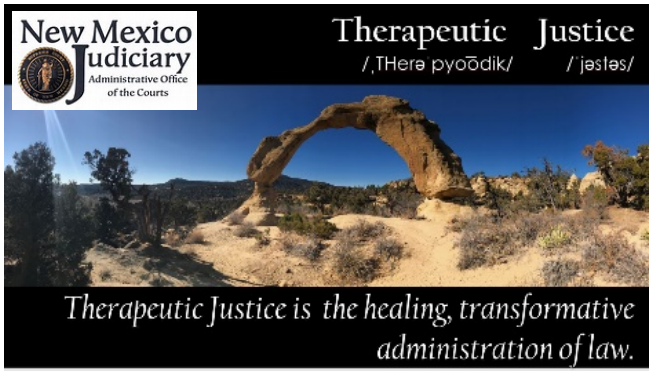

New Mexico Treatment Courts

CERTIFICATION

Reference Application

Official Application will be Emailed to you & Submitted Electronically via Google Forms

Date:

Judicial District:

Primary Treatment Court Judge:

Program Name:

Program Address:

City, State, & Zip:

Program Type (e.g. Adult, Veteran, Family, Behavioral Health, etc.):

Disposition Type (e.g. pretrial, pre-plea, post-plea, etc.):

PROGRAM QUESTIONS

Name of person completing this section:

Agency: Email:

1. How does the program ensure that participants from groups that have historically experienced sustained discrimination or reduced social opportunities because of their race, ethnicity, gender, sexual orientation, sexual identity, physical or mental disability, religion, or socioeconomic status receive equal access, retention, treatment, dispositions and incentives/sanctions? [1-15]

2. Describe how participant data have been used to make program modifications. [8-11]

3. How are participant eligibility requirements/criteria, intake, and referral standards communicated to referral sources and what are those referral sources? [3-5]

4. Describe how the court and supervision services are provided in a gender appropriate and culturally competent manner. [4-4]

5. How does your program ensure the accountability of the treatment provider to incorporate services and training consistent with the treatment court model and treatment best practices? [4-21,4-25]

6. How are responses to dilute UAs addressed? [6-14]

7. How are failure to appear for a drug test and tampering addressed? [6-15]

8. If you collect fees, please explain the collection process, whether and how they are used as an incentive, how community service corresponds, how payment plans are established, and how progress is monitored to ensure that a lack of payment does not become a barrier to phase advancement or graduation. [6-19]

9. Standard 8-12 relates to monitoring of participant progress, success, and satisfaction that includes a comparison of individuals who have historically experienced sustained discrimination or reduced social opportunities to the other participants, to identify—and work to address—any areas of inequity in treatment court access, retention, treatment and other services received, treatment progress, responses to behavior, outcomes achieved, and dispositions. This should lead to the development of a remedial action plan and timetable to correct any disparities and examines the success of the remedial actions. Explain how monitoring is done and what remedial action plans, if any, have been developed. [8-12]

10. Do you conduct any community education about the treatment court program and how it contributes to family and community well-being? If so, what have you done and with what groups? [8-9]

11. Describe how you have used the technical assistance in the past to improve program operations and ensure services are delivered effectively. [9-8]

12. Describe your policy committee and how it operates (members, frequency of meetings, past and current projects, etc.) [10-2]

13. How do you ensure the written consent for disclosure of participant information is understood by the participant and signed voluntarily? As part of your response, please address how long the participant has to review the consent prior to signing and whether the form is provided in a language they can understand. [C-10p2,C-10p3]

14. How and when does the participant receive an oral and written summary of federal confidentiality laws and regulations? [C-10p6]

15. Please thoroughly describe your program's approach to medical cannabis use by participants. If this is included in your policy and procedure manual, please just note the page numbers.

16. If you have implemented DIMS Recovery Management, please describe the results.

17. Describe how your program collaborates with other agencies within your local justice system to ensure the Risk-Needs-Responsivity framework is implemented.

18. Do you have a community supervision component? ☐ YES ☐ NO

19. Do community supervision staff (surveillance officer, probation officer, etc.) conduct field visits to participant residences, workplaces, etc.? ? ☐ YES ☐ NO ☐ N/A

20. Have you opened DIMS access for the DTJ certification team? ☐ YES ☐ NO

PROGRAM PROOF DOCUMENTS CHECKLIST → Google Drive

Use this checklist to confirm the upload of each proof document to the appropriate folder in the Google Drive. ***The Proof Document Crosswalk MUST be completed and submitted in conjunction with highlighting the highlighted required documents below, to draw attention to the standard being addressed within program practices/ procedures.*

- ☐ *Letter of Intent* (if not provided prior to the application)
- ☐ *Certification Application*
  - ☐ Program Application
  - ☐ Program Proof Documents
  - ☐ Treatment Provider Application & Proof Documents
  - ☐ Team Member Names and Email Addresses

- ☐ *Completed Proof Document Crosswalk* spreadsheet
- ☐ Agency MOUs/Agreements
- ☐ Team Member MOUs
- ☐ Budgets (if not already provided)
- ☐ *Program P&P*
- ☐ Policy Committee Documents (if not included in policies and procedures)
- ☐ Eligibility Criteria (both what is provided to justice partners and justice-involved persons)
- ☐ Participant Handbook (include all translations)
- ☐ Handbook Acknowledgment Form (include all translations)
- ☐ Written Consent / Release of Information Form(s) (include all translations)
- ☐ Performance Measures Report for Local Stakeholders (if available)
- ☐ Program *Quality Engagement Self-Check Survey* - if printed, or date completed:
- ☐ All Provider Contracts
- ☐ Training Logs (for each team member) – especially note most recent confidentiality training
- ☐ Surveillance P&P
- ☐ Peer Review or Other TTA Reports (as applicable)
- ☐ Evaluation Reports or Outcome Evaluations
- ☐ Treatment Provider P&P and Written Rules Governing the Rights & Conduct of Participants
- ☐ Treatment Provider Licenses, Business License, Taxation and Revenue Dept. Certificate, and Liability Insurance Coverage

TREATMENT PROVIDER INFORMATION

Name of person completing this section:

Agency: Email:

Individual Treatment Provider Medicaid Practitioner Number(s) *Note: This is related to Medicaid endorsement, NOT the certificate / license number, and should include each treatment staff member providing services*:

Treatment Practice / General Provider Number(s) *Note: This is related to Medicaid endorsement of the facility/program*:

TREATMENT PROVIDER QUESTIONS

1. Who conducts assessments (comment on the licensure, training, and expertise of those conducting the assessments)? [3-13]

2. What assessments are used, how and where are they conducted, and how do they inform treatment planning? [4-2,4-13]

3. Are your treatment/case management plans individualized? ☐ Yes ☐ No

4. Do you reassess the participants periodically? ☐ Yes ☐ No

5. If so, please describe the reassessment frequency and how the reassessment informs the treatment plan. [4-16]

6. How do you assure that participants meet the clinical criteria for admission to the program? [E-9]

7. How do you ensure treatment services are provided in a trauma-responsive, gender-appropriate and culturally-competent manner? [4-4]

8. Describe your internal quality assurance program including the counselor supervision process (for example: frequency of supervision, how supervision is structured, and the level of licensure of the supervising clinician). [4-20,4-22]

9. Describe the process for the prescription of psychotropic medicine and/or medication for substance use disorder (4-23)

10. Complete the chart below: [4-12]

Types of Treatment Modalities and Strategies Used (for example, CBT, behavioral, motivational approaches, etc.)	
Specific Treatment Modalities and Strategies Used (for example, Matrix Model, MRT, MET, M.I., etc.)	
Date of Original Training for Staff in the Specified Modality or Strategy	
Date of Most Recent Booster Training for Staff in the Specified Modality or Strategy	
If Group Oriented, How Many Treatment Staff Participate and What Are Their Credentials?	

11. Is Homework Assigned to Reinforce Treatment Concepts? ☐ YES ☐ NO

12. How are participants, and significant others, if applicable, informed of the rules regarding admission, discharge, expulsion, and program expectations for participants admitted to treatment? E-6

Please check the boxes below to acknowledge/confirm that the conditions are met and then sign in the appropriate place below the statements:

- ☐ All facilities where treatment occurs comply with applicable fire and safety standards established by the State Fire Marshal and health, safety and occupational codes enforced at the local level. [E-3]
- ☐ The treatment provider's services and facilities meet all requirements of the Americans with Disabilities Act of 1990, and all applicable state and local rules and regulations. [E-4]

Sign here:

TREATMENT PROVIDER PROOF DOCUMENTS → Google Drive

- ☐ Copies of all current provider licenses [4-22,a-c]
- ☐ Copies of all applicable business licenses and State of New Mexico Taxation and Revenue Department Certificate. [E-1]
- ☐ Evidence of general and professional liability insurance coverage or verification of immunities and limitations of the New Mexico Tort Claims Act Section 41-4-1, et. Seq, 1978. [E-2]
- ☐ Written policies and procedures that ensure compliance with the treatment court standards, the treatment court requirements and the scope of services. [E-5]
- ☐ Written rules governing the rights and conduct of participants. [E-6]

DRUG TESTING PROVIDER QUESTIONS

Name of person completing this section:

Agency: Email:

1. How do you ensure your alcohol and drug testing program is random? [4-32]

2. Describe your chain-of-custody for collected specimens. [F1d]

3. Was a criminal background check completed on staff prior to beginning to collect or test specimens? [F2p2]

☐ Yes ☐ No

The documents checked below are updated, marked, ready for review, and reflect our current practices:

- ☐ Policies and Procedures
- ☐ Drug Testing Protocols & Plan for Random Testing
- ☐ Agency MOUs / Agreements
- ☐ Team Member MOUs
- ☐ Team Member Training Logs
- ☐ Participant Eligibility Criteria
- ☐ Participant Handbook
- ☐ Participant Consent Form(s)
- ☐ Operational Budget (OpBud)
- ☐ Service Provider Contracts
- ☐ Certification Application Open-Ended Program Questions
- ☐ Certification Application Open-Ended Treatment Provider Questions

Primary Contact Name: Email:

Treatment Court Team Member Information

[*Not all positions will serve on each team*]

Team Position	Name	Email Address
Primary Judge		
Alternate Judge		
Program Director		
Program Manager/Coordinator		
Treatment Direct Services Provider		
Case Manager		
Defense Counsel		
Prosecutor		
Surveillance or Supervision Officer		
Adult Probation Officer		
Misdemeanor Compliance Officer		
Municipal / Metro Police Officer		
State Police Officer		
County Sheriff's Deputy		
Alumni / Peer		
Certified Peer Support Worker		
School Representative		
Veterans Affairs / VSO Rep.		
Veteran Mentor Coordinator		
Traditional Healer		
Tribal Community Advocate		
Tribal Participant Advocate		

Include additional team members below:

Please include the judicial officer's authorizing signature: