2955.0100 STANDARDS FOR CLIENT ADMISSION, INTAKE, AND ASSESSMENT.

Subpart 1. **Admission procedure and new client intake assessment; report required.**

A. A treatment program's clinical supervisor must develop and follow a written admission procedure that includes treatment staff determining the appropriateness of a client for the program by reviewing:

(1) the client's condition and need for treatment;

(2) the adjunctive and clinical services offered by the program; and

(3) other documents in the client's file relating to the client's treatment history, reason for treatment, and other clinically assessed needs.

B. The admission procedure must be coordinated with the nonclinical correctional facility conditions within which the program operates.

C. A clinical supervisor must develop and follow a written intake assessment procedure that determines a client's functioning and treatment needs. A client must have a written intake assessment report completed within 30 business days:

(1) after the client's admission to the program; or

(2) after the client has transitioned from pretreatment.

Subp. 2. **Intake assessments.**

A. A clinical supervisor must direct treatment staff to gather the information under subpart 1 during the intake assessment process and any reassessments under subpart 4. The staff members who conduct the intake assessment must be trained and experienced in administrating and interpreting assessments in accordance with their licensure or be supervised by a clinical supervisor.

B. A treatment program may contract with an outside entity to conduct an intake assessment if the entity is qualified under this part.

Subp. 3. **Intake assessment appropriate to treatment program's basic treatment protocol.** A treatment program may adapt the parameters under subparts 6 to 8 to conduct assessments that are appropriate to the program's basic treatment protocol. The rationale for the adaptation must be provided in the program's policy and procedure manual under part 2955.0140, subpart 1, item E.

Subp. 4. **Reassessment.** A clinical supervisor or treatment staff member may reassess a client to assist in decisions on the client's:

A. progress in treatment;

B. movement within the program's structure;

C. receipt or loss of privileges; and

D. discharge from the program.

Subp. 5. **Cultural sensitivity.** An assessment must take into consideration the effects of cultural context, ethnicity, race, social class, and geographic location on the client's personality, identity, and behavior.

Subp. 6. **Sources of assessment data.** Sources of assessment data may include:

A. collateral information, such as police reports, victim statements, child protection information, presentence assessments and investigations, and criminal history and juvenile justice data under Minnesota Statutes, section 13.875;

B. psychological and psychiatric test information;

C. client-specific test information, including deception and sexual interest and response assessments;

D. relevant medical information;

E. interviews with the client;

F. previous and concurrent assessments of the client, including substance use, psychological, educational, and vocational;

G. interviews, telephone conversations, or other communication with the client's family members, friends, victims, witnesses, probation officers, and police; and

H. observation and evaluation of the client's functioning and participation in the treatment process while in residency.

Subp. 7. **Information included in assessment.** An assessment must include the following information, as applicable to the client:

A. a description of the client's conviction or adjudication offense, noting:

(1) the facts of the criminal complaint or the delinquency petition under Minnesota Statutes, section 260B.141;

(2) the client's description of the offense;

(3) any discrepancies between the client's and the official's or victim's description of the offense; and

(4) the assessor's conclusion about the reasons for any discrepancies in the information;

B. the client's history of perpetration of sexually abusive or harmful behavior or criminal sexual behavior and delineation of patterns of sexual response that considers such variables as:

(1) the number and types of known and reported sexually abusive or harmful behaviors or criminal sexual behaviors committed by the client;

(2) the type of sexual aggression used and any use of weapons;

(3) the number, age, sex, relationship to client, and other relevant characteristics of the victims;

(4) the type of injury to the victims and the impact of the sexually abusive or harmful behavior or criminal sexual behavior on the victims;

(5) the dynamics and process of victim selection;

(6) the role of substance use prior to, during, and after any sexually abusive or harmful behaviors or criminal sexual behaviors;

(7) the degree of impulsivity and compulsivity, including any attempts by the client to control or eliminate offensive behaviors, including previous treatment;

(8) use of cognitive distortions, thinking errors, and criminal thinking in justifying, rationalizing, and supporting the sexually abusive or harmful behaviors or criminal sexual behaviors;

(9) the reported degree of sexual interest and response prior to, during, and after any sexually abusive or harmful behaviors or criminal sexual behaviors;

(10) a profile of sexual interest and response, including any paraphilic or sexually abusive fantasies, desires, and behaviors;

(11) the degree of denial and minimization, degree of remorse and guilt regarding the offense, and degree of empathy for the victim expressed by the client; and

(12) the developmental progression of sexually abusive or harmful behavior over time;

C. the client's developmental sexual history that considers such variables as:

(1) family of origin or other caretaker attitudes about sexuality and the sexual atmosphere;

(2) childhood and adolescent learning about sexuality, patterns of sexual interest, and sexual play;

(3) history of reported sexual victimization;

(4) sexual history time line;

(5) courtship behaviors and relationships, including marriages;

(6) experience of puberty;

(7) exposure to and use of sexually explicit materials;

(8) nature and use of sexual fantasies;

(9) masturbation pattern and history;

(10) sense of gender identity and sex role behavior and attitude;

(11) sexual orientation; and

(12) sexual attitudes and knowledge;

D. the client's history of any other aggressive or criminal behavior;

E. the client's personal history that includes such areas as:

(1) current living circumstances and relationships;

(2) prior out-of-home placements and living arrangements;

(3) nature of peer relations;

(4) play and leisure interests;

(5) medical history;

(6) educational history;

(7) substance use history;

(8) employment and vocational history; and

(9) military history;

F. a family history that considers such variables as:

(1) reported family composition and structure;

(2) parental separation and loss;

(3) family strengths and dysfunctions;

(4) criminal history;

(5) substance abuse history;

(6) mental health history;

(7) sexual, physical, and emotional maltreatment; and

(8) family response to the sexual criminality;

G. the views and perceptions of significant others, including their ability or willingness to support any treatment efforts;

H. personal mental health functioning that includes such variables as:

(1) mental status;

(2) intellectual functioning;

(3) coping abilities, adaptational styles, and vulnerabilities;

(4) impulse control and ritualistic or obsessive behaviors;

(5) personality attributes and disorders and affective disorders;

(6) posttraumatic stress behaviors, including any dissociative process that may be operative;

(7) organicity and neuropsychological factors; and

(8) assessment of vulnerability;

I. the findings from any previous and concurrent sex offender, psychological, psychiatric, physiological, medical, educational, vocational, or other assessments; and

J. the client's risk and protective factors, including at a minimum:

(1) how the factors may inhibit or contribute to the client's engagement in sexually abusive or harmful behavior; and

(2) the factors' current level of influence on the client.

Subp. 8. **Administering psychological testing, measures of risk and protective factors, and assessments of adaptive behavior.**

A. If applicable to the client, psychological tests; measures of risk and protective factors; and assessments of adaptive behavior, adaptive skills, and developmental functioning used in intake assessments must be standardized and normed for the given population tested.

B. Test results must be interpreted by a treatment staff member who is trained and experienced in interpreting the tests, measures, and assessments. The results may not be used as the only or the major source of the intake assessment.

Subp. 9. **Assessment conclusions and recommendations.**

A. The conclusions and recommendations of the intake assessment must be based on the information obtained during the assessment.

B. The interpretations, conclusions, and recommendations described in the assessment report must consider the:

(1) strengths and limitations of the procedures used in the assessment;

(2) strengths and limitations of self-reported information and demonstration of efforts to verify information provided by the client; and

(3) client's current conviction or adjudication offense and criminal history and juvenile justice data under Minnesota Statutes, section 13.875.

C. The interpretations, conclusions, and recommendations described in the assessment report must:

(1) be impartial and provide an objective and accurate base of data;

(2) note any issues or questions that exceed the level of knowledge in the field or the assessor's expertise; and

(3) address the issues necessary to make decisions on treatment and reoffense risk factors.

Subp. 10. **Assessment report.** One treatment staff member must complete the assessment report, which must be signed and dated and placed in the client's file. The report must include the following areas:

A. a summary of diagnostic and typological impressions of the client;

B. an initial assessment of the factors that both protect the client from and place the client at risk for unsuccessful completion of the treatment program and sexual reoffense;

C. a conclusion about the client's amenability to treatment; and

D. a conclusion on the appropriateness of the client for placement in the program as follows:

(1) if the program cannot meet the client's treatment needs, a recommendation for alternative placement or treatment is provided; or

(2) if the assessment determines that the client is appropriate for the program, the report must present:

(a) an outline of the client's treatment needs;

(b) recommendations, as appropriate, for the client's needs for adjunctive services in areas such as health, substance use disorder treatment, education, vocational skills, recreation, and leisure activities;

(c) a note of any concurrent psychological or psychiatric disorders, their potential impact on the treatment process, and suggested remedial strategies; and

(d) recommendations, as appropriate, for additional assessments or necessary collateral information, referral, or consultation.

Subp. 11. **Client review and input.**

A. A client must have the opportunity to review the assessment report under subpart 10 and discuss it with a treatment staff member and, if needed, to verify or correct information in the report. Nothing under this item allows the staff member to override the conclusions and recommendations of the review under subpart 9.

B. If the report is amended, the amended report must be signed and dated by the staff member.

Statutory Authority: *MS s 241.67*

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