Interagency Council on the Prevention of Sex Offenses
Registered Psychiatric Treatment Provider
Application

Name: _____

Agency/Program Name: _____

Address: _____

City: _____ Parish: _____ State: _____ Zip: _____

Phone Number: (_____) _____-_____ Fax Number: (_____) _____-_____

E-Mail Address: _____@ _____•_____

Highest Degree: _____ Date Received: _____

Registry Standards

By answering these questions you are stating that you do or do not meet the registry standards. The Council will not verify your answers. You are solely responsible for verifying and documenting the validity and accuracy of your responses. Any purposeful misrepresentation of your credentials or qualifications is unethical and potentially criminal.

1. Do you have a current license in good standing, by the State of Louisiana as a physician or psychiatrist? _____ Yes _____ No (If no, do not send in the application)

   Louisiana License: _____ Date Received: _____ License #: _____

Please enclose a copy of your state license for registry records. Please feel free to list all other certifications, licensing, and credentials. Identify which licensing or credentials are specific for offender treatment and/or forensics.

License/Certification	Date Received
_____	_____
_____	_____
_____	_____
_____ ____	_____

2. Have any formal complaints been filed against you and validated by your licensing board or been sanctioned by the board for sexual or violent misconduct or behavior? _____Yes _____No (If yes, do not send in the application)

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3. Have you had training in sexual offender treatment and in the application of pharmacological agents with sexual offenders _____Yes _____No (If no, do not send in the application)

   Total number of hours of training in sex offender treatment and assessment: _____

   Training received for the past five years: (40 hours per year required for registered treatment providers.) (Training hours should be specific sexual offender treatment, assessment, research, and intervention strategies.)

Date	**Name/Training/Trainer**	**Subject**	**Hours**
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Total Hours: _____

Documentation of training received does not need to be submitted.

4. Do you agree to include sexual offender treatment as defined by the Interagency Council as a component in the overall treatment plan of a sexual offender? _____Yes _____No (If no, do not send in the application.)

5. Have you ever been convicted of a felony without pardon? _____Yes _____No
   (If yes, do not send in application)

6. Have you ever had a validation, adjudication, or conviction for an offense of any kind involving sexual or violent misconduct or behavior? _____Yes _____No
   (If yes, do not send in application)

7. Do you commit to follow the ethical standards and principles established by the Association for the Treatment of Sexual Abusers (ATSA)? _____Yes _____No
   (If no, do not send in application)

8. Do you commit to, that if you provide a risk assessment and sexual offender treatment that you will provide Risk Assessment and sexual offender treatment as outlined in the definitions provided by the interagency Council utilizing only techniques and methods currently promoted and accepted in the field of sexual offender treatment? _____ Yes _____ No
   (If no, do not send in application)

9. Will you provide the information requested on the research and information session of the application? _____Yes _____No (If no, do not send in the application)

10. Are you a clinical member of the Association for the Treatment of Sexual Abusers (ATSA)? _____Yes _____No (You are not required to be a member of ATSA to be included on the registry.)

Are you a member of the Louisiana Chapter of the Association for the Treatment of Sexual Abusers (LA ATSA)? _____Yes _____No

(If you answer no you may still send in application and be listed on the registry if questions 1-9 were answered correctly.)

Research and Referral Information

I. Program Information

Which level best describes the amount of professional interaction you have with parole/probation officers regarding sex offenders: _____None _____Minimal _____Moderate _____High

A. Program Setting: (Check all that apply)

_____Mental health/Public agency
_____Autonomous/Private practice
_____Residential/Inpatient
_____Community-based/Outpatient
_____Court-sponsored
_____Prison-based
_____Assessment only, no therapy

B. List any language you offer treatment other than English. _____

C. How many sex offenders are you currently treating? _____

D. What is the total number of sex offenders you treated in the last twelve months? _____

E. What is the average cost of treatment? $_____ per session

F. Do you work with court mandated clients? _____Yes _____No

G. Do you work with probation, parole, and O.C.S. workers? _____Yes _____No

H. Do you obtain consultation, supervision, or collaboration from another mental health professional? _____ Yes _____ No If yes, please list:

Name	Degree	License	Registered Treatment Provider
_____	_____	_____	_____ Yes _____ No

_____ _____ _____ _____ Yes _____ No

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II. Type of Clients Served, Eligibility Criteria, and Classification

A. Which of the following groups of sex offenders do you treat? Check all that apply:

_____ Adjudicated Juveniles Only _____ Juvenile Females _____ Hearing Impaired
_____ Adults Only _____ Juveniles Only _____ Sight Impaired
_____ Adult Males _____ Mentally Retarded _____ Juvenile Males
_____ Court adjudicated only _____ Adult Females _____ Mentally Ill _____ Developmentally disabled _____ Clients with psychiatric diagnosis

B. Client Population: (Check all that apply)

_____Child sexual abusers (pedophiles) _____Rapists
_____Other paraphilias _____

1. Age Range:
   _____ Adults (19+) _____ Adolescents/Juveniles (13-18) _____ Children (3-12)
2. Do you classify offenders prior to placing them in a treatment program? _____Yes _____No

3. If yes, indicate how you classify the offenders checking all that apply:
   _____ Dual-diagnosis (substance abuse, mental retardation, mental impairment)
   _____ Judicial requirements (parole vs. probation client, CPS referrals, etc.)
   _____ Language ability (English, Spanish, etc.)
   _____ Offense Characteristics
   _____ Gender of Clients
   _____ Risk Assessment
   _____ Age of Clients
   _____ Other - Please explain _____

III. Program Components

A. Treatment Modalities. Please check all that apply:

1. Arousal Reconditioning
   _____ Physiological monitoring _____ Covert sensitization
   _____ Masturbatory satiation _____ Orgasmic reconditioning
   _____ Minimal arousal conditioning _____ Masturbatory training
   _____ Aversive techniques (Olfactory) _____ Aversive techniques (Faradic)
   _____ Modified aversive fantasy work _____ Sexual arousal card sort
   _____ Verbal satiation

2. Chemotherapy
   _____ Provera _____ Major tranquilizers _____ Minor tranquilizers
   _____ Lithium Carbonate _____ Prozac _____ Serotonin reuptake blockers

_____ Anafranil _____ Busbar _____ Other

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3. General and Offense Specific Treatments

_____ Personal victimization/trauma
_____ Autobiography
_____ Relapse process/cycle
_____ Victim Apology
_____ Bio-feedback
_____ Experiential therapies
_____ Dissociative state therapy
_____ Shaming
_____ Journal keeping
_____ Pre-assault/assault cycle
_____ Addictive Cycle
_____ Victims restitution
_____ Art therapies
_____ Bodywork/massage therapy
_____ Hypnosis

4. Adjunctive Treatments/Aftercare Planning

_____ Employment/Vocational issues
_____ ACOA
_____ NA
_____ Other
_____ SA (12 Step)
_____ AA
_____ Urinalysis monitoring

5. Other approaches, tools, etc.: _____

B. Do you have a clearly written treatment contract that is given to and discussed with clients?
_____Yes _____No

C. If yes, please indicate the contract requirements you include by checking all items that apply:

_____ Expectation of work to be completed by client, including homework assignments
_____ New offenses will be reported
_____ Requirements regarding dating and sexual behaviors
_____ Requirements regarding spouses, family, and significant others involvement
_____ Client agrees to actively participate in program
_____ Stipulations regarding employment, social activities, and residence
_____ Stipulations regarding access to victim (if incest, etc.)
_____ Disclosure of information (limited confidentiality)
_____ Limits regarding travel
_____ Client admits his offense
_____ Other-Please explain: _____
_____

D. Does your program have clearly stated, written program goals which are discussed with and given to clients? _____Yes _____No

E. Do you maintain individual treatment plans? _____Yes _____No

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F. If yes, how often are the plans reviewed?

_____ Weekly _____ Quarterly _____ Annually
_____ Monthly _____ Semi-Annually
_____ Other-Please explain: _____
_____

IV. Risk Assessment

Assessment Measures. Please indicate what measures you use for sexual offender risk assessment.

_____ Abel Sexual Interest Screening
_____ Abel and Becket Cognition Scale
_____ Attitudes Towards Women Scale
_____ Autobiography
_____ Behavioral Measures
_____ Burt Rape Myth Acceptance Scale
_____ Buss-Durkee Hostility Inventory
_____ Clarke Sexual History Questionnaire
_____ Cognitive Distortions Scale
_____ Psychosexual History
_____ Wechsler Intelligence Scales for Adults
_____ Wilson Sexual Fantasy Questionnaire
_____ HARE Psychopathy Checklist
_____ Interpersonal Reactivity Index
_____ Family Adaptability and Cohesion Eval.
_____ Michigan Alcohol Screening Test (MAST)
_____ Crowne-Marlowe Scale of Social Responsibility
_____ Minnesota Sex Offender Screening Tool
_____ Static 99
_____ Other - Please Specify: _____
_____ Other - Please Specify: _____

_____ Abel and Becket Cardsort
_____ Locus of Control
_____ MSI
_____ Neuropsychological Evaluation
_____ Novaco Anger Scale
_____ Personality Inventory
_____ Plethysmography
_____ Polygraph
_____ Projective Techniques
_____ Sexual Anxiety Inventory
_____ Situational Competency Test
_____ Structured Clinical Interview
_____ TONI-IQ
_____ Empathy Scales
_____ MCMI - III
_____ SASSI
_____ MMPI
_____ RRasor
_____ SONAR

V. Measuring Client Change

A. Measuring Client Change. Please indicate what measures you use in your program for assessment of a client's progress (post-test and on-going assessment).

_____ Abel Sexual Interest Screening
_____ Abel and Becket Cognition Scale
_____ Attitudes Towards Women Scale

_____ Abel and Becket Cardsort
_____ Locus of Control
_____ MSI

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_____ Autobiography
_____ Behavioral Measures
_____ Burt Rape Myth Acceptance Scale
_____ Buss-Durkee Hostility Inventory
_____ Clarke Sexual History Questionnaire
_____ Cognitive Distortions Scale
_____ Psychosexual History
_____ Wechsler Intelligence Scales for Adults
_____ Wilson Sexual Fantasy Questionnaire
_____ HARE Psychopathy Checklist
_____ Interpersonal Reactivity Index
_____ Family Adaptability and Cohesion Eval.
_____ Michigan Alcohol Screening Test (MAST)
_____ Crowne-Marlowe Scale of Social Responsibility
_____ Minnesota Sex Offender Screening Tool
_____ Other - Please Specify: _____

_____ Neuropsychological Evaluation
_____ Novaco Anger Scale
_____ Personality Inventory
_____ Plethysmography
_____ Polygraph
_____ Projective Techniques
_____ Sexual Anxiety Inventory
_____ Situational Competency Test
_____ Structured Clinical Interview
_____ TONI-IQ
_____ Empathy Scales
_____ MCMI - III
_____ SASSI
_____ MMPI
_____ RRasor

B. Please indicate which of the following you believe are the most important indicators of a client's progress by numbering items from 1 (most important) to 10 (least important).

_____ Acknowledgment of responsibility for offenses without denial, minimization, or projection of blame.
_____ Behavioral indications of work toward treatment goals.
_____ Ability to discern contributing factors to offending cycle.
_____ Capacity for victim empathy/demonstration of empathic thinking.
_____ Improvement in self-esteem.
_____ Positive changes in contributing factors to sexual assault behavior.
_____ Increases in positive sexuality.
_____ Pro-social interactions
_____ Positive family interactions.
_____ Openness in examining thoughts, fantasies, and behavior.
_____ Ability to counter irrational thinking/thinking errors.
_____ Ability to interrupt cycle and seek help when destructive or risk behavior pattern begins.
_____ Assertiveness and communication.
_____ Resolution of personal victimization or loss issues.
_____ Ability to experience pleasure in normal activities.
_____ Other - Please specify: _____

C. Tracking Recidivism

1. Do you maintain records that show the recidivism rate of your clients?

_____Yes _____No

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2. If yes, how do you define recidivism in your tracking system? Mark an X next to all items that apply:
   _____ Arrest for new sexual offense
   _____ Conviction for new sexual offense
   _____ Arrest for any offense
   _____ Admission by offender (without arrest or conviction) of any new offenses, sexual or otherwise
   _____ Conviction for any offense
   _____ Technical violations
   _____ Length of time between occurrences of offending behavior
   _____ Positive drug tests
   _____ Client evaluation (i.e., therapist assessment utilizing various methods, including polygraphs)
   _____ Counseling Non-Attendance
   _____ Other - Please Explain: _____
   _____

3. What time period do you track the clients in order to ascertain a recidivism rate?
   _____ 0 - 6 months
   _____ 6 months - 1 year
   _____ 1 - 2 years

   _____ 2 - 3 years
   _____ 3 - 5 years
   _____ Other - Please explain: _____
   _____

4. From what source do you derive your information to determine the recidivism rate of your program? (More than one of the following items may apply).
   _____ Parole/Probation officers
   _____ Client self-report
   _____ Plethysmography testing
   _____ Psychological testing
   _____ Therapists (and reporting from other therapists)
   _____ Other - Please explain _____
   _____
   _____ Law enforcement officers
   _____ Polygraph testing
   _____ Urinalysis testing
   _____ Client support system

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VI.Short Answer Questions

A. In your opinion, what major components should be present in an effective treatment model?

_____

_____

_____

_____

_____

B. What, in your opinion, should be the major components of aftercare?

_____

_____

_____

_____

_____

C. What are your major concerns about your ability to provide effective services for this population?

_____

_____

_____

_____

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I, _____, hereby affirm that the above information is true. I understand that I am solely responsible for the information I send to the Interagency Council for the Registry of Clinical Sexual Offender Treatment Providers. The responsibility of verifying, documenting, and validating my qualifications, experience, and answers on this questionnaire rests solely on me, my referral sources, my clients, and/or my licensing board. I understand that the Interagency Council will not verify or certify me as a Clinical Sexual Offender Treatment Provider, but will make the information that I submit to the Interagency Council available to those interested in the information.

I understand that if I do not answer the questions on the registry I will not be listed in the registry. If I did not answer the questions regarding the standards for the registry in a favorable manner, I will not be listed in the registry. In addition, I hereby give the Interagency Council permission to use the information in this application for research and will make the information available to other reputable organizations to use for research. I will not hold the Interagency Council responsible for clerical errors or mistakes regarding my data. I am responsible for verifying the accuracy of my registry data and information on the registry and will respectfully request corrections if I find errors on the registry regarding my registry data and application.

_____ _____
Signature **Date**

_____ _____
Witness **Date**

_____ _____
Witness **Date**