COUNCIL ON SEX OFFENDER TREATMENT QUESTIONNAIRE

Name	**Primary Mental Health/Medical License Number:**

Type of Service (check those that apply):
☐ Outpatient ☐ Inpatient ☐ Residential ☐ Institutional-Criminal Justice

Services Provided (check those that apply):
☐ Individual ☐ Group ☐ Family ☐ Marital ☐ Victim ☐ Parent of Juveniles

Which of the following groups of sex offenders do you treat? (Check those that apply):
☐ Adult Males ☐ Adult Females ☐ Juvenile Males ☐ Juvenile Females
☐ Mentally Retarded ☐ Developmentally Disabled ☐ Adjudicated Adults Only
☐ Adjudicated Juveniles Only ☐ Misdemeanor Offenders

Of the following, which applies to your program ? (Check those that apply):
☐ Behavioral ☐ Behavioral/Cognitive ☐ Bio-medical ☐ Family Systems
☐ Psycho/Socio/Educational ☐ Psychoanalytic ☐ Psychotherapeutic
☐ Relapse Prevention ☐ Other: _____

Fees and Payments:
Your fee per session: Group _____ Individual _____
Do you provide an assessment? ☐ Yes ☐ No
If yes, what is your fee for a full assessment? _____
Do you use a sliding scale for fees? ☐ Yes ☐ No
Do you accept insurance co-payments? ☐ Yes ☐ No

General Questions:
I shall comply with CSOT Standards of Practice? ☐ Yes ☐ No
Are you willing to work with a probation officer/parole officer? ☐ Yes ☐ No
Are you willing to provide court-ordered therapy? ☐ Yes ☐ No
Do you refer for polygraphs? ☐ Yes ☐ No
Do you refer for penile plethysmographs? ☐ Yes ☐ No
Do you utilize aversion techniques? ☐ Yes ☐ No
Do you offer therapy in any foreign language (s)? ☐ Yes ☐ No
If yes, then what languages (s)? ☐ Spanish ☐ French ☐ German ☐ Other
Do you treat sexual trauma survivors? ☐ Yes ☐ No
How long is your treatment program? ☐ <6 months ☐ 6 month-1 yr ☐ 1-2yrs
☐ Other specify _____
How long is each individual session? ☐ <60 mins. ☐ 60 mins. ☐ 60-90 mins. ☐ 90 mins.
How long is each group session? ☐ <60 mins. ☐ 60 mins. ☐ 60-90 mins. ☐ 90 mins
How frequent is each group session? ☐ 1x/week ☐ 2x/week ☐ Other specify _____

Check what applies to your assessment

☐ Comprehensive Clinical Review ☐ Intellectual Testing ☐ Psychological Testing
☐ Psychopathy Assessment ☐ Phallometry Assessment ☐ Substance Abuse
☐ Trauma Assessment ☐ Social Competence ☐ Educational Competence
☐ Risk Assessment- ☐ Static 99/99-R ☐ MnSOST-R ☐ SONAR ☐ SORAG ☐ ERASOR
☐ JSOAP ☐ JRAT ☐ RRASOR ☐VRAG ☐ HARE-PCL-R ☐ HARE-YV
Other specify _____

Check what applies to your treatment program

☐ Do you complete the initial treatment plan within 30 days? If no, when? _____
☐ Do you complete subsequent treatment plans at least once a year? If no, when? _____
☐ Do you do behavioral work with clients to modify their deviant sexual arousal?
☐ Do you measure the change in deviant sexual arousal? If yes how? _____

Issue Addressed in Treatment (Check those that apply)

☐ Victim Empathy ☐ Arousal Control ☐ Offense Cycle ☐ Cognitive Distortions
☐ Relapse Prevention ☐ Family Reunification ☐ Aftercare Treatment
☐ High Risk Factors ☐ SUD ☐ Chaperon Training ☐ Child Avoidance/Safety Plans
☐ Polygraphs (☐ Instant Offense, ☐ Sex History, ☐ Maintenance, ☐ Monitoring)

Adjunct Treatment Utilized (Check those that apply):

☐ Alcoholics Anonymous ☐ Adult Children of Alcoholics ☐ Anger Management
☐ Survivors of Sexual Abuse ☐ Narcotics Anonymous ☐ Stress Management
☐ Social Skills ☐ Sex Education ☐ Biofeedback ☐ Relaxation Techniques
☐ Sexually Transmitted Diseases ☐ Conflict Resolution ☐ Positive Sexuality
☐ Interpersonal Communication

Medication Utilized

☐ Anti-psychotic ☐ Anti-androgens ☐ Minor Tranquilizers ☐ Anti-depressants
☐ Other: _____