**Section 1910.200 Treatment Methods**

a) Sex offense specific treatment shall focus on eliminating abusive behavior by decreasing deviant thinking, impulses, and dysfunction; restructuring distorted thinking patterns that are supportive of continued offending; and improving overall health with the goal of decreased risk.

b) Sex offense specific treatment and intervention strategies shall be used and include a combination of individual, group, and family therapy unless contraindicated.

c) When clinically indicated, the provider may use physiological instruments such as the polygraph, plethysmograph, or Abel Assessment of Sexual Interests so long as the instrument is suited for use with juveniles whose functioning is consistent with that of the juvenile receiving treatment.

d) Empirically-supported treatment modalities currently indicated by research to be best practice based on treatment outcomes are preferred. The following are the preferred practices:

1) Individual therapy shall be used to address sex offense specific issues and attendant mental health issues, if present, and/or to support the juvenile in addressing issues in group, family, or milieu therapy. Provider to client ratio shall be 1:1.

2) Group therapy, proven to be one of the most effective treatment modalities for juveniles, is recommended and may be used to provide psycho-education, promote development of pro-social skills, and provide positive peer support. It may also be used for group process. Provider to client ratios shall be no less than 1:8 or 2:12.

3) Family therapy addresses family systems issues and dynamics. This model shall address, at a minimum, informed supervision, therapeutic care, safety plans, relapse prevention, reunification, and aftercare plans. Provider to client ratios shall be no less than 1:8 or 2:12. Because victims of juveniles who have committed sex offenses are often family members (e.g., younger siblings or foster siblings), the following conditions must be met prior to the initiation of family therapy:

A) The parent or guardian must give consent;

B) The victim must be receiving victim advocacy services, including therapy, and agree to participate in family therapy;

C) A child advocate for the victim must approve the victim's participation in family therapy in writing; and

D) The approved service provider, along with the MDT, has considered the risk of re-traumatization of the victim by having contact with the juvenile who committed the sex offense, and concluded that family therapy would be beneficial. Offender accountability and the assignment of responsibility are major determinants of whether family contact occurs.

4) Multi-family groups provide education, group process, and/or support for the parent and/or siblings of the juvenile. Inclusion of the juvenile is optional.

A) The treatment provider is responsible for establishing and maintaining confidentiality.

B) Staff to client ratios shall be designed to provide safety for all participants.

C) Provider to client ratios shall be no less than 1:8; 2:15; 3:18; or 4:24.

5) Psycho-education is required to teach definitions, concepts, and pro-social skills and must be offered in a group setting. Provider to client ratios shall be no less than 1:12 or 2:20.

6) Milieu therapy is used in residential treatment settings to supervise, observe, and intervene in the daily functioning of the juvenile. Provider to client ratios shall not be less than the following: 1:8 for juveniles 10-12 years of age; 1:10 for juveniles 13 years old and older.

7) Dyadic therapy is used when the treatment provider deems it beneficial and clinically appropriate.

8) Self-help or time limited treatments are used as adjuncts to enhance goal oriented treatment. Adjunct treatments must be complementary to sex offense specific treatment.