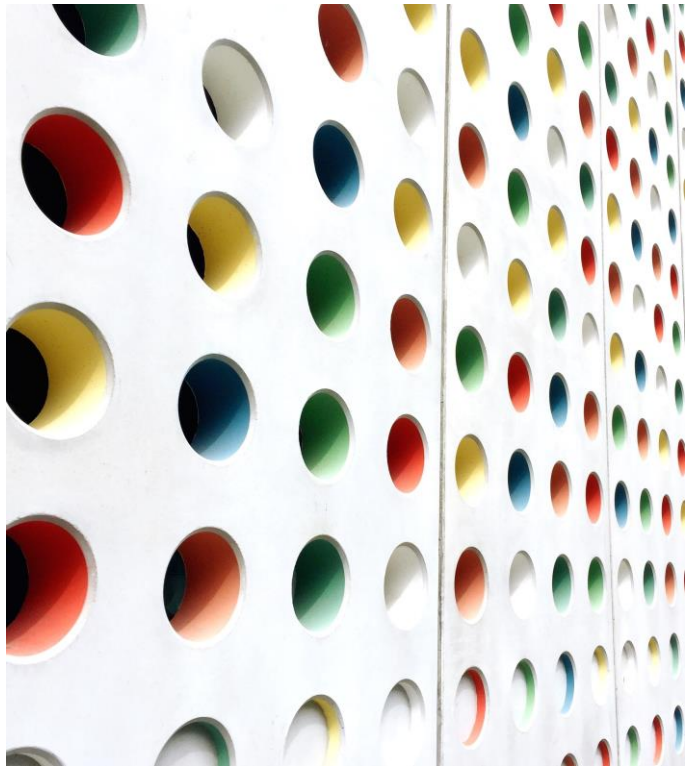
KANSAS SENTENCING COMMISSION

SENATE BILL 123



Pre-Sentence Assessments and Provider Certification Updates

TRISH BECK

KANSAS SENTENCING COMMISSION

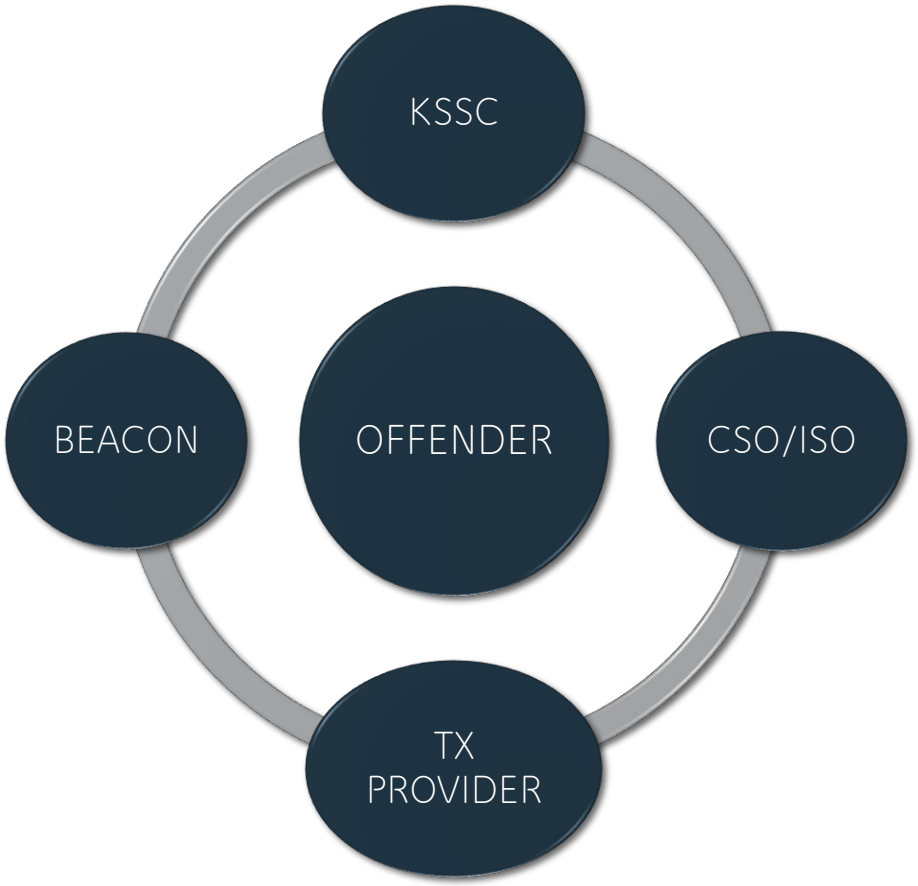
PROGRAM AUDITOR

SB123PAYMENTS@KS.GOV

TOPICS OF INTEREST

- WHO'S INVOLVED?
- COMMUNICATION
- DOCUMENTS
- PROVIDER CERTIFICATION UPDATES

WHO'S INVOLVED?



ALL OF US-

From Pre-Sentence ➡

Discharge of probation…

And everything in between.

The offender has been charged with a drug crime- possible eligibility to SB 123

KSSC- certifies, educates and pays for the SB 123 Program		
Beacon Health Options- educates and pays as a third party	**CSO/ISO**- starts the process and connects offender to a Treatment Provider	**Tx Provider**-Required to provide 1 or more treatment options in the continuum of services authorized up to 18 months

CSO's- Court Services

- Pre-sentence referrals- ONLY IF they score "eligible"
  - NO referrals for an Assessment if they don't qualify for SB123
- Communicate with the Tx Provider as to whether it's SB123 or not at the time of the referral
- If SASSI is performed- complete the form in its entirety (case#, name, test date, and draw the scoring graph)
- Don't have access to Athena

ISO's- Community Corrections

- Pre-sentence and Post-sentence referrals
- Communicate with Tx Provider immediately the case status (SB 123)
- Collaborate with Tx provider who will be generating the CPA and each keep a copy in offenders' file
- Have access to Athena
- Must contact KSSC to verify term dates on case(s)

Kansas Sentencing Commission
Probation Placement Criteria

PLACEMENT	WRNA	LS/CMI	SASSI-4
Diversion (K.S.A. 21-6825)	mid-range of moderate to high risk (15 and above)	mid-range of medium to very high risk (15 and above)	high
SB 123 (K.S.A 21-6824)	medium to high risk (22 and above)	high to very high risk (20 and above)	high
Court Services (KS S. CP. Rule 18.02)	low and moderate risk (0-21)	very low, low and medium risk (0-19)	n/a
Community Corrections (K.S.A. 75-5291(a)(2)(A))	medium and high risk (22 and above)	high and very high risk (20 and above)	n/a

Kansas Probation Assessment Scales

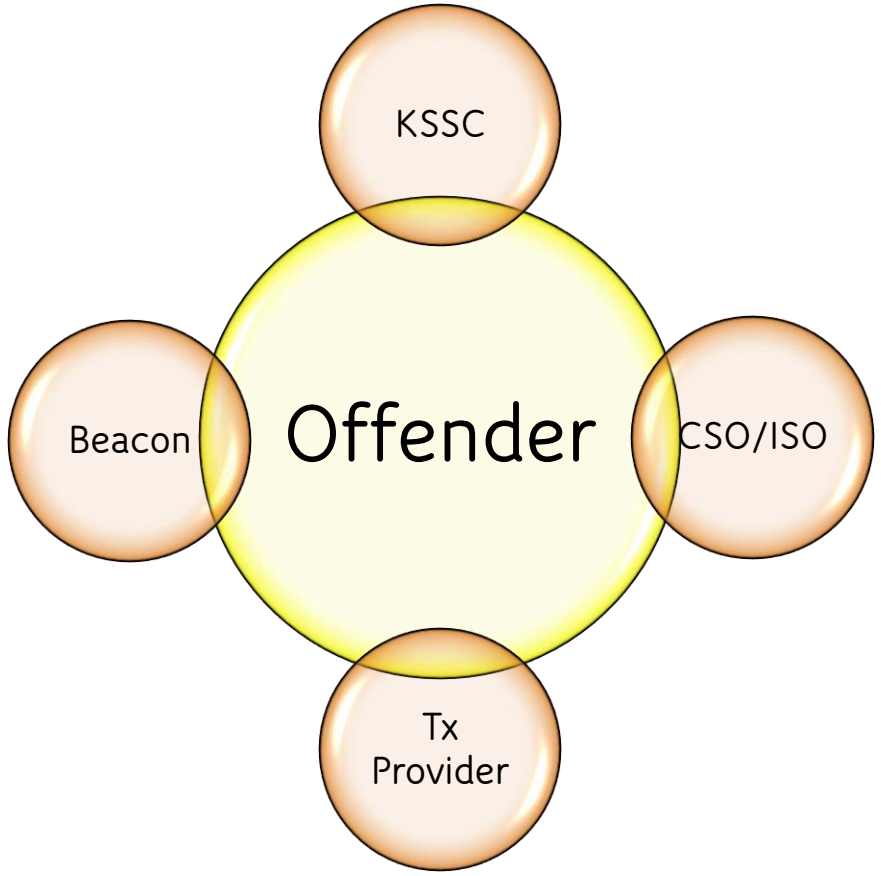
WRNA		LS/CMI	
Low	0-9	**Very Low**	0-4
Moderate	10- 21	**Low**	5-10
Medium	22-36	**Medium**	11-19
High	37+	**High**	20-29
		Very High	30+

Treatment Providers

State-Wide Approved Providers

- ALWAYS ask (before the assessment)
  - the CSO, ISO and even the offender, if the referral is SB 123
- Confirm with CSO/ISO (if possible)
  - sentencing date
  - KBI#
  - Soc sec#
  - Date of Birth
- Contact ISO when difficulties arise in Provider Connect.
  - KSSC will not notify Beacon without ISO verification

Communication



The primary reason we MUST communicate with each other…

The OFFENDER!

DOCUMENTATION

- SB123 for Purchase of Service
- Assessment Summary Form
- Cover of the SASSI-IV Sheet
- Clinical Interview Summary with ASAM Criteria
- Client Placement Agreement

Pre-Sentence Assessment- INVOICE

- Why the highlights?????

Kansas Sentencing Commission
Jayhawk Tower, 700 SW Jackson Street, Suite 501
Topeka, KS 66603

PRE-SENTENCE ASSESSMENT

INVOICE FOR PURCHASE OF SERVICE

(Please Type or Print Legibly, DO NOT USE WHITEOUT) (Use the TAB key to move from field to field, initial all changes)

1. Treatment Provider:	2. Date Assessment Completed (MM/DD/YYYY) Year:	3. Sentencing Date:
4. Address (location of services):	5. Supervising Agency:	
6. City/State/Zip:	7. Officer's Name: ☐ CSO ☐ ISO	
	8. Phone Number:	
9. Billing address: (if different than above)	10. County of Conviction:	

11. Offender Name: (Last)	(First)	(M.I.)	12. ATHENA Number:	13. TOADS Legacy KDOC# (if available)	14. KBI Number:	15. Court Case Number:

16. Modality: Pre-Sentence Assessment	17. Service Unit = 1	18. Total = $175	
19. Does the offender have insurance? ☐ No ☐ Yes			NOTE: IF OFFENDER HAS INSURANCE HAS IT BEEN BILLED FOR THIS SERVICE? ☐ No ☐ Yes ☐ N/A
20. LESS Insurance Reimbursement		$	IS THIS FORM FOR REPORTING PURPOSES? ☐ No ☐ Yes
21. TOTAL		$	Comments:

* PAYMENT WILL NOT BE PROCESSED UNLESS THE COMPLETED FORMS ARE ATTACHED TO THIS INVOICE:
- **APPLICABLE SB 123 ASSESSMENT SUMMARY FORM
- **COVER SHEET SASSI
- **CLINICAL INTERVIEW SUMMARY WITH ASAM CRITERIA

*** Please provide Assessment documentation to the supervising officer (CSO/ISO) for offender's file.*

Signature:, the Treatment Provider certify that this service/material has been provided and that this invoice is correct and true.

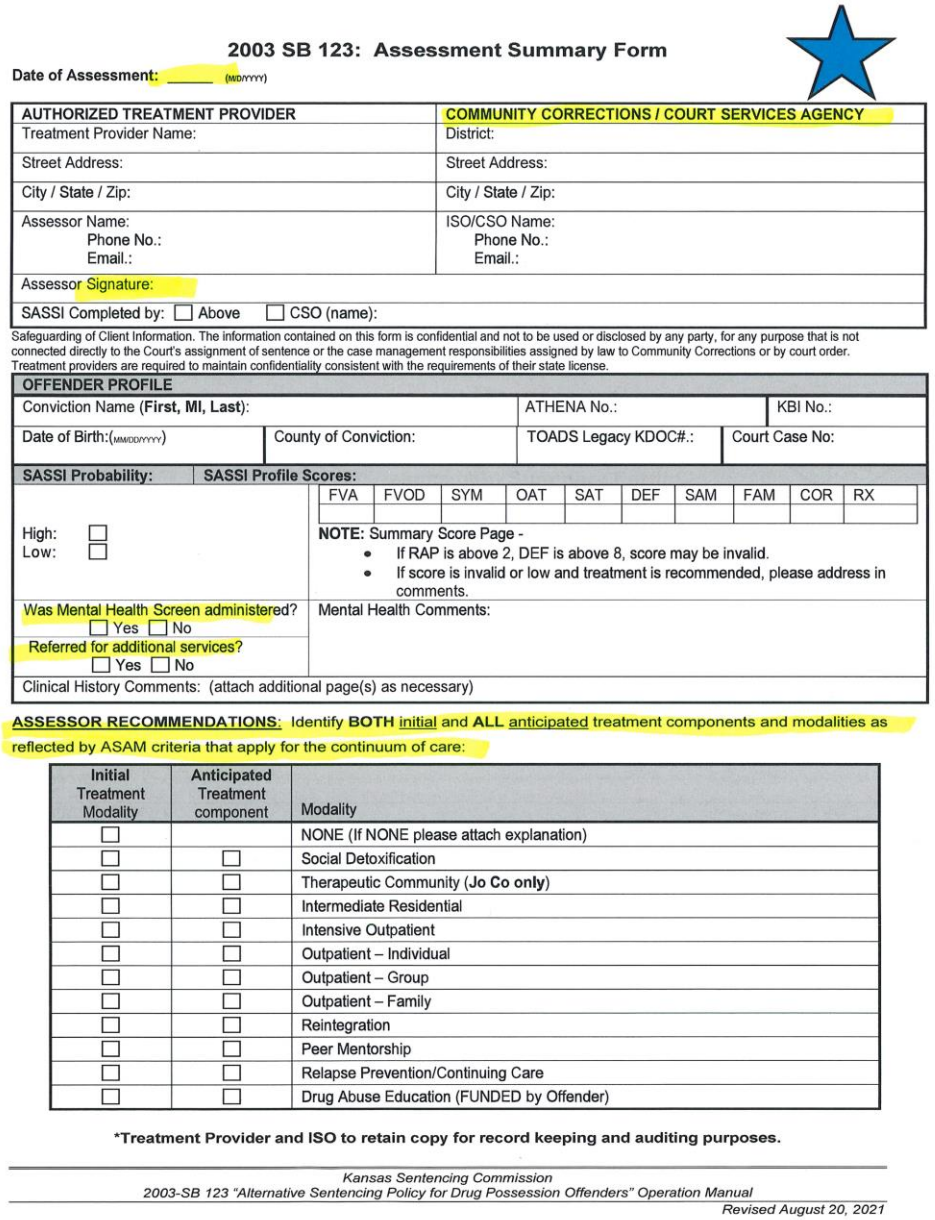
22. Treatment Provider:	Date:	Phone Number:

1 Copy to the Kansas Sentencing Commission 1 Copy to the Treatment Provider Rev. August 20, 2021

Problem areas

If you don't know- ASK
CSO= Court Services
ISO=Community Corrections

Assessment Summary Form



2003 SB 123: Assessment Summary Form

Date of Assessment: _____ (MM/YYYY)

AUTHORIZED TREATMENT PROVIDER	COMMUNITY CORRECTIONS / COURT SERVICES AGENCY
Treatment Provider Name:	District:
Street Address:	Street Address:
City / State / Zip:	City / State / Zip:
Assessor Name: Phone No.: Email.:	ISO/CSO Name: Phone No.: Email.:
Assessor Signature:	
SASSI Completed by: ☐ Above ☐ CSO (name):	

Safeguarding of Client Information. The information contained on this form is confidential and not to be used or disclosed by any party, for any purpose that is not connected directly to the Court's assignment of sentence or the case management responsibilities assigned by law to Community Corrections or by court order. Treatment providers are required to maintain confidentiality consistent with the requirements of their state license.

OFFENDER PROFILE

Conviction Name (First, MI, Last):		ATHENA No.:	KBI No.:
Date of Birth:(MM/DD/YYYY)	County of Conviction:	TOADS Legacy KDOC#.:	Court Case No:

SASSI Probability:	SASSI Profile Scores:
High: ☐ Low: ☐	FVA | FVOD | SYM | OAT | SAT | DEF | SAM | FAM | COR | RX **NOTE:** Summary Score Page - • If RAP is above 2, DEF is above 8, score may be invalid. • If score is invalid or low and treatment is recommended, please address in comments.
Was Mental Health Screen administered? ☐ Yes ☐ No Referred for additional services? ☐ Yes ☐ No	Mental Health Comments:
Clinical History Comments: (attach additional page(s) as necessary)	

ASSESSOR RECOMMENDATIONS: Identify **BOTH** initial and **ALL** anticipated treatment components and modalities as reflected by ASAM criteria that apply for the continuum of care:

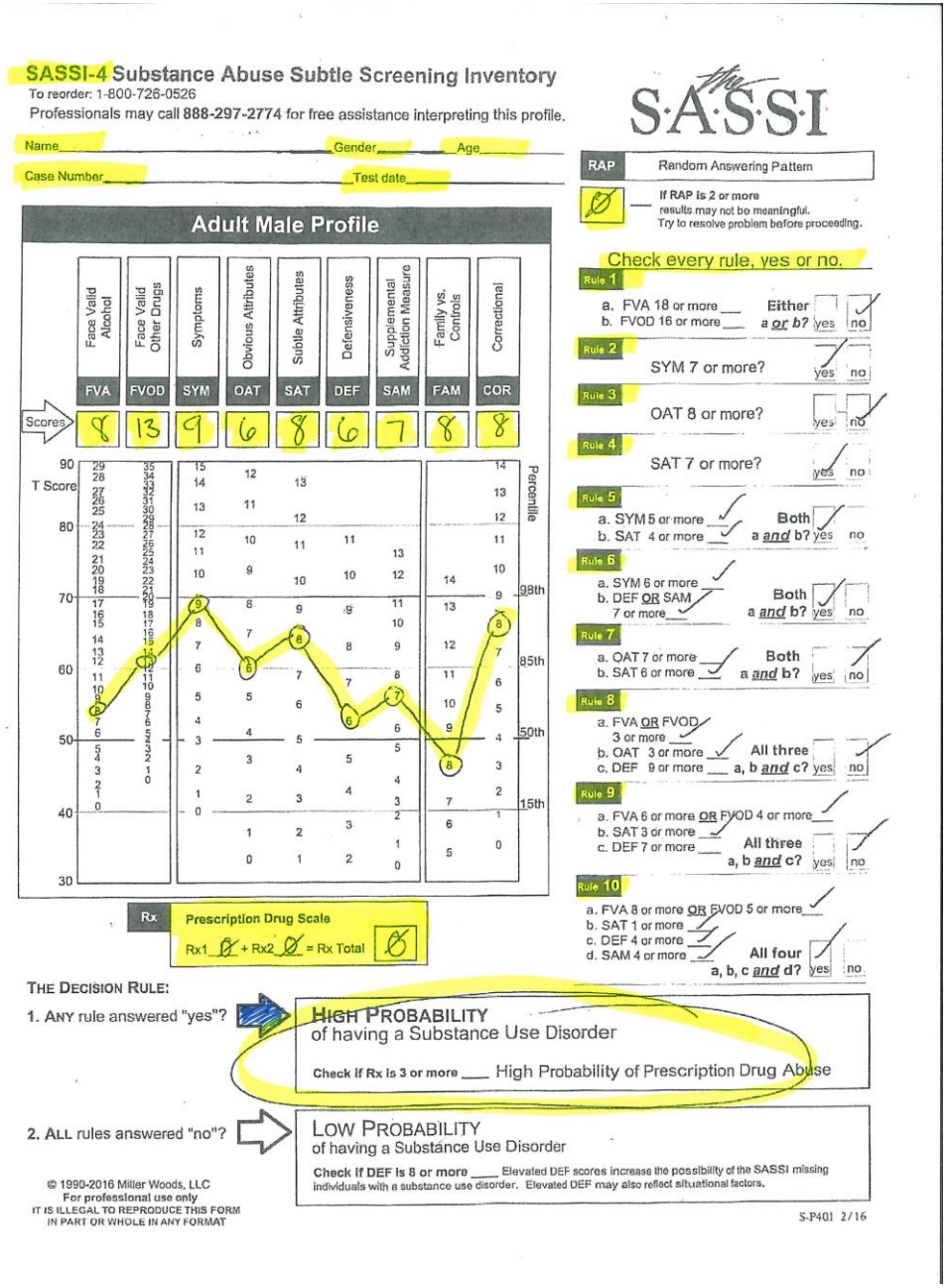
Initial Treatment Modality	Anticipated Treatment component	Modality
☐		NONE (If NONE please attach explanation)
☐	☐	Social Detoxification
☐	☐	Therapeutic Community (**Jo Co only**)
☐	☐	Intermediate Residential
☐	☐	Intensive Outpatient
☐	☐	Outpatient – Individual
☐	☐	Outpatient – Group
☐	☐	Outpatient – Family
☐	☐	Reintegration
☐	☐	Peer Mentorship
☐	☐	Relapse Prevention/Continuing Care
☐	☐	Drug Abuse Education (FUNDED by Offender)

***Treatment Provider and ISO to retain copy for record keeping and auditing purposes.**

Kansas Sentencing Commission
2003-SB 123 "Alternative Sentencing Policy for Drug Possession Offenders" Operation Manual
Revised August 20, 2021

- Date
- Agency
- Signature
- Mental Health screen?
- Referred for additional services?
- Recommendations
  - Identify **BOTH** <u>initial and ALL anticipated as reflected by the ASAM criteria</u>

- If they score HIGH- recommend treatment.
  - This is a court record and the offender has been sentenced to up to 18 months of treatment.



SASSI-4 Substance Abuse Subtle Screening Inventory

To reorder: 1-800-726-0526

Professionals may call 888-297-2774 for free assistance interpreting this profile.

the SASSI

Name_____ Gender_____ Age_____

Case Number_____ Test date_____

RAP Random Answering Pattern

0 — If RAP is 2 or more results may not be meaningful. Try to resolve problem before proceeding.

Adult Male Profile

Face Valid Alcohol	Face Valid Other Drugs	Symptoms	Obvious Attributes	Subtle Attributes	Defensiveness	Supplemental Addiction Measure	Family vs. Controls	Correctional
FVA	FVOD	SYM	OAT	SAT	DEF	SAM	FAM	COR
Scores 8	13	9	6	8	6	7	8	8

T Score 90 80 70 60 50 40 30 — Percentile 98th 85th 50th 15th

Check every rule, yes or no.

Rule 1
a. FVA 18 or more ___
b. FVOD 16 or more ___
Either a or b? yes ✓ no

Rule 2
SYM 7 or more? ✓ yes no

Rule 3
OAT 8 or more? yes ✓ no

Rule 4
SAT 7 or more? ✓ yes no

Rule 5
a. SYM 5 or more ✓
b. SAT 4 or more ✓
Both a and b? ✓ yes no

Rule 6
a. SYM 6 or more ✓
b. DEF OR SAM 7 or more ✓
Both a and b? ✓ yes no

Rule 7
a. OAT 7 or more ✓
b. SAT 6 or more ___
Both a and b? yes ✓ no

Rule 8
a. FVA OR FVOD 3 or more ✓
b. OAT 3 or more ✓
c. DEF 9 or more ___
All three a, b and c? yes ✓ no

Rule 9
a. FVA 6 or more OR FVOD 4 or more ___
b. SAT 3 or more ___
c. DEF 7 or more ___
All three a, b and c? yes ✓ no

Rule 10
a. FVA 8 or more OR FVOD 5 or more ✓
b. SAT 1 or more ✓
c. DEF 4 or more ✓
d. SAM 4 or more ✓
All four a, b, c and d? yes ✓ no

Rx Prescription Drug Scale
Rx1 0 + Rx2 0 = Rx Total 0

THE DECISION RULE:

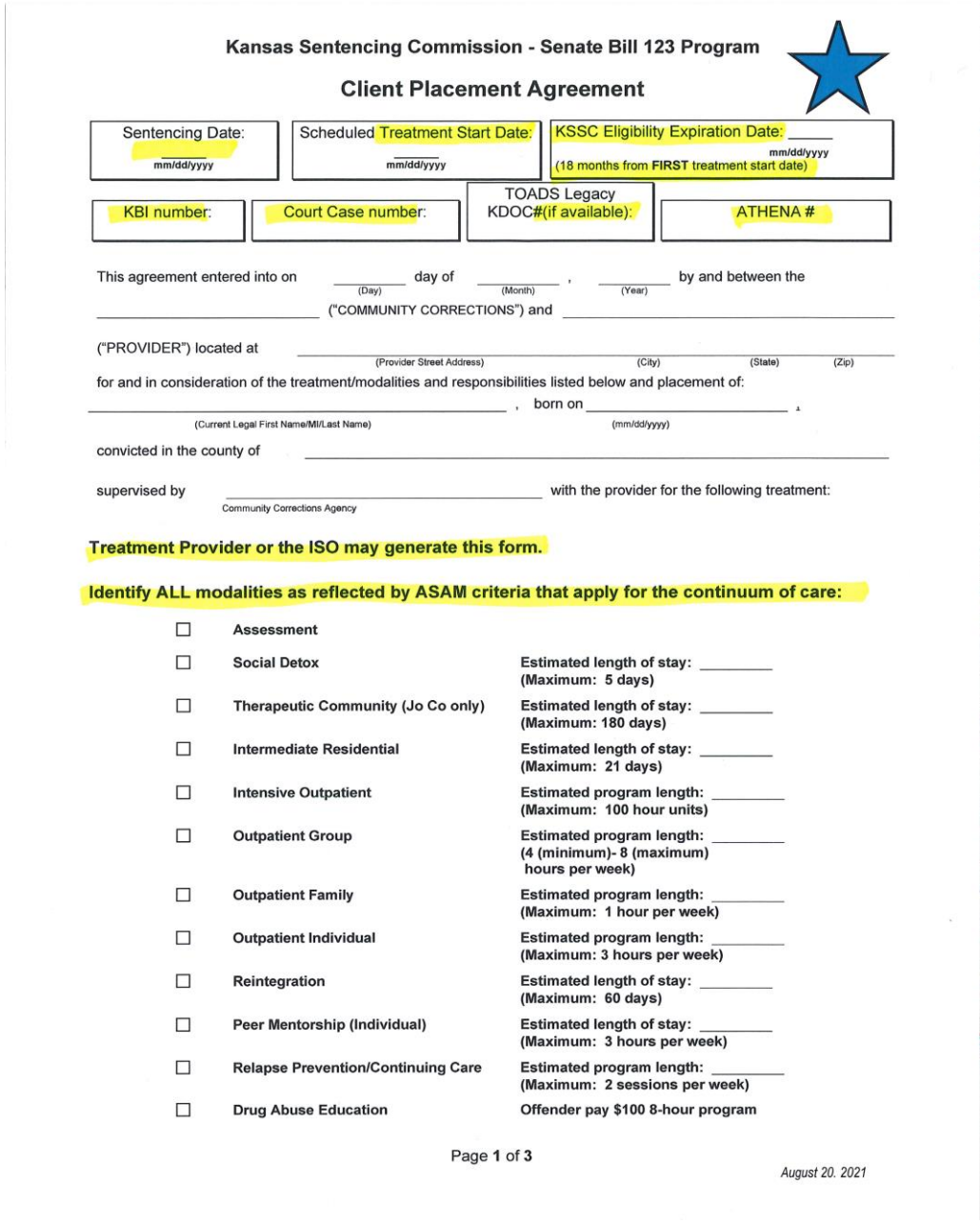
1. ANY rule answered "yes"? → HIGH PROBABILITY of having a Substance Use Disorder
Check if Rx is 3 or more ___ High Probability of Prescription Drug Abuse

2. ALL rules answered "no"? → LOW PROBABILITY of having a Substance Use Disorder
Check if DEF is 8 or more ___ Elevated DEF scores increase the possibility of the SASSI missing individuals with a substance use disorder. Elevated DEF may also reflect situational factors.

S-P401 2/16

SASSI-4

- The SASSI needs to have ALL areas completed
  - Name
  - Case number and test date
  - Scores and graph
  - High or Low probability



Kansas Sentencing Commission - Senate Bill 123 Program

Client Placement Agreement

Sentencing Date: ____ mm/dd/yyyy	Scheduled Treatment Start Date: ____ mm/dd/yyyy	KSSC Eligibility Expiration Date: ____ mm/dd/yyyy (18 months from **FIRST** treatment start date)

KBI number:	Court Case number:	TOADS Legacy KDOC#(if available):	ATHENA #

This agreement entered into on ____ (Day) day of ____ (Month), ____ (Year) by and between the

____ ("COMMUNITY CORRECTIONS") and ____

("PROVIDER") located at ____ (Provider Street Address) (City) (State) (Zip)

for and in consideration of the treatment/modalities and responsibilities listed below and placement of:

____ (Current Legal First Name/MI/Last Name), born on ____ (mm/dd/yyyy).

convicted in the county of ____

supervised by ____ Community Corrections Agency with the provider for the following treatment:

Treatment Provider or the ISO may generate this form.

Identify ALL modalities as reflected by ASAM criteria that apply for the continuum of care:

☐	**Assessment**	
☐	**Social Detox**	**Estimated length of stay: ____ (Maximum: 5 days)**
☐	**Therapeutic Community (Jo Co only)**	**Estimated length of stay: ____ (Maximum: 180 days)**
☐	**Intermediate Residential**	**Estimated length of stay: ____ (Maximum: 21 days)**
☐	**Intensive Outpatient**	**Estimated program length: ____ (Maximum: 100 hour units)**
☐	**Outpatient Group**	**Estimated program length: ____ (4 (minimum)- 8 (maximum) hours per week)**
☐	**Outpatient Family**	**Estimated program length: ____ (Maximum: 1 hour per week)**
☐	**Outpatient Individual**	**Estimated program length: ____ (Maximum: 3 hours per week)**
☐	**Reintegration**	**Estimated length of stay: ____ (Maximum: 60 days)**
☐	**Peer Mentorship (Individual)**	**Estimated length of stay: ____ (Maximum: 3 hours per week)**
☐	**Relapse Prevention/Continuing Care**	**Estimated program length: ____ (Maximum: 2 sessions per week)**
☐	**Drug Abuse Education**	**Offender pay $100 8-hour program**

Page **1** of **3**

August 20. 2021

CPA

- The top 7 boxes will NEVER change
- Anyone can generate this form- communicate with each other
- Identify ALL modalities as reflected by the ASAM criteria.

Gwyn Harvey, B.S., LAC
SB123 Certification Specialist
Kansas Sentencing Commission
Gwyn.S.Harvey@ks.gov

- Maintaining Certification
- Temporary Certification

Reminders:

Utilizing the change form.....

- Inform us of address, phone number or contact person changes.
- Any address change needs to also have an updated KDADS License with the new address submitted.
- Use the change form to add or delete staff, make any desired changes to your provider status.
- Submit all documents for new staff in a separate attachment, per staff person. (BSRB license, recent renewal, KCPM / KCPMT, SASSI IV certificate and a CBIC training document- if available)
- Submit updated agency KDADS licenses as soon as possible after receiving it.

CHANGE FORM

SB123 Treatment Provider Change Notification Form

Address Changes

Provider Name (location):			
Primary Contact:			
	Name		Title
	Email Address		Phone #
Old Address:			
New/Current Address:			
New/Current Phone #:		New/Current Fax#:	

Staff Departures / Additions[1]

Counselor Name	SASSI Certified	Certif. Doc.	Add (Y / N)	Delete (Y / N)	Effective Date

ALL DOCUMENTS (BSRB Lic., Certif. Doc., SASSI IV) FOR NEW STAFF MUST ACCOMPANY THIS FORM

Modality Changes / Service Termination[1]

	Effective Date
☐ Add Modalities[2] (List):	
☐ Delete Modalities (List):	
☐ Provider Termination of ALL Services[3]	

Treatment Provider Signature _____ Title _____ Date _____

[1] Add additional pages as necessary

[2] Requires submission of a Revised Implementation Plan

[3] Requires 30 day advance written notice to the SB123 Certification Specialist. Payment of Services rendered prior to the termination effective date will be made pursuant to KSSC policy.

Please forward document(s) to:

Kansas Sentencing Commission
Gwyn Harvey, SB 123 Certification Specialist
700 SW Jackson, Suite #501
Topeka, Kansas 66603
Telephone: (785) 296-3443
Gwyn.S.Harvey@ks.gov

FOR KSSC USE ONLY

Staff Signature: _____

☐ ATHENA Updated ☐ KSSC Notified ☐ CC Notified ☐ Copy to Provider File Date:

Temporary Certification

Purpose & Intent of the process

Both Temporary Certificates will be valid for six months

Mentorship tasks for providers with their new staff

Application Forms are available on our website

sentencing.ks.gov/sb-123/senate-bill-123

Prior to temporary certification expiration dates, KSSC will be reaching out with further instructions for ongoing certifications.

PEER MENTOR

Kansas Sentencing Commission

Application for Temporary Certification as a SB 123 Peer Mentor

Name _____

Phone Number _____

Agency Name _____

Address of Agency Office where services will be provided (if more than one address, please include all addresses and attach separately or below as needed)

_____

Supervisor's Name _____

Supervisor's Phone Number _____

Supervisor's Email Address _____

Name of Individual Co-signing Notes/Documentation _____

1. **KDADS certification as a KCPMT or KCPM MUST be included with application**. Please attach to this form and send to KSSC.
2. An individual with clinical licensure must be available to you for questions, consultations, and assistance. Peer mentors must provide services within the scope of practice defined by KSSC policy. Please see Cost Caps for Approved Modalities, found on KSSC's website, for more information or contact gwyn.s.harvey@ks.gov
3. Please list the modalities/services you plan to deliver or co-facilitate:

   _____

   _____

   _____

4. Please provide the name(s) of the curriculum/curricula you will be co-facilitating:

   _____

   _____

   _____

5. Information regarding the KSSC's policies and procedures is located at www.sentencing.ks.gov and you are encouraged to contact our office with questions at sb123payments@ks.gov.

Signature of Peer Mentor _____ Date _____

Signature of Supervisor _____ Date _____

CLINICIAN

Kansas Sentencing Commission

Application for Temporary Certification as a SB 123 Clinician

Name _____

Phone Number _____ Email _____

Agency Name _____

Address of Agency Office where services will be provided (if more than one address, please include all addresses and attach separately or below as needed)

_____

Supervisor's Name _____

Supervisor's Phone Number _____

Supervisor's Email Address _____

KDADS/BSRB licensure and SASSI IV certification MUST be included with this application. Please attach copies and submit to KSSC with this form.

1. In order to grant temporary certification, an individual with clinical licensure and SB 123 certification must be available to you for questions, consultation, and assistance as needed. Please provide the name, phone, and email for the individual providing this consultation for you.

   _____

2. Please list the modalities/services you plan to deliver or facilitate (please include assessment if applicable):

   _____

   _____

   _____

3. Please provide the name(s) of the curriculum/curricula you will be facilitating:

   _____

   _____

   _____

4. If you have never provided services to the SB 123 population previously, please provide a short summary of how you plan to familiarize yourself with the policies, procedures, and requirements of the program:

   _____

   _____

   _____

5. Information regarding the KSSC's policies and procedures is located at www.sentencing.ks.gov and you are encouraged to contact our office with questions at sb123payments@ks.gov.

Signature of Clinical Applicant _____ Date _____

Signature of Supervisor _____ Date _____

QUESTIONS?

KSSC SB 123 WEBSITE link
(sentencing.ks.gov/sb-123/senate-bill-123)