

IDAHO CHILD PROTECTION DRUG COURT STANDARDS & GUIDELINES FOR EFFECTIVENESS AND EVALUATION

Introduction

Idaho recognizes that child protection drug courts increase parent child reunification and reduce time children spend in out of home care, while assuring safe and stable families, free of substance abuse. Nationally, child protection drug courts utilize many evidence-based practices such as random and frequent drug testing, incentives and sanctions to shape behavior, close and coordinated supervision of parents, specific substance abuse and cognitive behavioral treatment approaches, and ongoing judicial monitoring. As the research basis for this specialized drug court model has grown, key practices that lead to desired outcomes have become clearer. These practices continue to fall within the original ten key components that define drug courts and ultimately account for their success.

Recent research clearly demonstrates that on both effectiveness measures and cost-efficiency measures, targeting substance dependent families at high risk to continue child maltreatment is most appropriate for child protection drug court participation.

Child Protection Drug Courts in Idaho

Idaho has a long and strong history of collaborative efforts between the courts and the Department of Health and Welfare Child Protection authority. Such efforts have included court improvement projects, joint multidisciplinary education events, and joint data system development efforts.

Drug courts in Idaho were officially recognized by the State Legislature in March of 2001 with passage of the Idaho Drug Court Act, and accompanying appropriations.

The Drug Court Act was later amended to include mental health courts and to authorize the district court in each county to establish a drug court which should include: *graduated sanctions and rewards, substance abuse treatment, close court monitoring and supervision of progress, and educational or vocational counseling as appropriate.* The District Court can also establish additional requirements, in accordance with standards developed by the drug court coordinating committee. While not specifically named in the legislation establishing the criminal drug courts, child protection drug courts began in Idaho early in the state's drug court movement. These courts, modeled on the general drug court approach, also utilized nationally recognized principles for the operation of child protection drug courts.

The Drug Court Act requires the Idaho Supreme Court to establish a Drug Court and Mental Health Court Coordinating Committee (DCMHCCC) to develop guidelines for drug courts that address eligibility, identification and screening, assessment, treatment and treatment providers, case management and supervision, and evaluation. Guidelines for the operation of child protection drug courts fall within this mandate and it is the

intention of the Idaho Supreme Court Drug Court and Mental Health Coordinating Committee that these child protection drug court guidelines be used to:

- Assist Idaho courts in establishing child protection drug courts that are founded on research-based or widely-accepted best practices;
- Maintain consistency of key child protection drug court operations across the state; and
- Establish a foundation for valid evaluation of the results and outcomes achieved by Idaho's Child protection Drug courts.

It is the intention of the DCMHCCC that the child protection drug court standards ensure:

- consistent, cost-effective operation;
- adherence to legal and research-based practices; and
- effective use of limited public resources, including the human resources of collaborating agencies

Guidelines Description

The purpose of this document is to set forth recommended guidelines to provide a sound and consistent foundation for the operation and evaluation of Idaho's child protection drug courts. These guidelines articulate the growing national consensus on effective practices, which are becoming increasingly well established by a substantial body of research demonstrating positive and cost-effective outcomes.

These guidelines are not rules of procedure and have no effect of law. They are not the basis of appeal by any child protection drug court participant, and lack of adherence to any guideline is not the basis for withholding any sanction or readmitting a participant who is terminated for any cause.

The guidelines provide a basis for each child protection drug court to establish written policies and procedures that reflect these guidelines, the needs of participants, and the resources available in the community.

The guidelines are based on principles gleaned from current research and credible published resources in the areas of drug courts, child welfare and addiction treatment. The guidelines were developed and refined through input from Idaho child welfare and drug court professionals and stakeholders, as well as acknowledged national experts, and represent a consensus about appropriate practice guidance.

The *Idaho Drug Court and Mental Health Court Act* states "The district court in each county may establish a drug court which shall include a regimen of graduated sanctions and rewards, substance abuse treatment, close court monitoring and supervision of progress, educational or vocational counseling as appropriate, and other requirements as may be established by the district court, in accordance with standards developed by the Idaho Supreme Court DCMHCCC."

In addition, the Idaho Drug Court and Mental Health Court Act states: "The [Drug Court and Mental Health Court Coordinating] committee shall also develop guidelines for drug

courts addressing eligibility, identification and screening, assessment, treatment and treatment providers, case management and supervision, and evaluation.”

These guidelines are organized under these statutory headings. In addition, **Coordination of Services** has been added to encompass guidelines related to the establishment and maintenance of the partnerships and collaboration, also envisioned in the statute, that are so vital to effective and sustainable child protection drug courts.

Child protection drug courts will be accountable to the Coordinating Committee and to the Supreme Court for operating in compliance with the standards.

Compliance Policies

The intent of Statewide Guidelines and Standards is to ensure that drug courts use scarce public resources in ways that assure the greatest positive return on the investment. Research has now clearly shown that certain operational practices strongly correlate with cost-beneficial outcomes, and the DCMHCCC has identified such practices in these Guidelines. Because of the variations in communities and their available resources, it is recognized that achieving operation within all of the guidelines must be an ongoing process over a reasonable period of time. However, how a court “measures up” to these practices and makes a good faith effort to achieve consistency will become the foundation for receiving ongoing state funding.

As always, the Supreme Court is committed to providing the guidance and support to enable all child protection drug courts to operate consistently within the approved Guidelines.

CHILD PROTECTION DRUG COURT STANDARDS & GUIDELINES FOR EFFECTIVENESS AND EVALUATION

Each district court shall establish written policies and procedures that describe how the drug court(s) will implement these statewide guidelines as well as any additional guidelines, policies, and procedures necessary to govern its operations.

Bold Standards:

Standards are designated as those in statute, national guidance or drug court best practice standards based on research. Where applicable, standards are bolded and sources were cited.

1.0 ELIGIBILITY

1.1 No person has a right to be admitted into a child protection drug court. [IC 19-5604]

1.2 No person shall be eligible to participate in a child protection drug court if:

The person is currently charged with, or has pled or been found guilty of a felony in which the person committed or attempted to commit, conspired to commit, or intended to commit a sex offense. [IC 19-5604.b.2]

1.3 Each child protection drug court shall establish written criteria defining its target population addressing the following considerations:

- (A) Child protection drug courts are intended for parents with an open child protection case and for parents with a high risk of continued child maltreatment including abuse or neglect.
- (B) Child protection drug courts are intended for parents for whom a qualified substance use disorder assessment has established the presence of a significant substance use disorder requiring treatment.
- (C) Child protection drug court is intended for parents with a moderate-high to high criminogenic risk (within a recommended range from, the LSI-R between 18-40).
- (D) Persons currently charged with, who have pled or have been adjudicated or found guilty of, a felony crime of violence or a felony crime in which the person used either a firearm or a deadly weapon or instrument may be admitted at the discretion of the drug court team and with the approval of the prosecuting attorney as specified in IC 19-5604, as amended 2011.**

1.4 Each child protection drug court should establish a written procedure for deciding how individuals will be considered for acceptance into child protection drug court, including who will have input into that decision, the criteria for inclusion and exclusion (as described in Standard 1.3), and the establishment of final control for admittance by the presiding child protection drug court judge.

1.5 Each child protection drug court should identify eligible and appropriate parents as early in the process as possible. Potential participants should be screened as soon as possible, educated about the program and the merits of participating, and placed promptly in the child protection drug court. Doing so capitalizes on a triggering event, such as a child protection complaint, removal of children from the home, or an arrest or probation violation, which can persuade participants to enter and remain in treatment.

Comment: Research in general jurisdiction drug courts suggests that admitting participants into drug court within 50 days of arrest (or other triggering event) shows improved outcomes and reduced costs.

Entering drug court quickly following the dependency petition can lead to faster substance abuse treatment entry, more rapid achievement of permanency and a shorter time to case closure.

Family Treatment Drug Court Evaluation: Final Phase I Study Report. (2006)

- 1.6 Child protection drug courts should implement a wide range of motivational techniques (ex: motivational interviewing[®], or motivational enhancement therapy[®]) to engage parents and keep them in treatment. Prior treatment failures or a current lack of demonstrated motivation for treatment should not solely exclude potential participants from admission.

- 1.7 Payment of fees, fines, restitution, or court ordered child support is an important part of a participant's treatment, but no one who is otherwise eligible should be denied participation solely because of inability to pay.**

Courts must establish a clear, regular payment plan to cover assessed financial responsibilities at intake and work closely with participants throughout participation to keep fee payments current as well as to address payment of other court related costs including restitution. Agreed upon payments must be closely monitored throughout all phases of child protection drug court and collection or necessary fee adjustment must be managed on an ongoing basis [IC 31--3201E]

The practice of allowing large child protection drug court or other fee balances to accrue and then deferring graduation until balances are paid is discouraged because of its impact on the court's operational costs and the court's ability to admit new participants. Courts should develop procedures for post-graduation collection of unavoidable fee balances, for example, filing civil judgment or other post-graduation collection procedures.

- 1.8 **Child protection drug court participants shall be responsible for payment of the cost of treatment, based on the established Department of Health and Welfare sliding fee scale, which recognizes all court related fees, fines, and other payments as deductions from income. Participants eligible for payment for treatment under the Medicaid program will be billed for through Medicaid with no co-payment required. [IC 31-3201E]**
- 1.9 Cooperation among problem-solving courts is encouraged, within the constraints of available resources, to facilitate the transfer of eligible applicants or current participants to the appropriate problem-solving court.

2.0 IDENTIFICATION AND ASSESSMENT

- 2.1 Prospective child protection drug court participants shall be identified through a uniform structured screening process designed to determine if they meet the established target population eligibility criteria.**
- 2.2 Each child protection drug court candidate shall receive a substance abuse assessment prior to acceptance into the court. Initial assessment procedures shall include, at a minimum, the Global Appraisal of Individual Needs- Short Screener (GAIN-SS). If it can be obtained on a timely basis, and the candidate meets other eligibility criteria, the full GAIN-Initial (GAIN-I) is preferable.**
- 2.3 Each child protection drug court candidate shall undergo a criminogenic risk assessment prior to acceptance into the court; such assessment procedure shall include, at a minimum the Level of Services Inventory – Revised (LSI-R) prior to acceptance into drug court. [IC 19-5604]**
- 2.4 Because a significant percentage of drug dependent/addicted individuals also have a diagnosable mental illness, child protection drug courts shall develop procedures to identify participants with a mental illness, to refer them to an available mental health provider for evaluation and treatment, and to seek regular input from that provider regarding these participants. Screening for mental illness shall use consistent state criteria.
- 2.5 The treatment plan for substance abuse or dependence shall be based on a clinical assessment, performed by a qualified professional, including a GAIN-I assessment. (GAIN-I).**
- 2.6 The child protection drug court should develop procedures for screening for trauma issues and be prepared to address such issues integrated with treatment.
- 2.7 Participants should be initially assessed by both court and treatment personnel to ensure that individuals are suitably matched to appropriate treatment and interventions designed to address their identified criminogenic needs.

3.0 TREATMENT AND TREATMENT PROVIDERS

- 3.1 Substance use disorder treatment paid for by state funds shall be provided in programs approved by the Idaho Department of Health and Welfare under promulgated *Rules and Minimum Standards Governing Alcohol / Drug Abuse Prevention and Treatment Programs*

- 3.2 Each child protection drug court should implement procedures to assure that treatment services are delivered within available financial resources.
- 3.3 Information regarding the specific treatment services delivered is essential for drug courts to cost-effectively manage the Child Protection Drug Court. Communication between treatment providers, DHW/Management Service Contractor, and court team should take place at least once a month, more often if needed, and include the following minimum elements:
 - (A) Projected treatment costs per client (according to the treatment plan)
 - (B) Services provided, and expenditures, per services, monthly and year-to-date, by client
 - (C) Expenditures, per provider, monthly and year to date, by services
- 3.4 Child protection drug court treatment is intended for chemically dependent/addicted individuals.
- 3.5 Treatment shall be provided to address identified, individualized needs with the expectation that the treatment program will consist of a majority of interventions being evidence-based practices, delivered with fidelity.
- 3.6 Group size for group treatment interventions should not generally exceed twelve members unless the fidelity to the specific intervention is based on a different number.
- 3.7 Treatment should include the following:
 - (A) Techniques to accommodate and address participant stages of change. Members of the child protection drug court team should work together to engage participants and motivate participation. The consistent uses of techniques such as motivational interviewing and motivational enhancement therapy have been found to reduce client defensiveness, foster engagement, and improve retention.
 - (B) Family education and / or treatment to address patterns of family interaction that increase the risk of continued child maltreatment, to develop family understanding of substance use disorders and recovery, family decision making, and to create an improved family support system.
 - (C) Referral of family members to appropriate community resources to address other identified service needs including but not limited to:
 - a. Transportation
 - b. Housing
 - c. Trauma (Informed) Interventions

- d. Domestic Violence
 - e. Life skills
 - f. Child Care
 - g. Recovery Coach
 - h. Marriage Counseling
 - i. Vocational Rehabilitation
 - j. GED
- (D) Incorporation of parenting, child support and custody issues, and the needs of children in the participant's family into the treatment plan and addressing these needs through the effective use of community resources.
- (E) Primary health care needs of the participant(s) and their children shall be integrated into the treatment plan.
- (F) Clinical/treatment staffings prior to every court staffing, or more frequently as needed, to review treatment goals, progress, and other clinical issues for each participant.
- (G) In addition to regular team staffings, providers should promptly report to the child protection drug court team information on the participant's behavior, compliance with, and progress in treatment; the participant's achievements; the participant's compliance with the court's requirements; and any of the participant's behavior that does not reflect a recovery lifestyle.
- (H) Progressive phases that include the focus and goals described below:
1. The focus of Phase 1 is Orientation, Stabilization and Initial Engagement. During this phase participants are expected to attempt to establish initial abstinence; understand and accept that he or she has an alcohol/drug dependence/addiction problem; demonstrate initial willingness to participate in treatment activities; become compliant with the conditions of participation in drug court; establish an initial therapeutic relationship; and commit to a plan for active treatment and for meeting the established child protection case plan.
 2. The focus of Phase 2 is the provision of Treatment. During this phase participants are expected to demonstrate continued efforts at achieving abstinence; develop an understanding of substance abuse and offender recovery tools, including relapse prevention; develop an understanding and ability to employ the tools of cognitive restructuring of criminal/risk thinking; develop the use of a recovery support system; and assume or resume socially accepted life roles, including education or work and responsible parenting and family relations.

3. The focus of Phase 3 is Transition to Community Engagement. During this phase participants are expected to demonstrate continued abstinence; demonstrate competence in using relapse prevention, recovery, and cognitive restructuring skills, in progressively more challenging situations; develop further cognitive skills such as anger management, negotiation, problem-solving and decision making, and financial and time management; connect with other community treatment or rehabilitative services matched to identified needs; demonstrate continued use of a community-based recovery support system; and demonstrate continued effective performance of socially-accepted parental and life roles.
 4. The focus of Phase 4 is Maintenance of Recovery Skills and Supports. During this phase, participants are expected to demonstrate internalized recovery skills and the ability to follow their aftercare plan with minimal program support; maintain abstinence, demonstrate ability to identify relapse issues, and intervene; and contribute to and support the development of others in earlier phases of the drug court program and demonstrate continued effective performance of socially accepted parental and life roles.
- 3.8 Movement through the drug court treatment should be based on individual participant progress and demonstrated competencies associated with each phase and should not be based on arbitrary timeframes in each phase.
- 3.9 The drug court staff and participants must integrate the timeframes imposed by the Adoption and Safe Families Act and the provision of reasonable efforts to reunite the family with the drug court program timeline.
- 3.10 Treatment shall be based on treatment need, and shall not be adjusted as a means of imposing a sanction for non-compliance or as an incentive. Level of care shall be adjusted based on each participant's response to treatment and not tied to phase structure. Participants shall not receive punitive sanctions if they fail to respond to a level of care that is substantially below or above their assessed treatment needs.**
- Adult Drug Court Best Practice Standards Volume 1. (2013). Pg.38*
- 3.11 Treatment services should be responsive to ethnicity, gender, age, and other characteristics of the participant.
- 3.12 Approved addiction treatment medications should be utilized with treatment services if there is approved need and resources are available.

Psychotropic or addiction medications should be prescribed based on medical necessity as determined by a treating physician with expertise in addiction psychiatry in addiction medicine.

- 3.13 The treatment provider should have detailed written guidelines describing how it will provide any of the treatment activities that are its responsibility, and the drug court should have written guidelines describing all treatment, including but not limited to mental health, domestic violence, etc., will be implemented.
- 3.14 It is preferable that the child protection drug court have no more than two treatment providers, with one provider preferred (that can make referrals to other ancillary treatment if individual circumstances require such referral).
- 3.15 The treatment representative should attend all drug court staffings and court sessions.
- 3.16 The child protection drug court shall use recovery coaches to support the recovery efforts of parents.

Substance Abuse Specialists in Child Welfare Agencies and Dependency Courts Considerations for Program Designers and Evaluators. (2010).

- 3.17 The child protection drug court should ensure that treatment providers integrate the behavioral health plan and the child welfare case plans. The child protection drug court will coordinate with all parties (including DHW, judge, social workers, etc.,) to track progress on the plans.

4.0 CASE MANAGEMENT AND SUPERVISION

- 4.1 Judicial assignment shall be made based on interest in the problem-solving court model and should be expected to last for a minimum of two years. Each child protection drug court shall have only one presiding judge and may have a “back-up” judge so long as both judges consistently attend staffings and drug court sessions. The assigned judge should be trained on the drug court model before presiding over drug court.**

Comment: Research has demonstrated that frequent rotations or short term assignments of judges adversely affect outcomes.

Adult Drug Court Best Practice Standards Volume 1. (2013). Pg.21

- 4.2 The child protection drug court in collaboration with the Trial Court Administrator will identify in their policy and procedures manual if the child protection drug court will adopt an integrated or parallel model.

- 4.3 In Phases 1 and 2 participants should appear before the judge in court at a minimum, twice per month (or once every two weeks).
- 4.4 The frequency of court appearances shall ordinarily decrease as the participant progresses through the phases of treatment. In Phases 3 and 4, court appearances before the judge may be determined by the individual child protection drug court but shall be at least once per month.

Adult Drug Court Best Practice Standards Volume 1. (2013). Pg. 21

- 4.5 Court phases 1-3 should consist of a minimum of nine months and phase 4 should consist of a minimum of three months.
- 4.6 Participants appear before the judge for status hearings no less frequently than every two weeks during the first phase of the program. The frequency of status hearings may be reduced gradually after participants have initiated abstinence from alcohol and illicit drugs and are regularly engaged in treatment. Status hearings are scheduled no less frequently than every four weeks.
- 4.7 The child protection drug court team shall include, at a minimum, the judge, prosecutor, defense counsel, child protection caseworker, Guardian ad Litem (Court Appointed Special Advocate), probation/community supervision officer, treatment provider, law enforcement representative, and coordinator. The team may also include other members such as mental health providers, primary health care providers, educators, drug testing personnel, and vocational services personnel, children’s attorney, GAL attorney.**

Guidance to States: Recommendations for Developing Family Drug Court Guidelines (2013). Pg. 10.

- 4.8 Prior to each of his or her court appearances, each participant’s treatment progress and program compliance should be discussed at a staffing by the child protection drug court team. During that staffing, the team should also discuss rewards or sanctions for the participant, progress in meeting expectations in the behavioral health and the child protection case plan, and court phase movement or graduation. Staffings should include the active participation of:

- (A) Judge
- (B) Prosecutor
- (C) Defense Counsel
- (D) Case Worker
- (E) Guardian Ad Litem (Court Appointed Special Advocate)
- (F) Probation officer
- (G) Treatment Provider
- (H) Law Enforcement Representative
- (I) Coordinator

Comment: Research has clearly demonstrated that the active participation of all team members is directly related to positive outcomes and cost-effectiveness for the drug court

Comments: Optimally, participation in staffings should be in person but communications technology may be utilized (examples: webinar, conference calls, streaming video, and web-cam). Although every effort should be made for all drug court team members to attend all staffings, exceptions may be made for vacations, health issues, or emergencies

- 4.9 The judge shall serve as the leader of the child protection drug court team, and shall maintain an active role in the court processes, including court staffing, conducting regular status hearings, imposing behavioral rewards, incentives and sanctions, and seeking development of consensus-based problem solving and planning.
- 4.10 Community supervision / probation shall generally play a significant role in the child protection drug court, as many participants will have concurrent criminal cases. It is understood that supervision in the child protection drug court setting will be individualized to the needs of participants as determined by the drug court team and may exceed the minimum risk-based supervision standards required by the Idaho Department of Correction or misdemeanor probation departments.
- 4.11 Each child protection drug court shall have a written drug testing policy and protocol describing how the testing will be administered, standards for observation to ensure reliable specimen collection, how quickly results will be available to the team, the laboratory to be used, procedures for confirmation, and process for reporting and acting on results.
- 4.12 Monitoring of abstinence through truly random, observed urinalysis or other approved drug testing methodology shall occur no less often than an average of twice weekly or ten times per month throughout court participation. More frequent drug testing may be required for randomization - but is neither evidence-based nor cost-effective - except in the case of alcohol testing which may be necessary on a more frequent basis.**

Exploring the Key Components of Drug Courts: A Comparative Study of 18 Adult Drug Courts on Practices, Outcomes and Costs. (2008). Pg. 43

- 4.13 Child protection drug court staff shall routinely have drug test results within 48 hours (including instant-test results).**

Guidance to States: Recommendations for Developing Family Drug Court Guidelines (2013). Pg. 8.

- 4.14 Drug testing should be available on weekends and holidays
- 4.15 The child protection drug court should give each participant a handbook setting forth the expectations and requirements of participation including:
- (A) Clear written guidelines identifying positive and negative behaviors, possible sanctions, incentives, and how the court utilizes those sanctions and incentives to modify behaviors;
 - (B) Court contact information with dates, times, and court locations;
 - (C) Drug testing locations, times, and process;
 - (D) Treatment contact information, location(s), and expectations;
 - (E) Probation contact information;
 - (F) Coordinator contact information;
 - (G) Fees and costs of participation; and
 - (H) Phase advancement and graduation criteria;

- 4.16 **Research has shown that for sanctions to be effective, they must be, in order of importance: (a) certain, (b) swift, (c) perceived as fair, and (d) appropriate in magnitude. While sanctions for noncompliance should generally be consistent, they may need to be individualized as necessary to increase effectiveness for particular participants. When a sanction is individualized, the reason for doing so should be communicated to the participant to lessen the chance that he or she, or his or her peers, will perceive the sanction as unfair.**

Research has shown that graduated, successive sanctions imposed on a participant increase their effectiveness.

In child protection drug courts that use jail time as a sanction, jail sanctions are imposed judiciously and sparingly. Unless a participant poses an immediate risk to public safety, jail sanctions are administered after less severe consequences have been ineffective at deterring infractions. Jail sanctions are definite in duration and typically last no more than three to five days. Participants are given access to counsel and a fair hearing if a jail sanction might be imposed because a significant liberty interest is at stake.

Adult Drug Court Best Practice Standards Volume 1. (2013). Pgs., 27-29.

- 4.17 Positive responses, incentives, or rewards to acknowledge desired participant behavior, as well as to teach appropriate behavior, should be emphasized over negative sanctions or punishment.

Comment: Research shows that an emphasis on recognizing and rewarding positive behavior is significantly more effective than focusing on punishing negative behavior.

- 4.18 Graduation criteria should include at a minimum:
- (A) Successful completion of substance abuse treatment;
 - (B) Successful completion of any chosen cognitive restructuring program;
 - (C) 6 months of continuous abstinence from alcohol or other drugs;
 - (D) Positive parenting performance;
 - (E) Maintenance of responsible vocational or educational status for a reasonable period of time;
 - (F) When employment, or educational prosocial activities are unable to be actuated demonstrated, legal ability to support (e.g. disability payments) oneself and family or volunteer service are also acceptable
 - (G) Demonstrated effective use of a community-based recovery support system;
 - (H) Payment of fees or an agreed upon payment plan for any outstanding balance; and
 - (I) Acceptable written relapse prevention and other aftercare activities plan.
- 4.19 All members of the drug court team should maintain frequent, ongoing communication of accurate and timely information about participants to ensure that responses to compliance and noncompliance are certain, swift and coordinated.
- 4.20 The child protection drug court shall have a written policy and procedure for adhering to appropriate and legal confidentiality requirements and should provide all team members with an orientation regarding the confidentiality requirements of 42 USC 290dd-2, 42 CFR Part 2.**
- 4.21 All drug court team members should be specifically identified in the “consent(s) for disclosure of confidential information”, signed by each participant. Additionally, each “consent for disclosure of confidential information” should include an option for consenting to the use of the confidential information for research and evaluation for the purpose of program improvement.
- 4.22 Care should be taken to prevent the unauthorized disclosure of information regarding participants. Progress reports, drug testing results, and other information regarding participant treatment and any information of this type disseminated to the drug court team should not be placed in a court file that is open to examination by members of the public. Information regarding one participant should not be placed in another participant’s file such as duplicate copies of group progress notes describing progress or participation of all group members.

5.0 EVALUATION

- 5.1 Specific and measurable criteria marking progress should be established and recorded in ISTARs for each drug court participant (i.e. drug testing results, compliance with program requirements, sanctions and incentives, participation in treatment, payment of fees, etc.).
- 5.2 Specific and measurable goals for the overall drug court should be established and used as parameters for data collection and information management.
- 5.3 Child protection drug courts should utilize the ISTARs Drug Court Module to record participant information and information on participation, phase movement, and graduation.
- 5.4 A wide variety of timely and useful reports should be available from ISTARs for review by drug court team members.
- 5.5** Child protection drug courts shall provide utilization data to the Idaho Supreme Court promptly by the 10th of the month. The utilization report provides at a minimum, the number of participants active in drug court at the start of the month, the number of new admissions to drug court during the month, the number of unsuccessful terminations and graduates during the month, the number of participants enrolled on the last day of the month, and the number of drug free babies born to female participants during the month
- 5.6 Data to assess whether the drug court is functioning as intended should be collected throughout the course of the court, including in the early stages of implementation.
- 5.7 Outcome evaluations using comparison groups should be implemented to determine long-term effects of the drug court.
- 5.8 Initial drug court intake information must be obtained for each participant assessed for entry into drug court. Complete intake and exit information must be obtained for all participants who enter drug court. This data must be entered into the ISTARs drug court module. This information is essential to evaluate the effectiveness of the Idaho child protection drug courts.
- 5.9 The district court of each county which has implemented a child protection drug court shall annually evaluate the program's effectiveness and provide a report to the Supreme Court, if requested [IC 19-5605].**
- 5.10 A client feedback evaluation should be conducted twice-per-year by each drug court.

- 5.11 An annual report, *The Effectiveness of Idaho Problem-Solving Courts Drug Courts* will be presented to the Governor and the Legislature by the *Idaho Drug Court & Mental Health Court Coordinating Committee*, no later than the first day of the Legislative session.
- 5.12 Evaluation results/ recommendations should be reviewed and implemented on at least an annual basis and be used to analyze operations, modify program procedures, gauge effectiveness, change therapeutic interventions, measure and refine program goals, and make decisions about continuing or expanding the program.
- 5.13 Evaluation results should be shared widely.

6.0 PARTNERSHIPS / COORDINATION OF SERVICES

- 6.1 A formal written agreement should provide the foundation for collaboration, working relationships, and operating policies and procedures at the statewide level, between the Idaho Supreme Court, the Idaho Department of Health and Welfare and the Idaho Department of Correction, updated as needed.
- 6.2** Each drug court should have a formal written agreement (e.g. MOU) to provide the foundation for collaboration, working relationships, duties and operating policies and procedures at the local level, among the key agencies responsible for the operation of each local drug court. The agreement will be signed by the local executive authority for each key agency, including at a minimum, the judicial district, the prosecutor, public defender, Department of Health and Welfare, the probation agency, treatment provider and Board of County Commissioners, updated as needed.
- 6.3 Each drug court should work to establish partnerships with additional public and private agencies and community-based organizations in order to generate local support and resources and to enhance drug court program effectiveness.
- 6.4 The Trial Court Administrator in each District should convene a meeting on an annual basis engaging the executive authority of each stakeholder agency or organization to identify and address district-wide issues affecting the operations and outcomes of the district's problem-solving courts.
- 6.5 The Coordinator for each drug court should convene a team meeting for addressing program issues such as policy changes, program development, quality assurance, communication, and problem-solving at least twice per year.

- 6.6 The Judge for each drug court should convene meetings at least twice each year to provide for cross-disciplinary and team development training for all members. The Judge, as team leader, is responsible for assuring participation. The child protection drug court Coordinator is responsible for assessing training needs and arranging training. Local, state, or national resources may be used including various distance learning opportunities such as video presentations or webinars.
- 6.7 A local coordinating committee of representatives from organizations and agencies including the court, CASA, child welfare, law enforcement, corrections, treatment and rehabilitation providers, educators, health and social service agencies, community organizations and faith community should meet regularly to provide feedback and input to the drug court program and aid in the acquisition and distribution of resources related to the drug court.
- 6.8 A state or regional training conference for drug court teams should be held annually, budget funds permitting.
- 6.9 Information on national and regional drug court training opportunities as well as available training resources will be disseminated to all drug courts, by the Statewide Drug Court Coordinator.

Conclusion

Research has clearly shown that child protection drug courts that follow the drug court model and use best practices produce positive child welfare outcomes including reduced time in out-of-home care, increased engagement in and completion of substance use disorder treatment, increased parent-child reunification, and decreased time to reunification. Idaho's courts can use these Standards and Guidelines as a foundation for creating new child protection drug courts and for maintaining and evaluating existing courts. These Standards and Guidelines will assure appropriate consistency while still enabling flexibility to shape child protection drug courts to meet regional needs. The result will be a strong, consistent, statewide system that will produce positive and cost effective outcomes for families and the community.