody of the State Office for Services to Children and Families and provide appropriate family planning information or referral.

(2) Provide family planning information or a referral to an appropriate family planning resource to minors 15 years of age and older who request family planning information.

Stat. Auth.: ORS 418.005
Stats. Implemented: ORS 435.205-235

Juvenile Sex Offender Assessment and Treatment

413-060-0400
Purpose
(Adopted 12/29/95)

Child sexual offenders characteristically begin their offending behaviors in early adolescence or younger. The sooner intervention can occur in this cycle, the better the offender can be taught to control his/her deviant actions. Because the treatment methods may be of an intrusive nature, these guidelines are set forth to help determine the appropriate type of treatment. This policy applies only to those who have been adjudicated for sex offenses.

Stat. Auth.: HB 2004
Stats. Implemented: HB 2004

413-060-0410
Definitions
(Adopted 12/29/95)

(1) "A.T.S.A." means Association for the Treatment of Sex Abusers.

(2) "Aversion Therapy" means behavioral therapy procedure which pairs a noxious smell with deviant sexual stimuli.

(3) "Behavioral Therapy" means therapy that attempts to decrease deviant sexual arousal and gives the offender tools for self-control.

(4) "Boredom Tapes" means homework assignments designed to reduce deviant arousal by satiation.

(5) "Cognitive Therapy" means therapy which attempts to alter the manner in which clients think about life and change their cognitive distortions.

(6) "Covert Positive Reinforcement" means therapy which attempts to pair the chain of events leading to a sexual assault with a self-initiated interruption scene followed by a reward scene.

(7) "Covert Sensitization" means therapy that attempts to reduce deviant arousal by instantly pairing pre-assault behaviors with highly aversive fantasies.

(8) "Deviant Sexual Fantasies" means fantasizing and becoming sexually aroused to children or violent themes.

(9) "Plethysmograph" means a device for measuring the sexual response pattern of a male or female client. It is called a penile plethysmograph for males and photoplethysmograph for females.

(10) "Polygraph" means an instrument that simultaneously records changes in such physiological processes as heartbeat, blood pressure, and respiration, and is often used as a lie detector.

(11) "Risk" means the potential for reoffending and for resisting or failing in treatment.

Stat. Auth.: HB 2004
Stats. Implemented: HB 2004

413-060-0420
Eligibility for Services
(Adopted 12/29/95)

Children under the age of 18 years, in the care, custody, and control of the State Office for Services to Children and Families, who have been adjudicated for sex offenses.

Stat. Auth.: HB 2004
Stats. Implemented: HB 2004

413-060-0430
Assessment
(Adopted 12/29/95)

(1) Preliminary Assessment. Assessment for treatment planning of juveniles with sexually aggressive behaviors should proceed only after adjudication has occurred.

(a) The goals of sexual offender specific treatment are:

(A) To stop sexually offending behavior;

(B) To protect members of society from further sexual victimization;

(C) To prevent other aggressive or abusive behaviors which the offender may manifest; and

(D) To promote healthy sexual development.

(b) When juveniles have sexually assaulted family members within their own home, it is strongly recommended that the offending juvenile be placed outside the home

in the least restrictive environment that allows for community safety, or where the assessment indicates. Offenders should not be placed in homes where other children may be endangered. They should be in settings where their behavior can be adequately monitored and controlled.

(c) For the purposes of treatment of sexually aggressive juveniles, it is essential to first evaluate and thoroughly assess each individual and determine the extent of the offending behavior. An assessment must include the following areas:

(A) Victim statements;

(B) History (family, educational, medical, psychosocial and psychosexual);

(C) Progression of sexually aggressive behavior development over time;

(D) Dynamics/process of victim selection;

(E) Intensity of sexual arousal prior to, during, and after offense;

(F) Use of force, violence, weapons;

(G) Spectrum of injury to victim, i.e., violation of trust, fear, physical injury;

(H) Sadism;

(I) Disassociative process;

(J) Fantasies: deviant or appropriate;

(K) Ritualistic/obsessive behaviors;

(L) History of assaultive behaviors;

(M) Chronic/situational factors;

(N) Sociopathy;

(O) Personality disorders; affective disorders;

(P) Attention deficit;

(Q) Post traumatic stress behaviors;

(R) Behavioral warning signs; identifiable triggers;

(S) Thinking errors;

(T) Locus of control, i.e. internal or external;

(U) Ability to accept responsibility;

(V) Denial or minimization;

(W) Victim empathy, capacity for empathetic thought;

(X) Family's denial, minimization, response;

(Y) Substance abuse; juvenile sex offender and family;

(Z) History of sexual victimization, physical, or psychological abuse;

(AA) Family dysfunction; family strengths;

(BB) Parental separation/loss;

(CC) Masturbatory patterns;

(DD) Impulse control;

(EE) Paraphilias;

(FF) Mental status/retardation/developmental disability;

(GG) Organicity/neuropsychological factors;

(HH) Number of victims.

(2) Assigning Risk Level. After an assessment has been completed, a determination should be made as to the risk level presented by the juvenile.

(a) Risk is defined as the potential for reoffending and for resisting or failing in treatment. Use Attachment 2, "Risk Assessment Profile," when determining the juvenile's risk level.

(b) The determination of risk for each adolescent offender should be a multidisciplinary decision involving the offender therapist, caseworker, SOSCF supervisor, juvenile department counselor and victim therapist.

(c) If the juvenile presents low risk according to the "Risk Assessment Profile," treatment should proceed focusing on cognitive restructuring.

(d) For juveniles who exhibit moderate to high risk according to the "Risk Assessment Profile," assessment of deviant arousal patterns may be conducted using the penile plethysmograph for males and the photoplethysmograph for females. In addition, the juvenile should receive a disclosure polygraph examination. These tools should be used in addition to assessment criteria listed in OAR 413-060-0430 to determine the treatment plan of choice. Under no circumstances should the results of these measurements be used in the courtroom setting or for any other reason except evaluation and monitoring of treatment. The plethysmograph should not be administered to prepubescent children.

(A) Use of the polygraph and plethysmograph should be made only with signed, informed consent of the offender and his/her parents/guardians using CF form 993, "Consent for Physiological Assessment of Sexual Interests." This informed consent is to be used regardless of whether a court order requiring its usage exists or not.

(B) The polygraph and plethysmograph exam should be administered only by persons licensed or certified by their respective disciplines. The plethysmograph should be administered in a laboratory setting and in accordance with the "Association for the Treatment of Sexual Abusers' Guidelines for Use of the Penile Plethysmograph."

Stat. Auth.: HB 2004
Stats. Implemented: HB 2004

413-060-0440
Treatment
(Adopted 12/29/95)

(1) Treatment in specialized offense-specific peer groups is the treatment of choice, and must address aggressive and exploitive behaviors. The family should be a key part of the treatment planning. The treatment is to be geared toward the chronological and developmental needs of the offender. Treatment issues to be addressed for all risk categories include the following:

(a) Substance abuse intervention;

(b) Sex education;

(c) Educational assessment for remedial or special education referrals;

(d) Social skills training;

(e) Assertiveness training;

(f) Anger management;

(g) Victimization issues - (sexual, physical, and emotional) their own and their victims;

(h) Family therapy;

(i) Cognitive restructuring;

(j) Values clarification;

(k) Stress management;

(l) Cycle recognition/self-intervention;

(m) Relaxation/biofeedback.

(2) In addition to the above, if the offender in the medium to high risk category demonstrates assaultive, compulsive, or repetitive acts of sexual offending, then behavioral therapy can be introduced. Also, behavioral therapy can be introduced after cognitive methods have failed.

(3) The decision to utilize aversion therapy should be discussed with the juvenile offender and his/her parent or guardian after other therapies have failed, and if, according to polygraph and plethysmograph examinations, the arousal patterns have not altered. The rationale for this choice should be documented in the case record. The SOSCF director or designee must then provide written consent to proceed. Should the parent/guardian or client refuse to sign, a review hearing should be requested to determine the course of action.

(4) Ongoing polygraph and plethysmograph testing should accompany behavioral therapy on a periodic basis to assess treatment progress. In order to graduate from treatment, the client must successfully "pass" a polygraph test which determines that they are not now offending, have disclosed all of their victims and offenses, and are exercising steps to successfully intervene in their offending cycle. Furthermore, they must also demonstrate reduction in deviant arousal patterns.

(5) Relapse prevention is an essential component to the juvenile's treatment plan. Whether he/she is placed in or out of the home, the primary parental figures, parole officer, or other significant figure in the juvenile's life should know and understand his/her assault cycle so as to support the offender in learning to intervene in his/her own cycle.

Stat. Auth.: HB 2004
Stats. Implemented: HB 2004