**Section 1905.300 General Standards for Treatment**

a) Treatment of sex offenders must be sex offense specific.

b) A treatment provider shall develop a written treatment plan with measurable goals based on the needs and risks identified in current and past assessments or evaluations of the sex offender.

c) The treatment plan shall:

1) Provide for the protection of victims and potential victims and not cause the victims to have unsafe or unwanted contact with the sex offender;

2) Be individualized to meet the unique needs of the sex offender;

3) Identify:

A) the issues to be addressed, including multi-generational issues if indicated;

B) the planned intervention strategies; and

C) the goals of treatment;

4) Define expectations of the sex offender, his/her family (when possible), and support systems;

5) Address the issue of ongoing victim input;

6) Describe the treatment provider's role in implementing the treatment plan.

d) A provider shall submit written quarterly progress reports to the referral source.

e) A provider shall employ treatment methods that are supported by current professional research and practice. Group therapy (with the group comprised only of sex offenders) is the preferred method of treatment. At a minimum, any method of psychological treatment used must conform to the standards for content of treatment and must contribute to behavioral monitoring of sex offenders. The sole use of individual therapy is not recommended with sex offenders and shall be avoided except when geographical (specifically rural) or disability limitations dictate its use or when it is clinically indicated. While group therapy is the preferred modality, individual therapy may be an appropriate adjunct treatment.

1) The use of male and female co-therapists in group therapy is highly recommended and may be required by the supervising agency.

2) The ratio of therapists to sex offenders in a treatment group shall not exceed 1:10.

3) Treatment group size shall not exceed 12 sex offenders.

4) The provider shall employ treatment methods that give priority to the safety of the sex offender's victims and the safety of potential victims and the community.

5) The provider shall employ treatment methods that are based on recognition of the need for long-term, offense-specific treatment for sex offenders. Self-help or time-limited treatment shall be used only as adjuncts to long-term, comprehensive treatment.

f) Sex offender-specific treatment may also be supplemented with treatment for drug/alcohol abuse, marital therapy, and/or crisis intervention services.

g) In order to achieve the goals of sex offense specific treatment, the following elements shall be addressed in treatment:

1) Offense Disclosure: The sex offender discloses all of his or her sexual offenses, reducing denial and defensiveness and/or assisting the sex offender in assuming full responsibility for his or her sexual offending. Completion indicators:

A) The sex offender makes a disclosure of all sex offenses.

B) The sex offender attends treatment sessions as ordered or required.

C) The sex offender completes all assigned tasks as required.

D) When available, the sex offender completes non-deceptive polygraphs on past and maintenance issues.

E) The sex offender consistently takes full responsibility for all of his or her actions, including sex offenses, as indicated by polygraph.

F) The sex offender holds himself/herself accountable for his/her behavior in general.

2) Offense-Specific Cognitive Restructuring: Cognitive distortions refer to distortions in thinking, including thinking errors that enable sexually offending behaviors. Identifying and correcting or changing sex offenders' cognitive distortions that fuel sexual offending is the purpose of this element of treatment. Completion indicators:

A) The sex offender identifies and restructures offense-specific cognitive distortions.

B) The sex offender assumes responsibility for offending.

C) There is evidence that offense-specific distortions have been restructured or changed as indicated by the lack of using cognitive distortions and that the sex offender holds self fully accountable when discussing the offenses.

3) Assault Cycle and Intervention: The assault cycle comprises the repetitive patterns of sexual offending. This element of treatment is intended to: identify the sex offender's patterns of offending, including risk factors; teach sex offenders self-management methods and skills to prevent re-offending; educate sex offenders and individuals who are identified as the sex offender's support system and the containment team about the potential for re-offending and the sex offender's specific risk factors; and require sex offenders to learn specific relapse prevention strategies, including the development of a written, specific relapse prevention plan, which should identify antecedent thoughts, feelings, situations, social behaviors, and any other behaviors associated with sexual offenses, along with specific interventions. Completion indicators:

A) The sex offender demonstrates identification of his/her own assault cycle and how he/she applies it to his/her daily lifestyle.

B) The sex offender demonstrates knowledge of relapse intervention concepts.

C) The sex offender has consistently demonstrated the effective use of relapse prevention skills, i.e., is able to diffuse cycle behaviors, relapse processes, deviant arousal and other factors that contribute to sexual offending.

D) The sex offender has disengaged from relationships that support his or her denial, minimization, and resistance to treatment.

E) The sex offender is engaged in relationships that are supportive of treatment and seeks feedback from his/her support system.

F) The sex offender has demonstrated consistently the ability to avoid high-risk environments.

4) Victim Empathy: Empathy is the capacity to understand and identify with another's perspective and experience the same emotions. The ability to develop victim empathy may vary from sex offender to sex offender and may have varying emphasis in treatment. Completion indicators:

A) The sex offender verbalizes and demonstrates victim empathy, identifies feelings, recognizes victim impact, assumes ownership of offenses, understands and takes the perspective of others, demonstrates emotional regret, and expresses feelings of empathy and remorse.

B) The sex offender demonstrates behaviors that indicate reduced risk of harm to victims.

C) Cautionary Note: TREATMENT TO ASSIST IN THE DEVELOPMENT OF VICTIM EMPATHY IS CONTRAINDICATED FOR PSYCHOPATHIC OFFENDERS.

5) Arousal Control: This element of treatment is intended to assess, identify, and decrease or replace deviant sexual desires, arousal, thoughts, and fantasies, replacing this deviancy with healthier sexual attitudes and functioning. Completion indicators:

A) The sex offender discloses deviant and/or violent sexual fantasies.

B) The frequency and intensity of deviant arousal, violent and/or sadistic fantasies, and masturbation to deviant fantasies are decreased.

C) The sex offender develops behavioral/self management strategies to reduce deviant arousal and behavior patterns, including eliminating self-abusive sexual behaviors.

D) The sex offender develops and maintains normal, non-victimizing fantasies.

6) Clinical/Core Issue Resolution: It is commonly assumed that offending involves multiple unresolved emotional issues and not just deviant sexual urges. Motivational dynamics that may fuel sexual offending or other victimizing or assaultive behaviors may arise from the effects of trauma or past victimization, key developmental events, or other unresolved problems or needs. It is critical for resolution of these core issues to occur without the sex offender assuming a victim stance. Sex offenders must still be held accountable for their offending when these issues are resolved. Completion indicators:

A) The sex offender has identified and resolved or mostly resolved core issues that may facilitate sexual re-offense. Core issues may include anger, power, control, inferiorities, dependency, insecurity, rejection, jealousy, possessiveness, resentment, and inadequacies in terms of self-worth and self-esteem.

B) The sex offender has identified and changed the effects of past trauma and past victimizations to decrease their impact on the risks of re-offending.

7) Social Skills and Interpersonal Restructuring: Social skills refer to specific communication skills and social behaviors. Interpersonal restructuring refers to redefining the way sex offenders form attachments or relate to others. Interpersonal deficits are frequently associated with attachment issues. The development of basic social skills replaces deficits and inappropriate attachments or relationships, diminishing the risk of sexual re-offending. This element of treatment is intended to: identify deficits in specific interpersonal skills and decrease the sex offender's deficits in social and relationship skills, where applicable; and assist sex offenders in developing and practicing social skills, improving the quality of their relationships with others. Completion indicators:

A) Demonstrates appropriate social relationships.

B) Demonstrates appropriate boundaries.

C) Has the skills to manage interpersonal relationship issues.

8) Lifestyle Balancing and Restructuring: Lifestyle balancing and restructuring refers to assisting sex offenders in changing their existing lifestyles to lifestyle patterns that minimize sexual re-offending and maintaining this lifestyle. The focus of this element of treatment is to: educate sex offenders about non-abusive, adaptive, legal, and pro-social sexual functioning; identify and treat sex offenders' personality traits, lifestyle, behaviors, patterns, and deficits that are related to their potential for re-offending; and maximize opportunities for the sex offender to develop a healthy self-esteem. Completion indicators will demonstrate a change in personality traits, lifestyle behaviors, patterns, and deficits related to the potential for re-offending, including:

A) Antisocial/psychopathic behaviors.

B) Narcissistic behaviors.

C) Borderline characteristics of behavior.

D) Schizoid behaviors.

E) Obsessive-compulsive/passive-aggressive behaviors.

F) Demonstrates a healthy and balanced lifestyle.

9) The provision of treatment referrals, as indicated, links sex offenders with other resources, such as medical, pharmacological, mental, substance abuse, and/or domestic violence services. Completion indicators:

A) Monitoring sex offenders' linkage with other referral resources.

B) Communication with others. Communication is a critical element in treatment, aftercare and supervision. This element of treatment maintains communication with significant persons in sex offenders' support systems, when indicated and to the extent possible to assist in meeting treatment goals.

h) Providers shall maintain sex offenders' files in accordance with the professional standards of their individual disciplines. The files shall:

1) Document the goals of treatment, the methods used, and the sex offender's observed progress, or lack thereof, toward reaching the goals in the treatment records. Specific achievements, failed assignments, rule violations, and consequences given should be recorded.

2) Accurately reflect the sex offender's treatment progress, sessions attended, and changes in treatment.