NEEDS ASSESSMENT OF PROBLEM-SOLVING COURTS

FOR THE 13TH JUDICIAL CIRCUIT COURTS

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For all who were generous with their time, we appreciate your trust to convey your thoughts and experiences into this Needs Assessment so that other Problem-Solving Courts' participants and team members might reap the benefits. A twenty-five year legacy of Drug Court operations requires a thank you to so many professionals who worked in the courtroom, in treatment providers and most importantly to the participants who graduated and showed us why we continue to champion proven strategies within the judicial system that empower drug using-people to change their lives.

Thirteenth Judicial Circuit
Problem Solving Court Team Members

- Chief Judge Ronald Ficarrotta
- Judge Jack Espinosa, Jr.
- Judge Denise A. Pomponio
- Judge Michael J. Scionti
- Office of the Public Defender, Julianne M. Holt
- Office of the State Attorney, Andrew H. Warren
- Administrative Office of the Courts, Problem Solving Courts
- Office of the Attorney General
- Office of Criminal Conflict and Civil Regional Counsel
- Guardian ad Litem
- Eckerd Kids
- Agency for Community Treatment Services, Inc. (ACTS)
- Drug Abuse Comprehensive Coordinating Office, Inc. (DACCO)
- Gracepoint – Mental Health Care
- North Tampa Behavioral Health
- Northside Mental Health Center
- Operation PAR, Inc.
- Phoenix House
- Tampa Crossroads

Other community providers offer treatment services for participants in Problem-Solving Courts; however, they did not participate in this Needs Assessment.

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Introduction

The drug epidemic that began over 30 years ago had an effect on the criminal justice system in the U.S. Early responses to this epidemic focused on law enforcement and incarceration, but had a relatively small impact in reducing drug-related crime. From these unsuccessful efforts emerged a growing consensus that incarceration without rehabilitative programs is not an effective strategy for interrupting the cycle of drugs and crime. Over the past twenty years, the courts and correctional systems have developed a range of rehabilitative programs intended to reduce recidivism. These include several treatment-based court initiatives, such problem-solving courts and other specialty court programs (Bureau of Justice Assistance, 2015).

Emergence of Problem-Solving Courts

Problem-solving courts began in the early 1990's in response to significant backlogs and overcrowding in the criminal justice system related to drug offenders, and to the ineffectiveness in preventing the rapid cycling of this population through the system (Terry, 1999). These programs attempt to address underlying problems of addiction and have incorporated a range of evidence-based treatment principles with the criminal justice system (Hora, Schma, & Rosenthal, 1999). Problem-solving court programs highlight services that provide coordination to facilitate ongoing involvement in community treatment and court supervision.

The Omnibus Crime Control Act passed by Congress in 1994 established the Drug Courts Program Office (DCPO) within the U.S. Department of Justice, and provided funding to support the development of drug courts throughout the country. Nearly 500 problem-solving courts were operational by 2001, and at present, there are over 3,100 problem-solving courts, half of which are adult drug courts (National Association of Drug Court Professionals, 2017). Problem-solving courts are now in all 50 states, the District of Columbia, Puerto Rico, and in many other countries.

Problem-solving court programs balance both the community's public safety interests and the rehabilitative needs of participants through collaborative partnerships between criminal justice and treatment systems, and a range of ancillary service providers (National Drug Court Institute, 2008). These programs reduce crime by placing drug-involved offenders in ongoing treatment supervised and monitored by the courts. Compared to traditional criminal courts, problem-solving courts represent a significant departure from adversarial proceedings and operations. Participation is voluntary, although individuals face significant consequences if they do not successfully follow program guidelines. A multidisciplinary team coordinates supervision by the problem-solving court judge and involvement in treatment.

The problem-solving court judge takes an active role in monitoring progress in treatment through frequent drug testing and mandatory court appearances, and encourages participants to stay in treatment through use of a wide range of graduated rewards and sanctions to encourage participant progress (National Drug Court Institute, 2001). Generally, treatment averages about a year, although incentives and sanctions can shorten or lengthen this time. Regular hearings in front of the problem-solving court judge support program guidelines and accountability. A comprehensive set of treatment services are provided by most problem-solving courts and include a phased approach that provides more intensive treatment during the first several months of treatment, followed by less intensive outpatient treatment in later stages of the program (Marlowe, 2010). Treatment typically includes case management, individual and group counseling, random drug testing, peer support groups, mental health services, and a range of other ancillary services.

Table 1 describes the Ten Key Components of Problem-Solving Courts developed by a national consensus panel convened by the U.S. Department of Justice and the National Association of Drug Court Professionals (NADCP; U.S. Department of Justice, 1997). In 2000 and again in 2009, the Conference of Chief Justices (CCJ) and the Conference of State Court Administrators (COSCA) issued

joint resolutions concluding that drug courts and other problem-solving courts are the most effective strategy we have for reducing drug abuse, preventing crime, and restoring families. In recognition of this fact, CCJ and COSCA called upon the justice system to extend the reach of problem-solving courts to every citizen in need, and further, to infuse the principles and practices of these proven programs throughout our system of justice. Their conclusions echo more than two decades of rigorous scientific research establishing that drug courts work and that fidelity to the Ten Key Components of the model is essential for achieving the most successful and cost-effective outcomes.

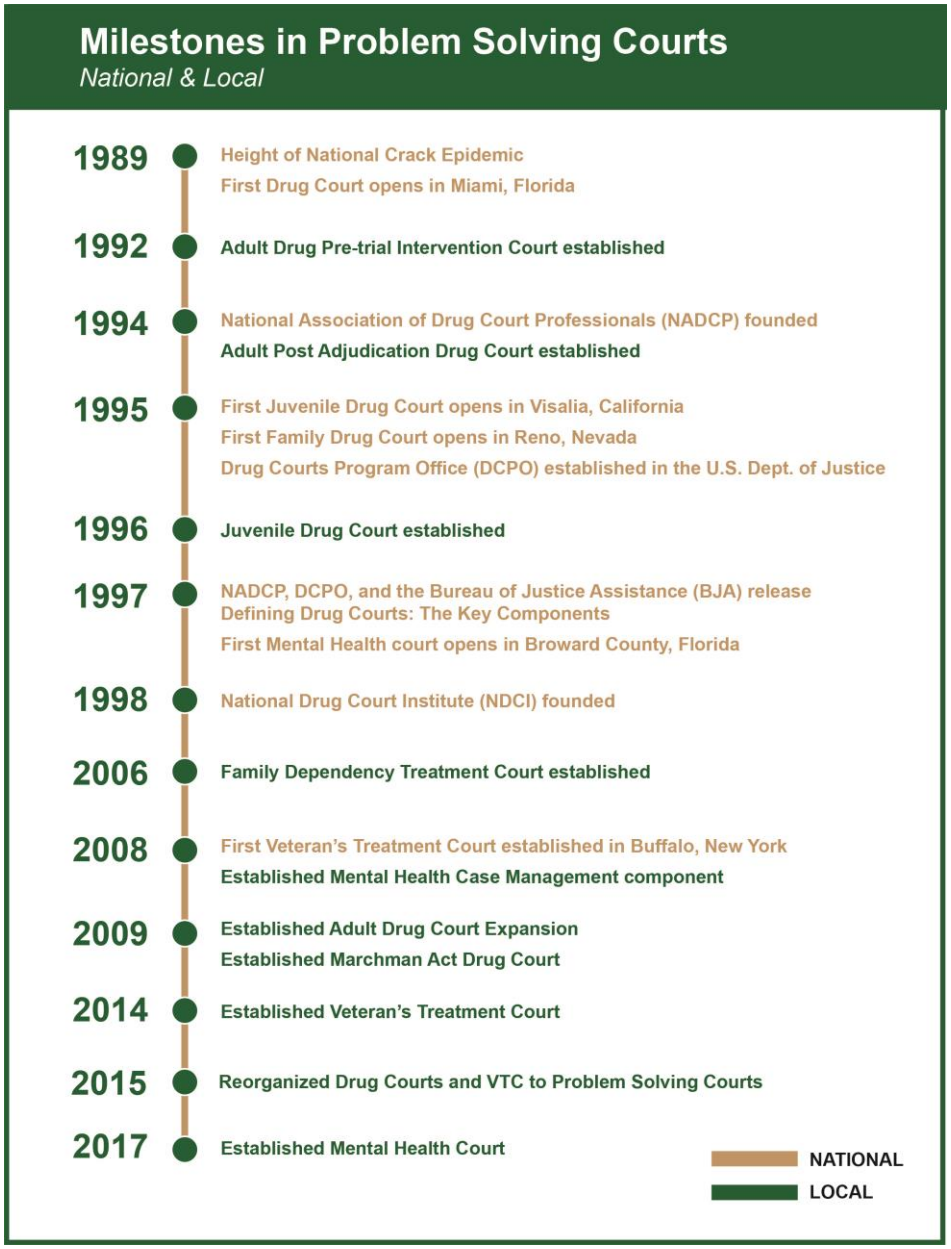
Table 1. Ten Key Component of Problem-Solving Courts

Key Component 1	Drug courts integrate alcohol and drug treatment services with justice system case processing.
Key Component 2	Using a non-adversarial approach, prosecution and defense counsel promote public safety while protecting participants' due process rights.
Key Component 3	Eligible participants are identified early and promptly placed in the drug court program.
Key Component 4	Drug courts provide access to a continuum of alcohol, drug, and related treatment and rehabilitation services.
Key Component 5	Abstinence is monitored by frequent alcohol and illicit drug testing.
Key Component 6	A coordinated strategy governs drug court responses to participants' compliance.
Key Component 7	Ongoing judicial interaction with each drug court participant is essential.
Key Component 8	Monitoring and evaluating achievement of program goals is necessary to gauge effectiveness.
Key Component 9	Continuing interdisciplinary education promotes effective drug court planning, implementation, and operations.
Key Component 10	Forging partnerships among drug courts, public agencies, and community-based organizations generates local support and enhances drug court program effectiveness.

Development of the 13th Judicial Circuit Problem-Solving Courts

Over the past 23 years, the 13th Judicial Circuit Court has been very successful in developing and maintaining numerous problem-solving courts. Note that the term "drug court" has been used previously in our circuit but was officially changed to "problem-solving court" in 2015. As can be seen below, Figure 1 depicts a timeline for problem-solving court milestones at both the national and local level.

Figure 1. National and Local Milestones in Problem-Solving Courts



History. As can be seen from the above timeline, the 13th Judicial Circuit Court has been on target with national best practices; establishing new problem-solving courts immediately after new guidelines were established. Table 2 describes the history of the different problem-solving courts in the 13th Judicial Circuit, eligibility criteria, treatment components, and funding sources.

Table 2. 13th Judicial Circuit Problem-Solving Court History

Adult Drug Pretrial Intervention Court (DPTI; 1992)	**History**. Adult Drug Pretrial Intervention (DPTI) court began in 1992, allowing first-time drug offenders the chance to avoid having a felony conviction on their record. The defendant signs a drug court contract and the State Attorney's Office agrees to drop charges upon program completion. The current presiding Judge is the Honorable Jack Espinosa, Jr.; there are 2 FTE Drug Court Specialists assigned to this division. **Eligibility**. Any person over the age of 18 who has not had a prior felony or pretrial intervention episode is eligible provided they waive their right to a speedy trial, admit to having a drug problem, and express a desire for treatment. **Treatment.** The treatment program is a year and typically involves group and individual counseling, drug screens, and participants spend about nine hours per week in treatment. Defendants are required to meet regularly with a Department of Corrections (DOC) Probation Officer and appear before judge for case reviews. **Funding**. In October 1995, the Department of Justice, Bureau of Community Assistance (Byrne) Grant managed by the Office of State Courts Administrator funded a Drug Court Coordinator position. In July 2017, Florida Department of Children and Families (DCF) Criminal Justice, Mental Health and Substance Abuse Reinvestment Grant financed treatment services in Hillsborough County.
Adult Post Adjudication Drug Court (Adult Drug Court; 1994)	**History**. The first Adult Post Adjudication Drug Court (Adult Drug Court) was established in 1994; it was designed to treat individuals whose substance use problems resulted in 3rd degree felony charges. The current presiding judge is the Honorable Denise Pomponio; there are 2 FTE Drug Court Specialists assigned to this division. **Eligibility**. Individuals who have prior non-violent felony convictions and do not score state prison are eligible. At the time of arraignment, each participant is evaluated by a Drug Court Specialist; options are made to the judge. **Treatment**. These options are included in probation along with regular drug testing and other requirements. Each participant is supervised by a DOC Probation Officer and expected to attend case reviews in front of the judge. **Funding**. This court received a grant in 2009 from the Substance Abuse Mental Health Services Administration (SAMHSA) Center for Substance Abuse Treatment (CSAT). This provided a Drug Court Specialist position, responsible for administering initial screenings and treatment services. Treatment is financed through DOC under contract with the Programs' Office throughout the state.

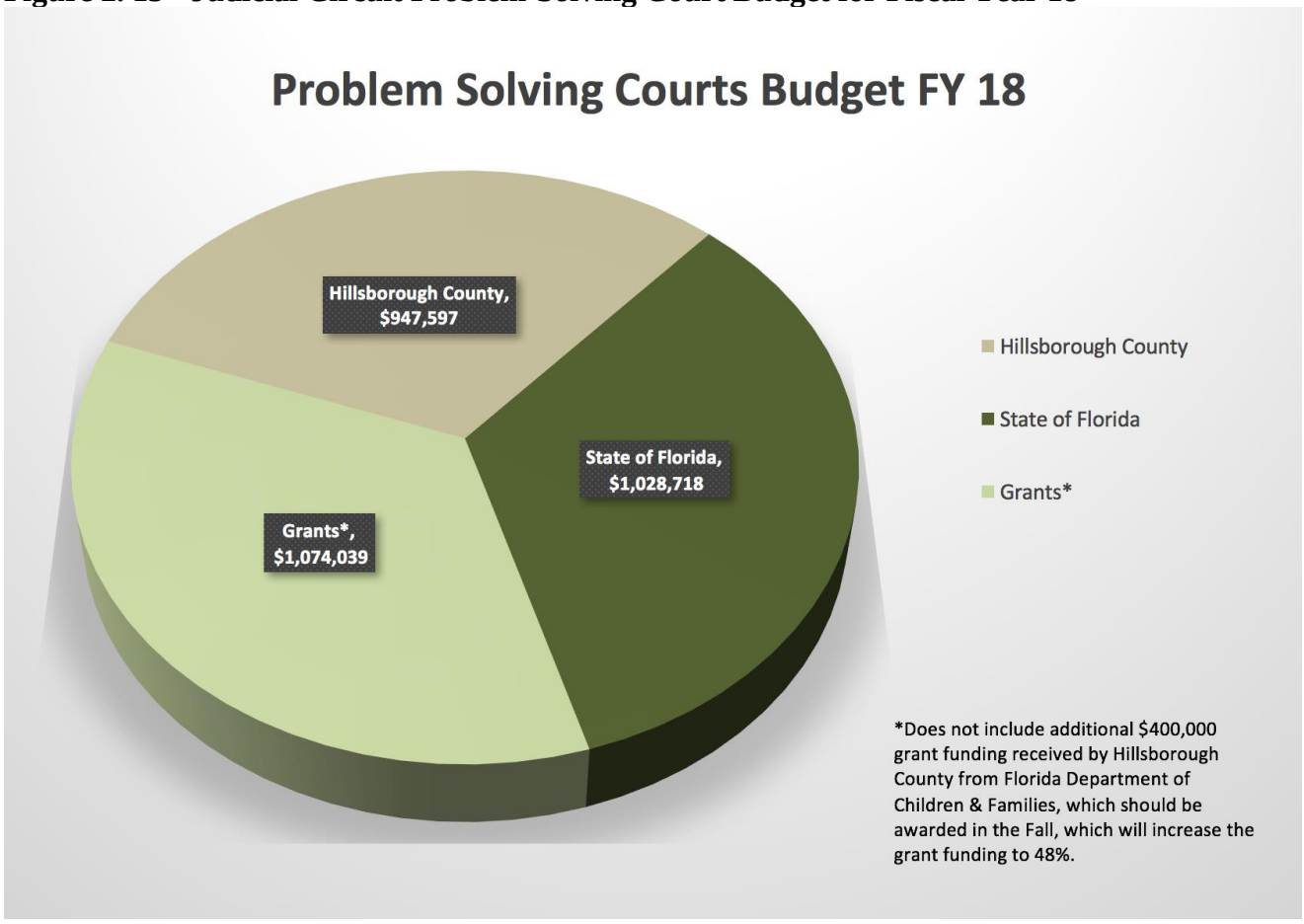
Adult Drug Court Expansion (2009)	**History**. The Adult Drug Court Expansion (DCE) program began in 2009. This program is for individuals who have prior non-violent felony convictions and is in lieu of going to prison. The current presiding judge is the Honorable Denise Pomponio; there are 2 FTE Drug Court Specialists assigned to this division. **Eligibility**. Individuals who have prior non-violent felony convictions and score state prison are eligible. The ideal scoring is between 44-60 points; however, over 22 are accepted in lieu of prison. At the time of arraignment, a Drug Court Specialist who makes options to the judge evaluates each defendant. **Treatment**. These options are included into probation along with regular drug testing and other requirements. Each participant in the program is supervised by a DOC Probation Officer and expected to attend regular case reviews in front of the judge. **Funding**. Initially funded by the Office of State Court Administrator through Edward Byrne Memorial Justice Assistance Grant under the American Recovery and Reinvestment Grant, this court is now funded by reoccurring state dollars that fund substance abuse treatment, including residential, intensive outpatient and outpatient levels of care. Additionally, funding includes psychiatric evaluation services and bus passes.
Juvenile Drug Court (JDC; 1996)	**History**. The first Juvenile Drug Court (JDC) in the State of Florida and one of the first in the nation was established in this circuit in 1996. The current presiding judge is the Honorable Denise Pomponio; there is 1 FTE Drug Court Specialist assigned to this division. **Eligibility**. Juveniles in the program must have been charged by the State Attorney with a crime and can enter the program from different referral sources: (1) Hillsborough County School District, (2) Juvenile Assessment Center (JAC), (3) Juvenile Arbitration Program, and (4) Juvenile Division Transfer. **Treatment**. JDC is a minimum six to twelve-month program in which participants are required to attend substance abuse counseling, submit to random drug screens, attend school or obtain a general equivalency diploma (GED), follow court-ordered sanctions, and comply with any other orders issued by the court. The end goal is to have the legal charges dismissed, the plea vacated and the petitions closed upon completion of the program. **Funding**. Received a grant from the Drug Court Programs Office, Dept. of Justice, shortly after the beginning operations. This provided two Drug Court Specialists positions who handle case management and in-court support for the judge. The treatment agency, ACTS, also received Byrne Grant funds for treatment during the first four years of the program. In 2002, the court received an Edward Byrne Memorial Grant to hire a Drug Court Specialist, especially to handle the case management functions, for the referrals coming from the schools.

Family Dependency Treatment Court (FDTC; 2006)	**History**. The Family Dependency Treatment Court (FDTC) program was established in 2006 due to the need for a specialized court for parents and/or caregivers of children whose lives have been impacted by substance use issues. The goal is reunification and assuming parent responsibilities in healthy and safe environment. The current presiding judge is the Honorable Jack Espinosa, Jr.; there are 2 FTE Drug Court Specialists assigned to this courtroom. **Eligibility**. Participants must meet these requirements: (1) new petition, (2) substance abuse issues in investigative report, (3) no past history of violent criminal offenses, (4) not be alleged sexual perpetrator, (5) not have an advanced terminal illness, (6) approved by FDTC Judge, and (7) reunification as a goal. **Treatment**. Participants in this court are required to attend substance abuse treatment and will receive every opportunity to be successful in their goal of reunification with their children. This court also ensures that the participant is compliant with all areas of the case plan designed by child welfare. **Funding**. Received two grants from the Substance Abuse Mental Health Services Administration (SAMHSA) Center for Substance Abuse Treatment (CSAT) office in 2006 and 2012 that provided treatment for FDTC clients and two Drug Court Specialist positions who handled case management and support for the judge; these position were sustained by Hillsborough County. The treatment agency, DACCO, also received funding from the Office of Administration for Children and Families during the first four years for those with a history of methamphetamine addiction. In July 2017, received a five-year SAMHSA grant for treatment services and evaluation.
Mental Health Pre Trial Intervention Court (MHPTI; 2008)	**History**. Mental Health Pretrial Intervention (MHPTI) is a variation of PTI and includes mental health treatment and monitoring in lieu of community service. MHPTI case management services were available in 2008 felony divisions, but in February 2017, the Mental Health Criminal Division was established for efficient justice administration. The current presiding judge is the chief judge, Honorable Ronald Ficarrotta; there is .5 FTE Drug Court Specialist assigned to this division. **Eligibility**. Persons approved by the State Attorney who meet the criteria for Pretrial Intervention (PTI) under Florida Statute 948.08 (2) and have a major mental health disorder are eligible for MHPTI. However, MHPTI is not intended to be used in lieu of Drug PTI for defendants charged with drug offenses. **Treatment**. The Mental Health Court Liaison works to find a community mental health provider to monitor defendant's treatment needs. Based on assessment, the treatment plan is included in contract between the State Attorney and the defense. **Funding**. In 2008, Florida Department of Children and Families (DCF) provided funding for a Court Mental Health Liaison, employed by Northside Mental Health, and then in 2014, Central Florida Behavioral Health Network provided funding through Gracepoint. Hillsborough County received funding in February 2017 from DCF Criminal Justice, Mental Health and Substance Abuse Reinvestment Grant to provide full-time Mental Health Court Liaison employed by Gracepoint Behavioral Health. ACTS offers comprehensive case management, behavioral health services, supportive housing resources, and incidental funding.

Marchman Act Drug Court (Marchman; 2009)	**History**. The Marchman Act Drug Court (Marchman) program was established in 2009; it was designed to court order participants to clinically relevant treatment if needed. The current presiding judge is the Honorable Jack Espinosa, Jr.; there are 2 FTE Drug Court Specialists assigned to this division. **Eligibility**. Participants must meet the following requirements: the participant must be substance abuse impaired; because of the impairment must have lost the power of self-control; be a danger to themselves or others because of their impairment; and refusing to attend treatment voluntarily. **Treatment**. The participants in this court are required to attend substance abuse treatment; weekly urine drugs screens; and mental health treatment, if recommended. The Marchman Court specialists monitor the respondent's compliance and report their progress to the judge. **Funding**. Received a grant from the Substance Abuse Mental Health Services Administration (SAMHSA) Center for Substance Abuse Treatment (CSAT) office in 2015, and 2018 is the 3rd and final year of this grant. This provided funding for treatment services as well as evaluation. Additionally, Hillsborough County has allocated treatment services for individuals involved in this court.
Veterans Treatment Court (VTC; 2014)	**History**. Veterans Treatment Court (VTC) was established in 2013 in order to divert veterans with service-related issues into available veteran treatment programs without compromising the safety of the public. This specialized court will increase the efficiency of the county criminal court system and permit access to state, local, and federal services and resources by utilizing Veterans Administration and Veteran Mentor Volunteer support systems. The current presiding judge is the Honorable Michael Scionti; there are 1.5 FTE Drug Court Specialists assigned to this division. **Eligibility**. The defendant must be a veteran discharged with honorable conditions who suffers from a military service-related mental illness, traumatic brain injury, substance abuse disorder, or psychological problem. **Treatment**. VTC uses a collaborative approach to treatment and rehabilitation including but not limited to regular court appearances, specialized substance abuse and mental health treatment services, compliance with medical and other personal appointments, one-on-one veteran peer mentor support, assistance in gaining access to veteran healthcare services and veteran assistance, housing assistance and linkage to vocational training, and educational and/or job placement. **Funding**. Received a grant from the Substance Abuse Mental Health Services Administration (SAMHSA) Center for Substance Abuse Treatment (CSAT) office in 2016. This provided funding for residential treatment, intensive outpatient, outpatient, and wrap around services. The grant extends to 2020 and evaluation is included in the grant.

Funding. As can be seen from Figure 2 below, the problem-solving court budget for FY 2018 is $3,050,354. This is impressive given that when the 13th Judicial Circuit began in 1992 there was relatively little funding for development and implementation. Over the past 25 years, the 13th Judicial Problem-Solving Courts has received funding that can be divided into three different categories: local funding ($947,597), state ($1,028,718), and federal grants ($1,074,039). Positions in both Post Adjudicatory Drug Court and Family Dependency Treatment Court (FDTC) were initially grant funded but through demonstrated success, Hillsborough County sustained the Drug Court Specialists. After the decline in the economy, the courts ceased to add positions through grant funding. Today, eleven positions serve Problem Solving Courts; 73% are funded by Hillsborough County, while the State of Florida provides funding for the remainder. It is important to note that almost 70% of funding is dedicated for substance use and co-occurring disorder treatment.

Figure 2. 13th Judicial Circuit Problem-Solving Court Budget for Fiscal Year 18



Problem-Solving Court Current and Past Census Statistics. Over the past six years, problem-solving courts have maintained statistics, with the exception of Marchman Act Drug Court that did not begin collecting census data until 2016. While Adult Drug Court Expansion maintains more detailed information through automation (i.e., Florida Drug Court Case Management System [FDCCSM]), each program now maintains data on their census, including active participants, those admitted, and those who have graduated from the program. As can be seen from Table 3, there has been a decrease in the number of participants across most of the problem-solving courts from 2011-2016. Of exception is Family Dependency Treatment Court (FDTC) which has seen a 35% increase in participants over the past six years. Although we only have data for two years, Veterans Treatment Court (VTC) has also seen an increase from 2015 to 2016, with 62 participants admitted in 2015 and 99 participants admitted in 2016, a 37% increase.

It is important to note the decrease in problem-solving court participants over the past six years has led to a decrease in the number of participants admitted and those who have graduated. Also, during the first six months of 2017 there has been an increase in the number of participants in each of the problem-solving courts, particularly Drug Pre-Trial Intervention (DPTI; N = 454) and Adult Drug Court Expansion (DCE; N = 91) which already has more participants than in 2016 total.

Table 3. Problem-Solving Court Census Statistics (2011 – 2016)

	Jan-Dec 2011	Jan-Dec 2012	Jan-Dec 2013	Jan-Dec 2014	Jan-Dec 2015	Jan- Dec 2016	% change 2011-2016
Adult Drug Pre-Trial Intervention (DPTI)							
Participants	526	534	426	415	413	410	***-22%***
Admitted	259	257	340	398	356	293*	
Graduates	221	174	183	208	207	201*	
Adult Post Adjudicatory Drug Court							
Participants	424	365	328	292*	228	155	***-63%***
Admitted	147	144	132	102	78	60	
Graduates	179	134	119	90	82	62	
Adult Drug Court Expansion (DCE)							
Participants	125	110	76	77	105	63	***-50%***
Admitted	45	54	37	50	24	32	
Graduates	42	33	37	25	27	16	
Juvenile Drug Court (JDC)							
Participants	288	247	215*	158*	234	9	***-97%***
Admitted	308	237	397	229	156	54	
Graduates	204	225	352	215	153	81	
Family Dependency Treatment Court (FDTC)							
Participants	150	132	104*	117	154	203	***+35%***
Admitted	121	71	43	89	109	107	
Graduates	34	32	39	27	33	23	
Marchman Act Drug Court (Marchman)							
Participants						412	
Admitted						145**	
Graduates						108**	
Veteran Treatment Court (VTC)							
Participants					62	99	***+37%***†
Admitted					83	130	
Graduates					16	72	

Note. Participants refer to those currently in each of the problem-solving courts which may include previous years
†Percent change only refers to 2015-2016 for VTC
*9-month data only per AOC staff (Jan-Sept)
**6-month data only per AOC staff (Jan-June)

Methodology

A Needs Assessment of the 13th Judicial Circuit Problem-Solving Court programs was conducted by the Florida Mental Health Institute at the University of South Florida funded by the Administrative Office of the Courts, 13th Judicial Circuit. This contract supported the Needs Assessment conducted by Dr. Kathleen Moore, Ms. Vanessa Tate, MPH, CPH, Ms. Haley Bland, and Ms. Cristina Aberno.

The purposes of this Needs Assessment are to identify gaps in services needed by court participants; ensure that evidence-based practices are being used by providers receiving court referrals; and develop the eligibility criteria that future providers must meet in order to contract with the court or receive court referrals. The Court also seeks to assess adherence to The Ten Key Components of Drug Courts and to identify recommendations by key stakeholders in order to improve the various problem-solving court programs. Additionally, the Court would like to identify minimum standards for contract holders as well as a list of recommended providers to be used as a tool for judges and case managers. The following is a brief summary of the needs assessment activities conducted during the period of January - June 2017. Below are a summary of the major activities of the needs assessment.

Key Needs Assessment Activities

Qualtrics Survey. Two Qualtrics surveys were developed utilizing previous problem-solving court literature as a guide. The first survey included general questions, which were further refined in the second survey to include court specific screening, assessment, and treatment questions after meeting with several experts in the field, including court administration and court staff who work in these problem-solving courts (see Appendix A for list of survey questions). The surveys were then beta-tested by more than a dozen court specialists before being distributed to community

treatment providers working with the 13th Judicial Circuit Problem-Solving Courts via email. Follow up interviews with the treatment providers were conducted by phone to gather missing or incomplete data. As indicated in Table 4, eight treatment providers completed all or at least 50% of the Qualtrics survey (a general survey and also a specific survey for each problem-solving court they participated in). The only surveys that were eliminated were duplicate or incomplete submissions where we were unable to follow-up and verify responses from treatment providers.

Table 4. Qualtrics Surveys Completed by Treatment Providers

	General	ADC	FDTC	JDC	Marchman	MHPTI	VTC
ACTS	X	X			X	X	
DACCO, Inc.	X	X	X	X	X		X
Gracepoint	X						
North Tampa Behavioral Health							X
Northside	X						
Operation Par, Inc.	X	X			X		
Phoenix House	X	X	X	X	X		
Tampa Crossroads	X	X	X		X		X

There were some important limitations to the Qualtrics survey that we learned in the process of conducting this Needs Assessment. The first limitation is that we failed to differentiate between the divisions within Adult Drug Court (DPTI, Post-Adjudication, and Expansion), which have two judges and three drug court specialists. These function differently from one another in some respects that would have been useful to tease out in the surveys, and perhaps even with the focus groups. The second limitation is the inconsistent way that treatment providers collect and report information (e.g., funding associated with residential beds; amount of time participants spend in treatment, phases of treatment, level of care; etc.). Treatment providers who accept participants from multiple courts found it particularly difficult to tease apart which court participants came

from and to specify reimbursement rates for residential beds by each problem-solving court. The research team attempted to communicate with those treatment providers who worked in multiple problem-solving courts to assist in parsing their data in a way that got to the essence of the information the court needed and worked with their data collection methods.

Focus Group Interviews. Focus group key stakeholder interviews were conducted to examine the perceived effectiveness of different components of the problem-solving court programs (see Appendix B for list of focus group questions). Additionally, we wanted to identify recommendations for improving the various problem-solving court programs from the perspectives of various different stakeholders. Interviews were conducted with professional staff working with problem-solving court programs including:

- Drug Court Specialists
- Public Defender's Office
- State Attorney's Office
- Problem-Solving Court Judges
- Family Dependency Treatment Court (FDTC) team

Review of Program Materials. The needs assessment also included a review of key program materials. These reviews helped to determine the type of information routinely compiled for participants, and helped identify court activities pertinent to the study. Among the documents reviewed are the following:

- Administrative Orders of the Court
- Problem-Solving Court Brochures
- Problem-Solving Court Policy Handbooks (if applicable)
- Standard Drug Testing Policies for Treatment Providers
- National Best Practice Standards for Problem-Solving Courts
- National Ten Key Components of Problem-Solving Courts
- Seminal research and evaluation reports on Problem-Solving Courts nationwide

Analyses

The results and findings of this report will be categorized by the 10 Key Components noted in the introduction. The purpose, best practices, and performance benchmarks of each Key Component will be discussed, followed by findings of evaluation activities such as Qualtrics survey (treatment providers), focus groups (court stakeholders), and review of policy information.

It is also important to note that there are treatment providers who routinely accept participants from the 13th Judicial Circuit Problem-Solving Courts who did not complete the Qualtrics survey and therefore the findings may not represent a full picture of the services provided. Significant efforts were undertaken to ensure that the largest and most commonly used treatment providers were invited to participate. Of the 13 treatment providers who were targeted for invitation to participate in the surveys, seven responded with at least 50% of the surveys completed, for a response rate of 54%*.

*Avon Park, BayCare Behavioral Health, Board Prep, James A. Haley Veterans Administration, and Salvation Army were invited to participate in the Qualtrics survey; however, responses from these providers were either limited (under 50% completed) or not provided.

Findings[1]

Key Component 1. Drug Courts Integrate Alcohol/Drug Treatment Services with Justice System Case Processing

Purpose. The focus of this component is on a coordinated response to participants; cooperation and collaboration of a team approach including drug court specialists, judges, prosecutors, defense counsel, corrections, law enforcement, and treatment agencies. Performance benchmarks include the following:

- **Documents** defining the drug court's mission, goals, eligibility criteria, operating procedures, and performance measures are developed, reviewed, and agreed upon.
- Court and treatment providers maintain ongoing **communication**, including frequent exchange of timely and accurate information about participant's overall performance.
- Mechanisms for sharing decision making and resolving conflicts among team members, such as **multidisciplinary committees**, are established to ensure professional integrity.

Needs Assessment Findings

Documents: Policy Manual / Participant Handbook. When asked in our focus groups whether each court had a policy manual or participant handbook, VTC was the only court to report having one. However, those interviewed reported that the policy manual and participant handbook is currently out of date but does define expectations for individuals in VTC. A focus group respondent noted that both the policy manual and participant handbook *"outlines a series of steps or goals (e.g., phase 1, phase 2, etc.) - it gives an expectation of what's needed to graduate."* Adult Drug Court also reported that there had been a manual or handbook a few years ago, but only for Expansion. One focus group respondent reported:

"Would like one, but it needs to be up to date. A lot of what exists is out of date. One for the problem-solving courts overall, then court specific." Another respondent noted, "*May have that, but in the form of administrative orders, outlines what every court is supposed to do, reviewing and trying to revise, but it's not something that goes to the public."*

[1]Please note that unless indicated otherwise, results for Mental Health Court/MHPTI are not included in findings analyses as this court did not begin enrolling participants until February, 2017.

Although not a participant handbook, some of the grant-funded court programs created participant flyers for their individual programs but need to be updated as well. These include DPTI (Medication-Assisted Drug Court Treatment [MADCT]), Family Dependency Treatment Court [FDTC], and Marchman Act Drug Court Treatment [MADCT]).

Communication. Most of the treatment providers across all problem-solving courts report receiving at least a basic screening (e.g., biopsychosocial, court order, history, eligibility information, need for treatment) typically conducted by a court treatment liaison on site. One treatment provider in each court reported that no screening or assessment is currently being conducted by the problem-solving court they serve. The vast majority of treatment providers report needing to supplement information received by the court with their own screening or assessment tool (see Table 5). Top reasons for conducting a separate screening or assessment: 1) Compare responses from participant with information given to court treatment liaison and upon intake at treatment providers; 2) Follow up on incomplete or dishonest answers when screened at court; and/or 3) Screening/assessment conducted at court does not satisfy treatment providers' internal policy, licensure, or accreditation requirements.

Table 5. Communication between Treatment Providers and Problem-Solving Court

	% Yes	% No
Does (insert problem-solving court here) conduct any type of screening or assessment with participants before admission to the program?	72.2%	27.8%
Do you use the screening or assessment information from (insert problem-solving court here)?	83.3%*	16.7%
Do you find that you need to supplement this information?	77.8%	22.2%
Do you conduct your own screening or assessment regardless of the information received from (insert problem-solving court here)?	100%	0%
Are drug test results included in the information received from (insert problem-solving court here)?	66.7%	33.3%
Does the program provide treatment status updates to court for participants enrolled in treatment?	100%	0%

* Only 67% of survey respondents answered this question.

All treatment providers in each of the problem-solving courts reported giving the court regular treatment status updates, which typically consist of attendance/dates of attendance and absences to treatment activities such as: 1) Group and individual therapy sessions, Alcoholics Anonymous, Narcotics Anonymous, or other support services; 2) Drug test results/date of drug test; 3) Progress/lack of progress since the most recent prior treatment status update; and 4) Recommendations.

Frequency and Quality of Communication. All treatment providers surveyed reported that staffing meetings occur within their organization at least weekly, and all treatment providers reported using ad hoc or informal methods of communication with the Problem-Solving Court. Treatment providers report varying levels of informal methods of communication, ranging from once per week or less to communicating at least 3x per week (see Table 6). These informal methods include e-mail, phone calls, and discussion prior to court judicial reviews. Table 7 describes staffing meetings between team members and range from less than once per month to weekly staffings. It is important to note that JDC treatment providers reported weekly or biweekly staffings (before JDC docket) and VTC providers typically reported staffings every other week (meet the day before VTC docket). During the focus group meetings, in VTC it was reported that standard practice is to submit oral reports to the court. Other comments included issues of communication, particularly within Adult Drug Court (i.e., DPTI, Post-Adjudicatory, and Expansion). There is little time for staffings and communication among team members before court due to the volume and numerous professionals working within these courts.

As MHPTI is getting underway, communication between ACTS and the court occurs at least weekly, and ACTS also has staffings at least every other week with collaborating organizations. Informal methods of communication are used once or twice per week between ACTS and MHPTI.

Table 6. Informal Methods of Communication

Length of Time	Avg. Total	ADC* (N=5)	JDC (N=2)	FDTC (N=3)	Marchman (N=5)	VTC (N=3)
Once per week or less	**22.2%**	40%	50%	33%	0%	0%
At least weekly	**22.2%**	20%	0%	33%	40%	0%
1-2x weekly	**33.3%**	20%	0%	33%	40%	67%
At least 3x per week	**22.2%**	20%	50%	0%	20%	33%

*For the purposes of the Qualtrics Survey, ADC also includes DPTI and Expansion

One focus group respondent from the FDTC team provided this illustrative quote:

"Communication is great having only one person from Office of the Attorney General, Regional Counsel, Guardian ad Litem, treatment, and drug court specialist. It helps to know who to go to for certain cases because we have stable people. It's the number one reason why we're successful. Having one person to contact helps case management. This is difficult to replicate in other courtrooms that run 5 full days a week with a higher caseload, you just can't do it the same way."

Table 7. Staffing Meetings between Treatment Agency and Problem-Solving Court

Length of Time	Avg. Total	ADC (N=5)	JDC (N=2)	FDTC (N=3)	Marchman (N=5)	VTC (N=3)
Less often than once per month	**44.4%**	80.0%	0%	67.0%	20.0%	33.0%
About once per month	**11.1%**	0%	0%	0%	40.0%	0%
More than once per month, but less than biweekly	**5.5%**	0%	0%	0%	20.0%	0%
Every other week (every two weeks, twice monthly)	**16.7%**	0%	50%	0%	0%	67.0%
At least weekly	**27.8%**	20.0%	50%	33.0%	20.0%	0%

Multidisciplinary Committee. Two of the reports reviewed were the 13th Judicial Circuit's Drug Court Administrative Orders S-2017-037 and S-2016-02. The first order describes the inclusion of a "Drug Court Oversight Committee" that oversees drug court operations in order to ensure proper training of court personnel and correct implementation of the drug court model. The committee is charged with recommending strategies to maintain the quality and effectiveness of drug court and to ensure that the many treatment options now available for drug court remain viable. The Drug Court Oversight Committee is comprised of representatives from the Public Defender and State Attorney's Office, Administrative Office of the Courts, Community Corrections' Office of the Department of Corrections, Hillsborough County Sheriff's Office, treatment providers, and judicial representatives as determined by the chief judge. Although the oversight committee is recognized in this administrative order, there was no record or indication that a meeting convened this past year.

Similarly, the 2016 order established a Veterans Treatment Court (VTC) Oversight Committee comprised of the Public Defender or designee, State Attorney or designee, Trial Court Administrator or designee, a representative of the Veterans Administration, Hillsborough County Sheriff or designee, chair of the Hillsborough County Bar Association's Military and Veterans Affairs Committee or designee, a representative of any other service provider identified by the State Attorney's Office or the Public Defender's Office, the presiding judge in Veterans Treatment Court, the administrative judge of the Veterans Treatment Court, the administrative judge of the Criminal Justice Division, and the chief judge or designee. However, there has been more recent activity with VTC because it is newly established and there is also a steering committee that meets monthly related to grant funding.

Key Component 2. Using Non-Adversarial Approach, Prosecution and Defense Counsel Promote Public Safety while Protecting Participants' Due Process Rights

Purpose and Best Practices. This component is concerned with the balance of three important areas: (1) nature of relationship between prosecution and defense counsel; unlike traditional case processing, problem-solving court case processing favors a non-adversarial approach; (2) problem-solving court programs remain responsible for promoting public safety; and (3) protection of participants' due process rights. Both the prosecuting attorney and the defense counsel play important roles in the court's coordinated strategy for responding to noncompliance. Performance benchmarks include the following:

- **Prosecutors and defense counsel participate in design of screening, eligibility, and case-processing** policies and procedures to guarantee that due process rights and public safety needs are served.
- For consistency and stability in problem-solving court operations, **court personnel (judge, prosecutor, and court-appointed defense counsel) should be assigned for sufficient period of time** to build a sense of teamwork and reinforce a nonadverserial atmosphere.

Needs Assessment Findings

Involvement of Prosecutors and Defense Counsel in Screening, Eligibility, and Case Processing. FTDC, JDC, and VTC all reported high involvement of multiple team members representing different aspects of the court, including the state attorney and defense counsel, in determining eligibility and case processing. When reviewing the Administrative Orders of the Court, legal eligibility criteria is clear. Although not asked specifically about eligibility and screening criteria, there seems to be some friction surrounding the mission and goals of problem-solving courts vs. traditional court. For example, one respondent commented: *"The main friction is between the attorneys and the court. The court and treatment are usually aligned."* Additionally, the majority of DPTI participants are represented by private attorneys, which makes coordinating case management difficult.

Problem-Solving Court Personnel Tenure. In November, 2016 Andrew H. Warren, was ushered in as the new State Attorney, which resulted in some turnover but a fresh perspective. The tenure for the Assistant State Attorneys in each problem-solving court ranged from 2 months

in MHPTI to 4 years in Adult Drug Court while the Assistant Public Defenders had longer tenures in their careers, with a range from 6 years to 26 years, and their careers have been primarily in Problem-Solving Courts. There was a wide diversity of tenure among the Drug Court Specialists, ranging from 2.5 years to 15 years of overall experience; the tenure in each problem-solving court ranged from 7 months in VTC to 5 years in FDTC. Additional members of the FDTC team have a significant amount of experience as well; the Guardian ad Litem representative had 14 years, the Office of the Attorney General representative had 9 years, the Regional Counsel representative had 7 years, and the Drug Court Specialist has 5 years of experience overall, 2 years in FTDC. Many of the FDTC focus group comments centered around how well the team works together because they have worked together for some time.

When assessing tenure by current position within Problem-Solving Court, VTC, FDTC, and JDC have had fairly consistent personnel working in these courts over the past few years with relatively few changes. However, there are occasions in which the Drug Court Specialist may switch to a different court due to workload and administrative issues. There has been more turnover and changes made among teams working in Adult Drug Court and Marchman Court; however, the judges in these courts have been serving in their positions for a significant length of time.

Key Component 3. Eligible Participants Are Identified Early and Promptly Placed in Drug Court Program

Purpose. This component is concerned with judicial action, taken promptly after arrest, capitalizes on the crisis nature of the arrest and booking process. Rapid and effective action also increases public confidence in the criminal justice system. Moreover, incorporating substance use concerns into the case disposition process can be a key element in strategies to link criminal justice and substance use treatment systems overall. Performance benchmarks include the following:

- **Eligibility screening based on established written criteria**; criminal justice officials are designated to screen cases and identify potential problem-solving court participants.
- **Trained professionals screen for eligible individuals** for substance use problems and suitability for treatment.
- **Initial appearance before judge occurs immediately** after arrest or apprehension to ensure program participation and enroll in substance use treatment services.

Needs Assessment Findings

Eligibility Screening. After reviewing the Administrative Order for each of the problem-solving courts, legal eligibility criteria is clear. The State Attorney and Public Defender's Office determine whether each participant meets criteria for legal eligibility.

Trained Professionals Screen for Eligibility. All treatment providers in all courts conduct both screening and assessment for mental health and substance use disorders. As can be seen in Table 8, the majority of treatment staff have a Bachelor's or Master's degree when conducting screenings (72%) and/or assessments (76%). It is noteworthy that all individuals conducting assessments have at least an Associate's degree.

Table 8. Education Level of Treatment Provider Staff

Education level	Avg. Total	ADC (N=5)	JDC (N=2)	FDTC (N=3)	Marchman (N=5)	VTC (N=3)
Individual conducting *screenings*						
High School/GED	**5.5%**	20.0%	0%	0%	0%	0%
Associate's/Vocational Training	**16.7%**	0%	0%	33.3%	20.0%	33.3%
Bachelor's	**27.7%**	40.0%	0%	33.3%	40.0%	0.0%
Master's or higher	**44.5%**	40.0%	50.0%	33.3%	40.0%	66.7%
N/A (no screening is conducted)	**5.5%**	0%	50.0%	0%	0%	0%
Individual conducting *assessments**						
High School/GED	**0%**	0%	0%	0%	0%	0%
Associate's/Vocational Training	**22.2%**	25.0%	0%	33.3%	20.0%	33.3%
Bachelor's	**16.7%**	0.0%	0%	33.3%	40.0%	0%
Master's or higher	**58.8%**	75.0%	100%	33.3%	40.0%	66.7%

*There was one treatment provider who did not respond in ADC

As can be seen in Table 9, the majority of participants who have been screened and assessed have been diagnosed with a substance use disorder, and approximately two-thirds have been diagnosed with a mental disorder (ranging from 47% in JDC to 85% in VTC). Additionally, the majority of treatment providers do not have any restrictions in eligibility for persons diagnosed with specific mental disorders. Among providers who do have restrictive criteria, only psychosis and paranoid schizophrenia were cited as not accepted. However, some comments gleaned from the focus group interviews contradict this statement. For example, several comments stated, *"Treatment providers cannot treat because of mental health issues. Need additional trauma counseling."*

For those with a mental disorder, there is a range specific for medication stabilization from 20% in Marchman Act Drug Court to 67% within FDTC. There are no requirements that participants in MHPTI must be stabilized on medication in order to enter treatment; however, this

court excludes violent crimes, sex crimes, and antisocial behavior diagnoses.

Table 9. Substance Use and Mental Health Diagnosis/Medication

Characteristics	Avg. Total	ADC (N=5)	JDC (N=2)	FDTC (N=3)	Marchman (N=5)	VTC (N=3)
Substance Use/Mental Health						
Substance use disorder diagnosis*	**91.8%**	95.0%	97.5%	93.3%	91.0%	83.3%
Mental disorder diagnosis*	**65.8%**	61.5%	47.0%	66.7%	64.8%	85.0%
Co-occurring disorder diagnosis*	**62.9%**	61.5%	47.0%	63.3%	63.8%	73.3%
Program requires participant with a mental disorder to be stabilized on medication	**38.9%**	40.0%	50.0%	66.7%	20.0%	33.3%

*There was one treatment provider who did not respond in ADC

Table 10 illustrates priority given to participants who are considered high risk for recidivism. The majority of problem-solving courts do give priority to those participants considered being high risk for recidivism with a range from 40% in Marchman Act Drug Court to 67% for JDC and VTC.

Table 10. Priority Given to Participants Perceived as High Risk for Recidivism

	Avg. Total	ADC (N=5)	JDC (N=2)	FDTC (N=3)	Marchman (N=5)	VTC (N=3)
Yes	**55.6%**	60%	50%	66.7%	40%	66.7%
No	**44.4%**	40%	50%	33.3%	60%	33.3%

***Screening and Assessment Evidence-Based Practices*.** All treatment providers surveyed across all problem-solving courts (including MHPTI) report using screening and assessment instruments that utilize evidence-based criteria. There were a wide variety of evidence-based tools that were cited by the treatment providers in the Qualtrics survey, including but not limited to:

- Addiction Severity Index (ASI)
- American Society of Addiction Medicine (ASAM) criteria
- Beck Depression Inventory (BDI)
- Behavioral Health Index (BHI)

- Columbia Suicide Rating Scale
- Global Appraisal of Individual Needs (GAIN)
- Mental Health Screening
- Patient Health Questionnaire (PHQ)
- Post Traumatic Stress Disorder Check List (PCL-5/ PCL-M)
- Swanson, Nolan and Pelham (SNAP) Questionnaire
- Texas Christian University (TCU) Drug Screen
- University of Rhode Island Change Assessment (URICA) Motivation to Change

In addition to using an evidence-based screening and/or assessment instrument, the intake process conducted by all treatment providers includes information about participants' personal history, including drug use, sexual orientation/gender identity, and personal strengths. Additional information that is collected during the screening and assessment process is described in Table 11.

Table 11. Intake Screening and Assessment

	Avg. Total	ADC (N=5)	JDC (N=2)	FDTC (N=3)	Marchman (N=5)	VTC (N=3)
Does the Intake Screening…						
Identify issues related to family members and/or significant others?*	**96.0%**	100.0%	100%	100%	100%	100%
Include a risk assessment that screens for criminogenic factors?**	**87.5%**	100%	50.0%	100%	80.0%	100%
Utilize agency-developed screening questions?	**66.7%**	60.0%	50.0%	66.7%	60.0%	100%
Does the Assessment…						
Identify issues related to family* members and/or significant others?	**100%**	100.0%	100%	100%	100%	100%
Include a risk assessment that screens for criminogenic factors?	**76.5%**	50.0%	50.0%	100%	80.0%	100%
Utilize agency-developed assessment questions?	**82.3%**	75.0%	100%	66.7%	80.0%	100%

*There was one treatment provider who did not respond in ADC
**There were two treatment providers who did not respond in ADC

Initial Appearance before Judge Occurs Immediately. Although this varies by each of the problem-solving courts, no one reported any issues. The only delay in entry in treatment was DPTI and MHPTI that included the comments:

"There are problems with how long it takes for someone to even get into the DPTI program... During that time they're not in jail, the first 6 weeks usually is the state compiling whether they're going to charge them or not and then the next 3 weeks is defense, we get discovery and meet with client and then at second court date they'll decide if they wish to accept that program or not and then from there it would be DOC getting them information from the court, they accepted, filling out paperwork. And we do have a large majority of the docket for DPTI is private attorney, there was 150 on the docket today and 110 were private attorneys so that left the Public Defender with 40…"

"The waiting period is long before they're accepted because right now it's just Mental Health Pre Trial Intervention so I would say as soon as from the date of arrest that someone's entered is 3 months and that's too long…There's a cap of 40 in EODI and 20 in MHPTI so there's not even enough funding if we want to do it quicker, there might not be enough capacity. There can be a residential component if they meet criteria, but again that's capped at a number of beds that can be used at ACTS Keystone and I believe they limit it to 28 days…"

Key Component 4. Drug Courts Provide Access to Continuum of Alcohol, Drug, and Related Treatment and Rehabilitation Services

Purpose. This component is concerned with frequent, regular communication to provide timely reporting of a participant's progress and to ensure that responses to compliance and noncompliance are swift and coordinated. While primarily concerned with criminal activity and substance use, problem-solving court team also needs to consider co-occurring problems such as mental illness, medical problems, homelessness, educational deficits, unemployment and poor job preparation, spouse and family troubles, and the long-term effects of childhood physical and sexual abuse. If not addressed, these factors will impair an individual's success in treatment and will compromise compliance with program requirements. Performance benchmarks include the following:

- Individuals are initially screened and periodically assessed by both court and treatment personnel to ensure that **treatment services and individuals are suitably matched**.
- **Treatment services are comprehensive** and include but not limited to group counseling, individual and family counseling, relapse prevention, 12-step self-help groups, preventive and primary medical care, medication-assisted treatment, and detoxification.
- **Treatment services are accessible**.
- **Funding for treatment is adequate**, stable, and dedicated to problem-solving court.
- **Treatment Services have quality control** and are accountable.
- Treatment designs and **delivery systems are sensitive** and relevant to issues **of race, culture, religion, gender, age, ethnicity, and sexual orientation**.

Needs Assessment Findings

Treatment Services and Individuals Are Matched. Although most participants can get into problem-solving court fairly quickly, the primary issue arises when a higher level of care is needed (whether initially screened or after being admitted into a program). Currently, both JDC and VTC do not have any participants waiting to obtain residential treatment. Adult Drug Courts had nine participants in Post-Adjudication, seven participants in Expansion, and two participants in DPTI awaiting a residential bed. FDTC currently has ten participants and Marchman Act Drug Court has 56 participants waiting for a residential bed. Although data was not available for adult drug courts, FDTC and Marchman Act data indicate that almost 60% waiting for a residential bed were male. Often these participants are waiting in jail, as they need to be in a locked facility and

jail is the only secure option when no residential beds are available. There have also been issues reported for participants who may require medication to manage mental health conditions, but may have been non-compliant on their medication at the time (within the past 24-48 hours) they are taken into custody. These individuals experience significant mental deterioration when denied access to necessary medications, particularly when in jail. Individuals with mental disorders face additional difficulties managing in confined facilities and symptoms of mental disorders can worsen, especially when they are not properly managed by medications that have been prescribed to the individual before they were taken into custody. Strikingly, even the Mental Health Pre-Trial Intervention Court (MHPTI) reported long waiting times for their participants. Some comments include:

"From the date of arrest to entering treatment is about three months and that's too long. I think it's just a system issue between getting the discovery from the state, seeing if the client qualifies legally, see what their prior records are, then they're referred to the Mental Health Court liaison, they take a few weeks at least to do their evaluations, so it's everyone. And there's a cap, so there's not even enough funding if we want to do it quicker, there might not be enough capacity. And community mental health takes just as long or longer."

"I don't understand why Expansion court is limited to 4 providers: Crossroads, DACCO, ACTS and Phoenix House. We don't use West Care or all the others. I'd say close to 20% are waiting in jail for a bed."

"Waiting times up to 3 months (ADC Expansion), often in jail…need to have a lockdown program."

"They go to the receiving facility, beds are full, send to hospital (ER), hospital releases them… have to start the process over again. Unless medically necessary, they are discharged from the ER. The worse the MH problems, less options."

Treatment Services Are Comprehensive. As illustrated by Table 12, the majority of treatment providers provide multiple levels of care. Of note, detox facilities for adults have historically been difficult to fund. In the follow up surveys conducted with the treatment providers, all indicated that

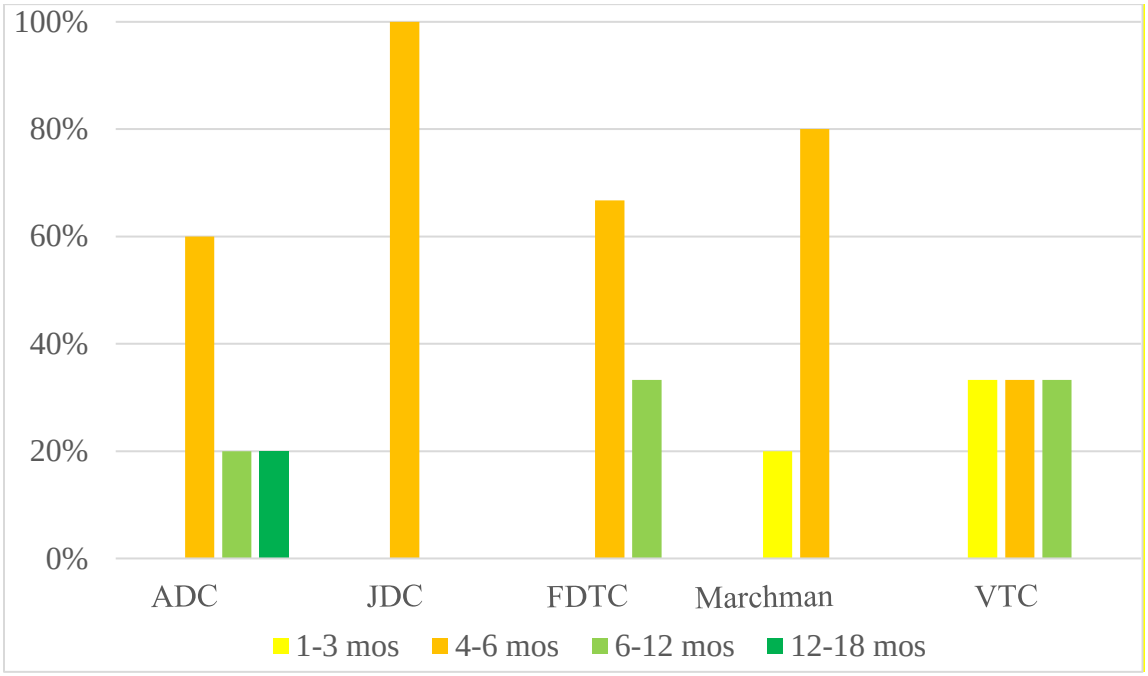
they provide multiple levels of care, even if they do not neatly fall within the categories given. Additionally, case management services are provided by 97% of treatment providers surveyed and treatment plans are tailored to individual needs. The vast majority of treatment providers (94%) focus on outpatient treatment, with residential treatment reserved for those who have experienced multiple relapses or who are at risk for harm to self or harm to others. A recurring theme in the focus groups were, *"We are always in need of residential beds."* Additionally, *"When they go to the receiving facility, beds are full."* It is important to note that three treatment providers provide home-based services for FDTC and VTC (DACCO, Operation Par, and Tampa Crossroads).

Table 12. Treatment Provider Levels of Care

Levels of Care	Avg. Total (% yes)	ADC (N=5)	JDC (N=2)	FDTC (N=3)	Marchman (N=5)	VTC (N=3)
Residential	**88.9%**	100%	0%	100%	100%	100%
Intensive Outpatient	**72.2%**	60%	100%	67.7%	60%	100%
Outpatient	**94.4%**	100%	100%	100%	100%	67.7%
Recovery Support	**72.2%**	80%	50%	67.7%	80%	67.7%
Detox	**38.9%**	60%	0%	67.7%	20%	33.3%

Treatment providers also were asked the average length of treatment for each of the problem-solving courts. As can be seen in Figure 3, treatment duration ranged from 1-3 months (Marchman and VTC) to 12-18 months (ADC) with an average of 4-6 months duration in treatment for all of the problem-solving courts.

Figure 3. Treatment Duration



As can be seen by Table 13, other services provided by treatment providers beyond substance use treatment include mental health services (100%), GED and educational services (86%), vocational/job placement (57%), and housing services (57%). Services coordinated include transportation to and from court and treatment (100%), benefits including insurance, food stamps, and bus passes (100%), vocational classes (86%), coordinating housing opportunities (86%), food banks (57%), and helping to access legal services (43%).

Table 13. Treatment Services Provided/Coordinated for Participants

	% Yes
Services Provided	
Mental Health Services	100%
GED/Educational	85.7%
Vocational/Job placement	57.1%
Housing	57.1%
Services Coordinated	
Transportation	100%
Benefits (i.e., Medicare/Medicaid, insurance, etc.)	100%
Educational/Vocational Classes	85.7%
Housing	85.7%
Food Banks	57.1%
Legal Services	42.9%

Additionally, 57% of treatment providers who responded to the survey indicated they were providing Medication-Assisted Treatment (MAT) services (ACTS, DACCO, Operation PAR, and Phoenix House). Of the treatment providers providing MAT services, only DACCO and Operation PAR (50%) utilize Methadone. All treatment providers providing MAT services utilize Vivitrol, Suboxone, and Buprenorphine. Treatment providers described their process for determining which medication to use for MAT. First, the client must be a good candidate for the medication. For example, Vivitrol is the only effective medication for persons with alcohol problems. Second, results from the screening and lab tests are discussed with each participant and a final determination is made by the physician or psychiatrist on staff.

Characteristics of Treatment. All treatment providers across all the problem-solving courts report that treatment incorporates manualized instruments and modified treatment curricula (see Table 14). All treatment providers also report addressing trauma history and co-occurring disorders for their

participants. Almost 65% of treatment providers reported that participants diagnosed with co-occurring mental and substance use disorders receive the same treatment as participants diagnosed with only a substance use disorder. Some comments include:

"The problem with mental health treatment, depending on what the diagnosis is, they'll give them a psych evaluation, but as far as the follow up mental health treatment. I don't believe some of the providers cover that enough. They focus more on the substance abuse and as long as you're taking your medication you can stay in treatment, but don't discuss the mental health. Providers can't handle people with PTSD, any sort of psychosis. They don't take people if they're on Risperdal"

"So when you have to go into the community to find people treatment it's much more difficult especially meeting their mental health needs, the drug treatment is out there, but the mental health treatment is lacking."

Table 14. Treatment Characteristics

Treatment Characteristics	Avg. Total (% yes)	ADC (N=4)	JDC (N=2)	FDTC (N=3)	Marchman (N=5)	VTC (N=3)
Use manualized instruments for treatment services?	**58.8%**	80%	100%	33.3%	60%	33.3%
Modified treatment curricula?	**76.5%**	80%	50%	100%	60%	100%
Address participant's trauma history and current symptoms of trauma?	**100%**	100%	100%	100%	100%	100%
Are participants treated for co-occurring mental disorders?	**100%**	100%	100%	100%	100%	100%
Do participants with co-occurring disorders receive same treatment as participants diagnosed with only substance use disorder?	**64.7%**	80%	50%	66.7%	80%	33.3%

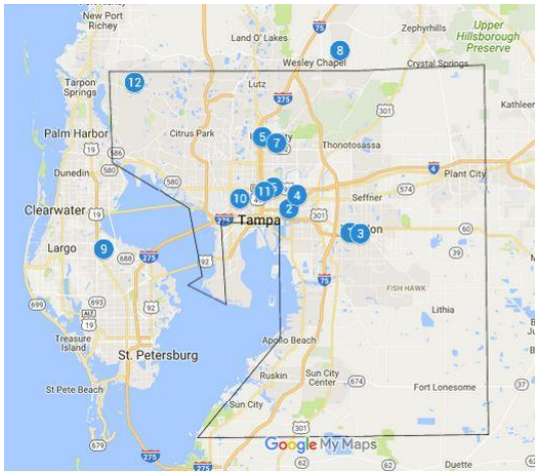
Treatment Evidence-Based Practices. All treatment providers surveyed across all problem-solving courts (including MHPTI) reported using treatment curricula that utilize evidence-based criteria. There were a wide variety of evidence-based treatment curricula cited by the treatment providers in the Qualtrics survey, including but not limited to:

- Accelerated Resolution Therapy (ART)
- Boys/Girls Council
- Cannabis Youth Treatment

- Helping Men/Women Recover
- Living in Balance
- Matrix Model
- Moral Compass
- Motivational Enhancement Therapy (MET)/Motivational Interviewing (MI)
- Pathways
- Prolonged Exposure Therapy
- Seeking Safety
- Teen Intervene
- Texas Christian University (TCU) Relapse Prevention
- Transcranial Magnetic Stimulation

Treatment Service Are Accessible. As can be seen from Figure 4, treatment provider locations are scattered across Hillsborough County. However, there is a dearth of treatment accessibility in the southern and most northern parts of the County. In particular, those treatment providers working within JDC are only located in the Brandon and East Tampa area.

Figure 4. Map of Treatment Provider Locations



Some comments from focus group interviews include:

"Transportation and bus passes are a problem particularly in the East county area, Plant City, or Thonossassa. If you live in Plant City you have a problem with bus transportation regardless of

who you are."

"The lack of transportation in the city and county seriously impacts ability to get to treatment."

When referring to JDC, another individual responded similarly, "*the number one reason that people decline drug court is because of the logistics, these are kids that can't get themselves there, the sessions typically are at 4:00 and the court and treatment providers think it's reasonable to expect a family to get a child 2 or 3 times a week for months on across town."*

Funding for Treatment is Adequate and Dedicated to Problem-Solving Court. Funding was reportedly dependent on multiple factors and difficult to determine based on the series of responses. The data indicates that treatment providers and justice partners capture this information in a different format, though it was clear that grant revenue, the Hillsborough County Health Care Plan and the Florida Department of Corrections provides substantial sources of treatment funding throughout the Problem Solving Courts. A comment included:

"Treatment providers are doing the best with what they have."

"I think money is a challenge, resources."

Treatment Services Have Quality Control/Accountability. All of the treatment providers surveyed reported that their program is 100% CARF certified (i.e., Commission on Accreditation of Rehabilitation Facilities). CARF International is an independent, nonprofit accreditor of health and human services. All providers are also Department of Children and Families (DCF) certified and this licensure process is governed and regulated by Chapter 397, F.S., and Chapter 65D-30, Florida Administrative Code (F.A.C.).

Treatment Service Delivery. Information from the Table 15 illustrates participant demographics over the various problem-solving courts. As can be seen, gender percentages range from 42% male in FDTC to 98% in VTC with an overall average of 70% male and 30% female. In terms of race/ethnicity, the majority of participants are White/Caucasian (ranging from 47% in JDC to 76% in FDTC) followed by Black/African-American (ranging from 14% in FDTC to 26% in JDC). Hispanic

origin had an overall total of 16% with a range from 7% in VTC to 21% in JDC. In terms of age range, only two courts work with participants under the age of 18 (JDC and Marchman). The breakdown of those 12-17 in JDC show the majority 16-17 years (57%) followed by 14-15 years (37%). In terms of adult age ranges, the majority of participants fall under the age range of 25-40 years (43%) followed by 18-25 years (21%).

Table 15. Participant Demographics*

	Avg. Total	ADC (N=5)	JDC (N=2)	FDTC (N=3)	Marchman (N=5)	VTC (N=3)
Gender						
Male	**66.8%**	64.0%	78.0%	42.3%	61.0%	98.3%
Female	**33.1%**	36.0%	22.0%	57.7%	39.0%	1.5%
Transgender	**0.01%**	0%	0%	0%	0%	0.2%
Race/Ethnicity						
White/Caucasian	**67.0%**	73.0%	46.5%	75.5%	66.8%	62.2%
Black/African-American	**19.7%**	13.2%	26.0%	13.9%	20.2%	31.1%
Native Hawaiian/Pacific Islander	**0.2%**	0%	1.5%	0%	0%	0%
Other	**12.3%**	12.8%	26.0%†	10.1%	12.8%	4.7%
Hispanic	**15.9%**	16.4%	21.0%†	18.5%	17.4%	6.7%
Age						
12-13			5.5%			
14-15			36.5%			
16-17			57.0%			
18-25	**23.9%**	29.6%	1.0%	30.0%	32.0%	10.0%
26-40	**47.1%**	56.6%	0%	55.0%	42.0%	63.3%
41-64	**10.6%**	12.6%	0%	13.3%	20.6%	25.0%
65+	**1.2%**	1.2%	0%	1.7%	1.2%	1.7%

*Note. Data compiled by Treatment Provider Qualtrics Survey

† One of the treatment providers includes "Hispanic" in the "Other" classification for Race/Ethnicity.

The Qualtrics surveys distributed to the treatment providers also asked about certain demographic information (Table 16), in order to assess whether the demographics of the individuals working within the treatment providers were representative of the clients they serve. Providers also were surveyed whether Spanish speaking and interpretive service were available at their agency. This varied from not at all to having someone on staff 40 hours per week. It is important to note that a direct comparison cannot be made between Tables 15 and 16. Table 15 represents participants in Problem-Solving Courts only, whereas Table 16 is representative of the treatment staff overall, not just employees who work with Problem-Solving Court participants.

Table 16. Treatment Provider Staff Demographics*

	Total	ACTS	DACCO	Gracepoint	Northside	Operation PAR	Phoenix House	Tampa Crossroads
Gender								
Male	**47.1%**	60.0%	23.0%	50.0%	25.0%	27.0%	50.0%	95.0%
Female	**52.9%**	40.0%	77.0%	50.0%	75.0%	73.0%	50.0%	5.0%
Transgender	**0%**	0%	0%	0%	0%	0%	0%	0%
Race								
White/Caucasian	**50.9%**	45.0%	44.0%	50.0%	54.0%	68.0%	40.0%	55.0%
Black/African-American	**34.6%**	35.0%	36.0%	50.0%	39.0%	32.0%	30.0%	50.0%
Asian	**1.6%**	0%	3.0%	0%	3.0%	0%	0%	5.0%
Other	**13.0%**	20.0%	17.0%	0%	4.0%	0%	30.0%	20.0%

*Note. Demographic data is not available for North Tampa Behavioral Health because they did not complete a general survey,

Table 17 describes the special populations that treatment providers utilized treatment specific to the population. Few treatment providers provide services for gender identity, sexual orientation, or military sexual assault. While 100% of treatment providers report that they use specialized treatment approaches for participants with trauma and/or PTSD, several comments in the focus groups centered around the need to better identify trauma in the screening and assessment process. Some comments include:

"Identifying trauma in a clinical assessment, sexual assault, domestic violence, etc. Without identifying trauma, treatment rarely works. Allow case workers to identify the trauma. Trauma isn't being treated as an acute problem." Another respondent commented, *"They (participants) could have PTSD from other sources, they could have other mental illness and I don't think that's a primary focus… which is going to make them fail because if you're not treating those things, they're going to keep using."*

"There aren't enough services for Bilingual clients, they're very limited as to what they understand and what they can speak."

Table 17. Specialized Treatments

Are Specialized Treatment Approaches Used For…?	Avg. Total (% yes)	ADC (N=4)	JDC (N=2)	FDTC (N=3)	Marchman (N=5)	VTC (N=3)
Participants with co-occurring mental and substance use disorders?	**100%**	100%	100%	100%	100%	100%
Participants with a history of trauma/PTSD?	**100%**	100%	100%	100%	100%	100%
Military (active duty and/or veterans)?	**75.0%**	75.0%	n/a	100%	60.0%	100%
Military – combat?	**53.3%**	50.0%	n/a	33.3%	40.0%	100%
Military – sexual assault?	**46.7%**	25.0%	n/a	66.7%	20.0%	100%
Juvenile/young adults participants?	**82.4%**	75%	100%	100%	100%	33.3%
Gender specific?	**94.1%**	100.0%	100%	100%	80.0%	100%
Gender identity and sexual orientation?	**31.3%**	25.0%	0%	33.3%	40.0%	33.3%

Key Component 5. Abstinence Monitored by Frequent Alcohol and Illicit Drug Testing

Purpose. This component is concerned with frequent court-ordered substance use testing. An accurate testing program is the most objective and efficient way to establish a framework for accountability and to gauge each participant's progress. Further, it is recognized that alcohol use frequently contributes to relapse among individuals whose primary drug of choice is not alcohol. Drug testing is central to monitoring of participant compliance. It gives the participant immediate information about his or her own progress, making the participant active and involved in the treatment process rather than a passive recipient of services. Performance benchmarks include the following:

- **Drug testing procedures are based on established and tested guidelines**. Contracted laboratories analyzing urine or other samples should also be held to established standards.
- Testing may be **administered randomly** or at scheduled intervals, but occurs no less than twice a week during the first several months of an individual's enrollment. Frequency thereafter will vary depending on participant progress.
- Scope of testing is sufficiently broad to detect participant's **primary drug of choice** as well as other potential drugs of abuse, including alcohol.
- Elements contributing to the reliability and validity of a urinalysis testing process include: direct observation, verification temperature, **written procedures** and documented chain of custody for each sample collected, and procedures for verifying drug testing accuracy.
- **Court is immediately notified** when a participant has tested positive, failed to submit to drug testing, submitted the sample of another, or has adulterated a sample.

Needs Assessment Findings

Drug Testing Procedures. As can be seen in Table 17, the majority of treatment providers responded that they have capability to do random alcohol and drug testing including using a breathalyzer) and testing for Spice/K2. Half of providers require random drug testing once a week, the other half require drug testing twice per week The average turnaround time for off-site drug testing is approximately 2 days, with a range of 0-7 days. About two-thirds of providers reported that drug screens are always observed by a staff member, one provider never monitors drug screens, and one provider monitors drug screens when someone of the appropriate gender is available.

A little over half of the providers report they have a written drug testing policy and about a

third offer on-site drug testing. The average cost for a drug test is $30-$35, with a range of $0-$55. Drug testing generally becomes cost-prohibitive to the participant at the cost of $35-$50 per test. Regardless of the participants' ability to pay, they are typically charged for a positive drug test that required confirmation from an outside lab.

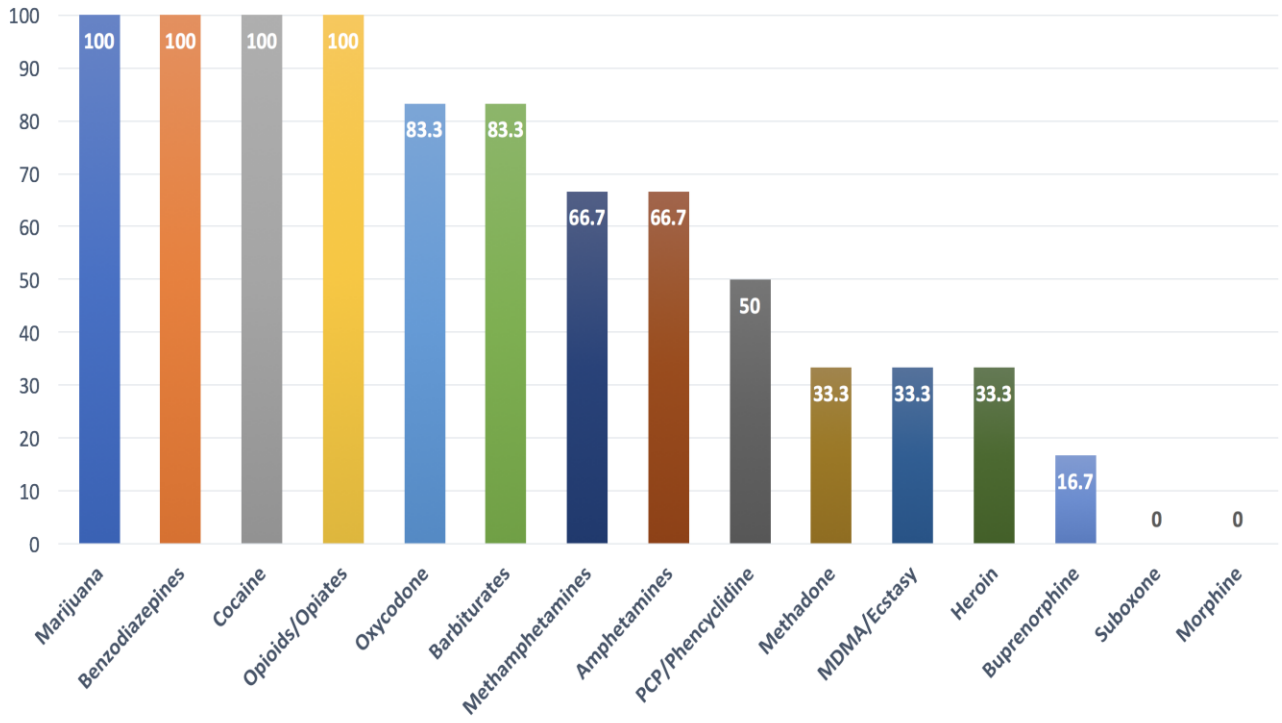
Table 18. Alcohol/Drug Testing Capabilities by Treatment Providers

Treatment Provider Responses	% Yes
Offer alcohol and drug testing	85.7%
Random drug testing*	83.3%
Breathalyzer*	83.3%
Test for Spice/K2*	83.3%
Urinary Analysis**	66.7%
Offer presumptive screening**	66.7%
Written drug testing policy	57.1%
On-site drug testing lab*	33.3%

*There was one treatment provider who did not respond in ADC
**There were two treatment providers who did not respond in ADC

As can be seen in Figure 5, there are a variety of substances included in drug panels conducted by treatment providers. All providers test for marijuana, benzodiazepines, cocaine and opioids/opiates followed by oxycodone, barbiturates, methamphetamine and amphetamines. Less than half reported testing for PCP, methadone, MDMA and heroin with 0% reported testing for Suboxone and morphine.

Figure 5. Substances Included on Drug Panel



Some comments include:

"In the intake we always tell them it's two random screens a week no matter where you are in the program, that is consistency which sets a tone."

"The statute created an alternative sanctions program so the DOC can, if they test positive, they can do something behind the scenes before it even gets to the judge. I think if they're non-compliant he will set the court date out with the hearings. He'll give them an incentive to test clean."

Key Component 6. Coordinated Strategy Governs Drug Court Responses to Participants' Compliance

Purpose. This component is concerned with a coordinated strategy, including a continuum of responses, to continuing drug use and other noncompliant behavior that can provide a common operating plan for treatment providers and other court personnel. The criminal justice system representatives and the treatment providers develop a series of complementary, measured responses that will encourage compliance. Performance benchmarks include the following:

- **Recognize incremental progress toward goal**, such as attending court appearances, arriving at treatment program on time, attending and participating in treatment sessions, cooperating with treatment staff, and submitting to regular drug testing.
- **Reward cooperation as well as respond to noncompliance**: praise from judge for regular attendance or for a period of clean drug tests, encouragement from treatment staff or the judge at particularly difficult times, and ceremonies in which tokens of accomplishment are awarded in open court for completing a particular phase of treatment.
- Appropriate **sanctions should be imposed** for continued substance use; sanctions should increase in severity for continued failure to abstain.

Needs Assessment Findings

Incentives and Sanctions. Problem-solving court programs respond in an expeditious manner to apply both incentives and sanctions. According to focus group interviews with the judges, the court imposes sanctions based upon reports from treatment providers and probation officers. Progressive sanctions are administered for non-compliance, positive drug tests, and unsatisfactory performance in treatment, absconding from treatment, and new arrests.

If participants commit program violations, the judge can impose an appropriate sanction. Repeated violations of program requirements, and a failure to make satisfactory progress in the program may cause the judge to remove the participant from the program and impose a sentence based on the original charge. All final decisions regarding termination from the problem-solving court programs are made by the respective judges who oversee each of the problem-solving courts. Table 18 describes some of the incentives and sanctions used in the problem-solving courts.

Table 19. Use of Incentives and Sanctions

Incentives	• Encouragement and recognition • Furloughs to travel out of county or out of state • Advancement to the next phase of treatment • Early termination of probation • Formal graduation and a certificate of completion • Other incentives the court deems appropriate • Community service hours instead of court costs
Sanctions	• Increased frequency of substance abuse testing • Extended probation • Demotion to an earlier phase of treatment • More extensive treatment regimen • Brief periods of incarceration • Termination from the problem-solving court program • Reinstatement of criminal proceedings

Some comments included:

"I think my judge uses incentives and sanctions very well. If it's a minor infraction like tests positive for alcohol once rather than locking them up in jail, he'll give them 50 extra community service hours and tell them to reevaluate their treatment plan with their provider. If the participant is doing particularly well, he'll waive certain cost or turn cost into a lien so they can graduate or get them called earlier in the docket, he'll space out dockets more frequently."

"The judge does the same, that is a big deal, they don't have a lien, they can work off court costs. Their presence can be waived, if they're in inpatient treatment, they're almost always waived because they're a residential participant, but I've had the judge waive people because they're going to work or want to go out of town, that's another incentive, they'll let them travel too if they're doing well. So we waive them, but normally he does want to see them, but he puts them to front of the docket."

"The judge won't put them in jail as a punishment, it's more for safety until a bed is available. For incentives they can get early term, when they graduate they get a coin and the judge is very good about praising people, he'll approve travel and reduce screens if they're doing well. Court cost for community service hours. Unless the participant is agreeing to the modification of giving them different sanctions and the attorneys fight it then the judge can't do it because you can't modify the terms of their probation unless they're in a violation or they agree to it. When they complete the program in Veterans they get a certificate and a coin and the judge does a little speech and gives them a chance to talk about their success."

Key Component 7. Ongoing Judicial Interaction with Each Drug Court Participant Is Essential

Purpose. This component is concerned with the judge, who is the leader of the problem-solving court team, linking participants to substance use treatment and the criminal justice system. This active, supervising relationship, maintained throughout treatment, increases the likelihood that a participant will remain in treatment and improves the chances for sobriety and law-abiding behavior. Ongoing judicial supervision also communicates to participants that someone in authority cares about them and is closely watching what they do. The structure of problem-solving courts allows for early and frequent judicial intervention. A problem-solving court judge must be prepared to encourage appropriate behavior and to discourage and penalize inappropriate behavior. Performance benchmarks include the following:

- **Regular status hearings** are used to monitor participant performance.
- **Payment of fees, fines and/or restitution is part of participant's treatment**; court supervises payments and takes into account participant's financial ability to fulfill these obligations.

Needs Assessment Findings

Status Hearings. Most participants appear before the judge for judicial review hearings every 30-45 days, and these reviews are currently scheduled accordingly. When a participant appears in court, the judge enters into a dialogue with the participant and acknowledges satisfactory participation or applies any needed progressive sanctions. As noted previously, progress in the program and compliance with court requirements are rewarded with judicial praise, and other incentives. At each court appearance, the judge is given a progress report prepared by the treatment provider or the probation officer regarding drug test results, attendance, and participation. The judge asks questions about the participant's progress, and discusses any specific problems experienced by the participant. In Juvenile Drug Court, the judge describes how she gets *"off the bench, I'm a hugger."* The judge also engages in conversation with the adolescent asking, *"what are your plans 10 years from now?"*

Some additional comments include:

This is the *"first time they've ever been told someone is proud of them."*

Another comment addressed status hearings prior to the judge's entrance to the courtroom: *"That is a clerical operation, procedure that was introduced a number of years ago in order to reduce overcrowding in the courtroom prior to court starting. There's a staffing and then there's a consensus and those are the agreement of people that can be released as compliant and given a new court date. She's sitting up there in the judges' chair in a full open courtroom marking them as completed because they were given a new court date and didn't have to remain for the judge."*

Although status hearings are a necessary component of problem-solving court, just over half of treatment providers have dedicated court liaisons. Of the treatment providers that report having a court liaison (N=4), only one treatment provider attends status hearings regularly (daily); the remaining attend as needed.

Fees and Fines. In reviewing participant agreements, DPTI and VTC, the participants agree to complete all monetary conditions thirty days before graduation. With the court's permission in VTC, certain costs are converted to community service at a rate of $10.00 per hour. One of the comments included:

"She really pushes that so whenever they terminate they don't have a lien, they don't have a bill. She'll give them $15 an hour for community service hours versus 10. So a lot of times our clients are being terminated off of probation with having zero balance."

Key Component 8. Monitoring and Evaluating Achievement of Program Goals Is Necessary to Gauge Effectiveness

Purpose. This component is concerned with coordinated management, monitoring, and evaluation systems. Program goals should be described concretely and in measurable terms to provide accountability to funding agencies and policymakers. It is critical that problem-solving courts be designed with ability to gather and manage information for monitoring daily activities, evaluating the quality of services provided, and producing longitudinal evaluations. Management and monitoring systems provide timely and accurate information about program operations, enabling them to keep the program on course, identify developing problems, and make appropriate procedural changes. Program management provides information needed for day-to-day operations and for planning, monitoring, and evaluation. Program monitoring provides oversight and periodic measurements of the program's performance against its stated goals and objectives. Performance benchmarks include the following:

- Data needed for **program monitoring and management** can be obtained from records maintained for day-to-day program operations.
- Monitoring and management data are assembled in useful formats for regular review and is gathered through an **automated system** that can provide timely and useful reports.
- Automated and **manual information systems must adhere to written guidelines** that protect against unauthorized disclosure of sensitive personal information about individuals.
- **Independent evaluator** should conduct evaluation design and for preparing final reports. About six months after exiting a drug court program, comparison groups should be examined to determine long-term effects of the program.

Needs Assessment Findings

Program Monitoring. All treatment providers indicated on the Qualtrics survey that they measure participant satisfaction regarding their services (e.g., education, vocational, mental health, housing, or other available services). We did not request the results of any such surveys; therefore, we do not have data from program participants themselves.

The vast majority of treatment providers across all Problem-Solving Courts (including MHPTI) report monitoring fidelity to evidence-based treatments on a regular basis (83.3%). One treatment agency (ACTS) reported that they do not monitor fidelity to treatment in Marchman Act Drug Court or in Adult Drug Court; however, ACTS does monitor fidelity for MHPTI participants. Only one other treatment agency reported that they do not monitor fidelity to evidence-based treatments on a regular

basis. For the treatment providers that do monitor fidelity, their responses were fairly consistent in the methods used to monitor fidelity. Quality assurance standards, direct observation, documentation monitoring, training, and evaluations were the most commonly mentioned methods of monitoring fidelity among treatment providers in all problem-solving courts.

Automated System. As stated previously, only Adult Drug Court Expansion and VTC maintain detailed information through automation (i.e., Florida Drug Court Case Management System [FDCCSM]). Currently, each program now maintains data on their census, including active participants, those admitted, and those who have graduated from the program. All treatment providers report using electronic records at least partially. Forty-three percent of treatment providers report using only electronic records management, and 57% of treatment providers are using a combination of electronic and paper records. Electronic records are kept securely on an encrypted database and paper records are kept securely with limited personnel access.

Manual Information Systems Must Adhere to Written Guidelines. The treatment protocol addresses participant confidentiality, which requires protected encrypted data files sent electronically to those authorized to access information. However, there did not appear to be any written court policy regarding this performance benchmark. One comment included:

"Respect for confidential information, put limits on it and how far we should go is a good conversation to have in every one of the courts. We do not know where they're being kept, the records is there a copy floating around, are the files secure, are they destroyed, that's important to clients. And standardizing the whole compliance process for all courts is a good thing because we shouldn't have different standards everywhere."

Process and Participant Outcome Evaluation. The only reports over the last ten years focusing on both process and participant outcomes have been grant-funded. Four SAMHSA grants have been completed, with final reports highlighting major outcomes of the programs. Some comments include:

"I think a follow up would useful for the purpose of figuring out what components were valuable and what components led to a lack of recidivism because part of the issue is that it's a one size fits all, everybody is getting the same treatment, the same thing and some of them may not need it. I think it would be helpful. I think if we had feedback from people who did the whole thing, were successful and they can say this what really helped me and this didn't, then they can tailor the treatment."

"Yes, I didn't expect it to for some reason but I've seen where the children, when they come back for graduation, that there has been a change from when they started, they were failing grades, weren't coming home on time to graduation day when they come back they always have positive things to say and their parents are present and always have positive things to say. So I would say it seems successful."

Key Component 9. Continuing Interdisciplinary Education Promotes Effective Drug Court Planning, Implementation, and Operations

Purpose. This component is concerned with education and training; this ensures that goals and objectives, as well as policies and procedures, are understood by problem-solving court team members. Education and training programs also help maintain a high level of professionalism, provide a forum for solidifying relationships among criminal justice and substance use treatment personnel, and promote a spirit of commitment and collaboration. All need to understand and comply with drug testing standards and procedures. For justice system or other officials not directly involved in the program's operations, education provides an overview of the mission, goals, and operating procedures of the drug court. Performance benchmarks include the following:

- **Key personnel attain a basic education level**, as defined in staff training requirements and in the written operating procedures.
- **Attendance at education and training sessions** by all problem-solving court personnel is essential. Regional and national drug court training provide information on innovative developments.

Needs Assessment Findings

Education and Training Courses for Court and Treatment Staff. The 13th Judicial Circuit has had a presence at the National Association of Drug Court Professionals (NADCP) Conference during the last decade through the aid of grant revenue from Substance Abuse Mental Health Services Administration (SAMHSA) and state funds enabled a team from Adult Expansion Drug Court to attend NADCP last year. This year there were teams from both Marchman and VTC represented and next year, FDTC will also be represented. Additionally, the Office of the State Court Administrator sends a team to an annual Florida Behavioral Health Conference in Orlando. This year's 2017 conference included a team of three court staff and representatives from the State Attorney's Office and Public Defender's Office.

There is regular training and conference attendance for problem-solving court staff including judges, public defenders, state attorneys, treatment providers, and drug court specialists. One hundred percent of the treatment providers who responded to the Qualtrics survey reported that their agency provides the following types of trainings: 1) in-person trainings, 2) online webinars, 3) agency policies and procedures, and 4) Trauma/Trauma-Informed Care. Approximately 86% of treatment providers

reported providing trainings for continuing education credits (only Tampa Crossroads reported not providing this kind of training). Only Gracepoint (14%) reported that staff members receive trainings just once per year; however, 86% of treatment providers report that staff members receive trainings four times per year or more. All treatment providers also report that staff members have been cross-trained for both mental health and substance abuse services. Additionally, all treatment providers in all problem-solving courts report that individuals who conduct screenings and assessments receive training at least annually. Finally, 100% of treatment providers in all problem-solving courts report that persons who are involved in direct care services receive training in evidence-based curricula at least annually.

All the treatment providers who responded to the Qualtrics survey reported that they offer staff training on cultural competency. Fifty-seven percent of treatment providers (ACTS, DACCO, Operation PAR, and Tampa Crossroads) provide both general cultural competency training as well as training specific to the populations they serve. Twenty-nine percent of treatment providers (Northside and Gracepoint) provide only general cultural competency training; Northside uses JACHO guidelines and standards for cultural competency. Phoenix House (14%) reported only providing cultural competency training that is specific to the target populations served.

Some comments include:

"There needs to be an education about treatment court and how it should work along with mental health and the fact that we do and should have access to other facilities."

"We used to all work as a team way back when, the state, the PD, the court evaluators and the judge, we all traveled to the different facilities so we all had a good understanding. Judge pretrial intervention is a gift from the state legislature and should be looked on as a gift."

Key Component 10. Forging Partnerships among Drug Courts, Public Agencies, and Community-Based Organizations Generates Local Support and Enhances Drug Court Program Effectiveness

Purpose. This component is concerned with developing coalitions among community-based organizations, public criminal justice agencies, and substance use treatment systems. Forming such coalitions expands the continuum of services available to participants. The problem-solving court is a partnership among organizations—public, private, and community-based—dedicated to a coordinated and cooperative approach. The problem-solving court fosters a system-wide involvement through its commitment to share responsibility and participation of program partners. Performance benchmarks include the following:

- **Linkages are formed between community groups and criminal justice system**; linkages are a conduit of information to the public about problem-solving court and available community services and local problems.
- Participation of public and private agencies, as well as community-based organizations, is formalized through a **steering committee**.

Needs Assessment Findings

Linkages Formed between Community Groups. Of particular note from the focus group conducted with the judges, one participant discussed an obstacle for colleagues on the bench is procuring funding or sponsorships for court funding because judicial canons prohibit judges from participating in the solicitation of funds or other fund-raising activities. Problem-solving courts in other jurisdictions have instituted incentives such as a "fishbowl" filled with prizes such as a $5 gift card for coffee or sandwiches. These prizes are often derived from the corporate sponsorships from community businesses; however, these partnerships must be forged by a 3rd party or the corporate sponsor approaching the court. The court cannot solicit such partnerships.

However, VTC has wonderful assets with their volunteer mentoring component. This court has now recruited approximately 40 volunteer mentors and each one is paired with a veteran participant in the court. Some comments include:

"The judges' hands are tied with soliciting community involvement."

"Mentoring is a great asset."

"I think we have a leg up on all the other problem-solving courts because it's heavily supported by the community, everyone wants to support Veterans, there's a lot of different Veteran organizations in

the community that are willing to help with furniture, housing, toys for their kids, jobs. They have extra resources allocated to them, that's a strength. The support that we get from the VA and vast array of medical care and mental health care that they can get as opposed to the other problem-solving courts gives them a leg up."

Steering Committee. Each of the divisions of court with grant awards have a Steering Committee and meet on a monthly basis to ensure compliance and program milestones. Additionally, progress reports are submitted to the funders bi-annually and to other stakeholders, upon request.

Integrative Findings and Recommendations

The 13th Judicial Circuit Problem-Solving Court programs have been providing alternatives to incarceration to substance-involved individuals over the past 25 years since 1992. They have been on target with national best practices, establishing six problem-solving courts with the most recent being the Mental Health Court which officially began in February, 2017. Currently, the budget for FY 2018 is $3,050,354 divided into three categories: local funding ($947,597), state ($1,028,718), and federal grants ($1,074, 039). Positions in both Post Adjudicatory Drug Court and FDTC were initially grant funded but through demonstrated success, Hillsborough County sustained the Drug Court Specialists. Currently, 11 positions serve these courts with 73% funded by Hillsborough County, while the State of Florida provides funding for the remainder. Collaboration has resulted in consistent grant funding throughout the history of the programs.

Although there have been a number of key changes over time that have influenced the problem-solving court programs, each program appears to be invested in making positive enhancements to improve the process. During the course of the needs assessment, there have been a number of programmatic strengths noted, as well as some challenges identified as problematic and worthy of examination. The following section will summarize key areas for recommended enhancements as well as noteworthy strengths of the problem-solving court program.

General Problem-Solving Court Recommendations

Strengths and/or Challenges	Recommendations and/or Opportunities	Stakeholders Responsible for Recommendation
Key Component One		
Policy Manual: There is no overall manual delineating policies and procedures for the problem-solving courts. VTC is the only problem-solving court that has a policy manual (but is out of date and needs to be updated).	Development of written policy and procedures governing operation of the problem-solving courts would significantly improve quality and consistency of services. This manual will serve as the foundation for specific programmatic manuals where required. Annual review of the policy manuals would be beneficial as policies and procedures may change over time.	**Oversight Committee** will establish a subcommittee to develop policy recommendations. These will then be discussed in Oversight Committee in order to develop and implement policy manual.
Participant Fliers: Several of the problem-solving courts have participant fliers (particularly those with grants) but these need to be updated.	Development and update of participant fliers (as opposed to a handbook) for each of the problem-solving courts. Annual review of these participant fliers would be beneficial as eligibility criteria, treatment protocol, and requirements may change over time.	**Public Defender's Office** and **State Attorney's Office** will create language from participant agreement related to eligibility. **Administrative Office of the Court** will develop or update participant flyers for each problem-solving court for distribution.
Court Staffings: Both formal and informal methods of communication are used including e-mail, phone calls, and face-to-face communication. Some of the courts do utilize more formal court staffings, typically before each docket.	Research has demonstrated better outcomes when a more formalized staffing process is included to discuss treatment options and compliance issues. Open and frank dialogue between all team members prior to court review hearings is a key drug court component and each court should review current court staffing process. Knowing that time constraints may impede regular court staffings, focus should be on more complicated cases such as relapse and noncompliance.	**Problem-Solving Court Judges** will initiate discussions with their team about best options for court staffings. **Drug Court Specialists** should coordinate staffing agenda with the attorneys and treatment providers.

Strengths and/or Challenges	Recommendations and/or Opportunities	Stakeholders Responsible for Recommendation
Oversight Committee: Oversight Committees exist by virtue of Administrative Orders S-2017-037 and S-2016-032, affecting DPTI, Post Adjudication and VTC. These committees are comprised of various stakeholders in the judicial system; however, VTC is the only one that has met with regularity in the last year. In addition, there are other Steering Committees related to grant management from Marchman and VTC, which include representatives involved in the administration of the grants.	With the evolution of Problem Solving Courts, it may be more efficient and beneficial to establish one overall Oversight Committee. Consider composition beyond Public Defender, State Attorney, and treatment provider, to include jail, evaluation, probation, and community representatives. The primary committee could meet on a quarterly or semiannual basis to review how each program is performing and to address any needed changes to its policies and procedures. Steering Committees for each of the divisions could then meet to address specific needs, as necessary.	**Chief Judge** will be responsible for designating committee members.
Key Component Two		
Case Processing: Defense Counsel that work in our problem-solving courts must often provide information not only about the benefits of drug court but also about the potential costs of participating in drug court.	The implementation of the problem-solving court policy manual may help outline benefits for participants' attorneys contemplating involvement in a problem-solving court. This will help when discussing options with participant in order to ensure they have a genuine choice.	**Defense Attorneys (both Private Attorneys** and **Public Defender's Office** will be responsible for understanding the drug court standards in order to best counsel their client.
Eligibility Criteria for Juvenile Drug Court (JDC): According to the court census, JDC has decreased their docket from 288 participants in 2011 to 9 participants in 2016. Rationale for why the JDC participant decrease may be less juvenile arrests overall and the delinquent act citation program (marijuana possession). Treatment accessibility issues also exist as the two providers are located in the East Tampa and Brandon area.	Opportunities may exist for expanding eligibility criteria for this court including those cases that are post-adjudicatory, multiple offender levels, etc. In terms of treatment accessibility, options may include satellite offices in other locations or mobile treatment van.	**Administrative Office of the Court**, **Chief Judge**, **Public Defender's Office**, and **State Attorney's Office** will be responsible for meeting to discuss JDC criteria options. **Treatment Providers** involved in JDC will meet to discuss alternate options for treatment sessions.

Strengths and/or Challenges	Recommendations and/or Opportunities	Stakeholders Responsible for Recommendation
Key Component Three		
Screening and Assessment Process: This process is not standardized across all problem-solving courts and may not provide sufficient clinical information to support a comprehensive assessment.	Identify best practices and clinical standards for treatment providers. It is recommended that all treatment providers utilize ASAM criteria for screening and assessment. Utilization of additional screening and assessment tools should be reviewed on an annual basis. These should all be approved by AOC and endorsed by National Registry of Evidence-Based Program Practices (NREPP) or other National Panels.	**Treatment Providers** will be responsible for identifying best practices for screening and assessment tools.
Screening and Assessment Process for Co-Occurring Disorders: This process is not standardized across all problem-solving courts and does not provide sufficient clinical information to support a comprehensive assessment.	Utilization of additional co-occurring screening and assessment tools should be reviewed on an annual basis. These should all be approved by AOC and be endorsed by National Registry of Evidence-Based Program Practices (NREPP). Or other National Panels	**Treatment Providers** will be responsible for identifying best practices for co-occurring screening and assessment tools.
Residential Wait-List: Most of the problem-solving courts have a wait list for treatment residential beds. Participants often sit in jail waiting for a treatment bed due to relapse. Due to potential use in community, a locked facility while waiting for a bed is needed in order to protect their safety.	Identify opportunities to increase secure beds in detox facilities rather than jail. All stakeholders agree waiting for a residential bed in jail is less ideal than in a detox facility where they can receive recommended treatment. There also needs to be transparency regarding the waitlist: clear guidelines and clarification regarding priority and exclusionary criteria filling beds by Treatment Providers.	**Oversight Committee** will establish a subcommittee to discuss best practice options for this population. **Problem-Solving Court Director** and **Drug Court Specialists** will maintain a wait list for each division and submit to Oversight Committee.

Strengths and/or Challenges	Recommendations and/or Opportunities	Stakeholders Responsible for Recommendation
Key Component Four		
EBP Treatment Services: Review of treatment protocols and services indicate that there does not appear to be an overall set of treatment principles or philosophy that is used to guide the implementation of evidence-based treatment services across providers.	Quality and consistency of clinical services may be enhanced by developing best practices and clinical standards for treatment providers. Inclusion of specific language associated with future funding for court services would be helpful. Effectiveness and utility of EBPs for treatment protocols should be reviewed on an annual basis. Treatment fidelity practices and use of instrument tools should also be conducted on an annual basis.	**Treatment Providers** will be responsible for identifying national evidence-based treatment practices.
EBP Treatment Services for Co-Occurring Disorders: Review of treatment protocols and services indicate that there does not appear to be an overall set of treatment principles or philosophy that is used to guide the implementation of clinical services specific for co-occurring disorders and trauma-informed care.	Quality and consistency of clinical services specific for co-occurring disorders and trauma-informed care may be enhanced by developing best practices and clinical standards for treatment providers. Inclusion of specific language associated with future funding for court services would be helpful. Effectiveness and utility of EBPs for co-occurring disorders and trauma-informed care treatment protocols should be reviewed on an annual basis. Treatment fidelity practices and use of instrument tools should also be conducted on an annual basis.	**Treatment Providers** will be responsible for identifying national evidence-based treatment practices for co-occurring disorders and trauma-informed care.
Treatment Accessibility: There are areas within Hillsborough County that do not have treatment providers nearby such as South County and areas within northern Hillsborough County.	Without expanded or new treatment providers, opportunities may exist to expand the catchment area by utilizing a mobile treatment van. There may be opportunities to obtain additional grant funds specific for treatment accessibility issues but will require additional discussion as priority of needs.	**Oversight Committee** will confirm the need for treatment accessibility and transportation issues.

Strengths and/or Challenges	Recommendations and/or Opportunities	Stakeholders Responsible for Recommendation
Treatment Service Delivery: Although it appears that there is staff diversity across the treatment providers that responded to the Qualtrics Survey, some participant demographic information is not captured that is important when responding to funding announcements such as religiosity, cultural issues, sexual identity, and sexual orientation.	Within existing resources, there should be a way to include specific demographic information that is relevant for future funding opportunities. These include religion, cultural diversity, sexual orientation, youth homelessness, LGBTQ, and socioeconomic information. Without capturing this information, it is difficult to provide data on access and service use.	**Administrative Office of the Court** will explore different options for including more demographic information. **Treatment Providers** will expand participant database to include this demographic information.
Key Component Five		
Drug and Alcohol Testing: Majority of treatment providers responded that they have capability to do random alcohol and drug testing and presumptive screening. However, almost half do not have a written drug testing policy and only a third offer on-site drug testing.	Every treatment provider who works with any problem-solving court must adhere to drug testing policies and procedures. These policies and procedures should reflect established and tested guidelines indicated by NADCP. These should be administered randomly, test sufficiently to determine participant's primary drug of choice, and include process of notification to the court.	**Treatment Providers** will submit written drug testing policy to the AOC annually.
Key Component Six		
Incentives and Sanctions: Problem Solving Courts are stretched for tangible resources and have difficulty offering rewards of more than minor value but the concept of incentives and sanctions are inherent in the phases of treatment as more privileges are earned or lost based on the level of care.	As participants advance in treatment phases, they receive incentives. These are recognized at treatment and during case reviews but could be reinforced during court hearings on the record. One opportunity is to use the "fishbowl" where participants are allowed to earn chances to draw paper from a fishbowl; these can be some tangible and non-tangible incentives, such as certificates of accomplishments. Incentives and sanctions should be communicated in the participant flier.	**Treatment Providers** will be responsible for including any incentives in the court reports and the judges can reinforce on the record. **Oversight Committee** will be responsible for coordinating fishbowl incentives.

Strengths and/or Challenges	Recommendations and/or Opportunities	Stakeholders Responsible for Recommendation
Key Component Seven		
Specialized Dockets/Track: Several of the specific problem-solving courts have very large dockets (i.e., DPTI, Expansion, and Marchman) which often make it difficult to conduct regular staffings and court hearings. For example, the 2016 DPTI census had 410 participants throughout the year and the first half of 2017 was 454 participants; over twice the docket of any other court.	One recommendation for these larger court dockets would be to have specialized dockets/tracks. Prior research and future funding suggests that the following groups could be considered for specialized tracks: opioid users, young adult offenders, and women. This would also enable keeping caseloads at a manageable size with those courts having over 400 participants. This would also assist treatment providers in identifying protocols for EBP tracks. A longer term goal may involve the use of technology for compliance dockets, allowing participants virtual presence from treatment providers.	**Oversight Committee** will be responsible for reviewing the different problem-solving court census and demographics to determine which would benefit from specialized dockets/tracks.
Key Component Eight		
Management information system (MIS): There are only two problem-solving courts (VTC and Expansion) that consistently uses an automated data system.	Ability to make accurate management decisions related to funding, resource management, and program outcomes would be enhanced by an effective MIS system. VTC is using DCCM; Drug Court Specialists enter information from treatment providers and Dept. of Corrections also inputs information for court hearings. The Problem Solving Courts Director is currently working to get SAO and PD access to the system. While systematic usage of DCCM in VTC is still early, it has same application for Expansion and DPTI. All parties working together will better capture information related to recidivism. Data entry into other MIS for Marchman and FDTC should be a priority. This may be labor intensive so hiring student interns for data entry would be beneficial.	**Problem-Solving Court Director** to coordinate access for DCCM to team members in Expansion and DPTI. Include census reports for each problem-solving court to Oversight Committee as a standing agenda item.

Strengths and/or Challenges	Recommendations and/or Opportunities	Stakeholders Responsible for Recommendation
Key Component Nine		
Training: Grant funding has allowed travel for team members to attend NADCP and Vet Com over the past 10 years. However, not all problem-solving staff are able to attend these national trainings / conferences. There does not appear to be systematic local and statewide trainings on a regular basis and not everyone gets to attend these trainings. Also, additional training will help address the friction between attorneys and court surrounding mission and goals of problem-solving courts vs. traditional court.	While all team members could benefit from training related to EBP, including treatment providers, it is important to note that would also be helpful to address training in other key components, such as Using the Non-Adversarial Approach, Prosecution and Defense Counsel while Protecting Participant's Due Process Rights. Returning to some of these key components will assist to strengthen the problem-solving court team and to improve decision-making related to clinical interventions. It is recommended that a quarterly training would occur throughout the year.	**Oversight Committee** will establish a subcommittee to develop training priorities. This would be a recommended standing agenda item for the Oversight Committee.
Key Component Ten		
Community Linkages: Problem-solving courts used to have a more prominent presence at various local community agency meetings. Although some problem-court staff attend some community meetings, it is not on a regular basis.	Identify various community organizations to attend on a monthly basis including the Hillsborough County Anti-Drug Alliance (HCADA) and the Tampa Alcohol Coalition (TAC).	**Oversight Committee** to recommend attendance at various community organizational meetings.

Summary and Conclusion

The current needs assessment examined the implementation and practices of the 13th Judicial Circuit Problem-Solving Court Programs is similar to others developed across the country that provide court-ordered involvement in substance abuse treatment and a range of related services to primarily non-violent felony offenders. These programs offer a range from three to 18-month involvement in treatment services, in addition to court and community supervision, with gradually less intensive services provided over time. The current needs assessment was conducted through a variety of methods, including surveys, focus group interviews, and review of program records and other descriptive materials.

This needs assessment represents a first step in examining the effectiveness of the 13th Judicial Circuit Problem-Solving Court. Findings from this needs assessment are overall favorable and offer promise that the problem-solving court programs will have long-term effects in reducing criminal recidivism and substance use among program participants. Each of the problem-solving court programs are likely to maximize the impact on participant outcomes and cost savings by increasing rates of retention and graduation, and several steps and interventions are recommended in this report to address these important issues. Given the scope of this needs assessment, it would be useful to also examine the problem-solving court programs during an extended follow-up period and to identify major outcomes among program participants, including criminal justice involvement (e.g., arrest, incarceration), program retention and graduation, substance use, mental health and trauma symptomatology, and employment over at least a one-year follow-up period.

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Appendix A1: Treatment Provider Qualtrics Survey General Questions

1. Which agency do you work for?
    a. ACTS (1)
    b. DACCO (2)
    c. BayCare Behavioral Health (3)
    d. Tampa Crossroads (4)
    e. Avon Park (5)
    f. Operation PAR (6)
    g. Phoenix House (7)
    h. Board Prep (8)
    i. Salvation Army (9)
    j. North Tampa Behavioral Health (10)
    k. VA (11)
    l. Other (Please specify) (12) _____

2. Please list the zip code of the primary location for your agency.

3. Please list any additional zip codes of locations where services are provided.

4. What is your maximum capacity for PROBLEM-SOLVING COURT PERSONS ONLY across all locations for the following: (If N/A please type 0)
    a. _____ Detox (1)
    b. _____ Residential (4)
    c. _____ Intensive Outpatient (3)
    d. _____ Outpatient (2)
    e. _____ Aftercare/Recovery Support (5)

5. For the most recent fiscal year, please specify the following number of persons for PROBLEM-SOLVING COURT ONLY:
    a. _____ Screened (1)
    b. _____ Deemed eligible and admitted (2)
    c. _____ Deemed eligable but not admitted (3)
    d. _____ Received services (4)
    e. _____ Successfully discharged (5)
    f. _____ Unsuccessfully discharged (6)
    g. _____ Medical discharge (7)
    h. _____ Neutral discharge (8)
    i. _____ Maximum benefit (9)

6. Does your program have a written drug testing policy?
    a. Yes (1)
    b. No (2)

7. Please provide the written drug testing policy.

8. Does your program offer drug and alcohol testing?
    a. Yes (1)
    b. No (2)

9. Do you have an on-site lab?
    a. Yes (1)
    b. No (2)

10. Does your program offer presumptive screening?
    a. Yes (1)
    b. No (2)

11. What is the average turn-around time for off-site drug and alcohol testing?

12. If confirmation from an outside lab is required, is the client charged?
    a. Yes (1)
    b. No (2)
    c. N/A (3)

13. Regardless of ability to pay, when is the client charged for drug test results that have to be confirmed by an outside lab?
    a. When results are positive (1)
    b. When results are negative (2)
    c. Charged no matter the results (3)
    d. Not charged no matter the results (4)

14. Please specify the cost of a typical drug screening panel for the client. (Please specify a single number, not a range. If your agency does not utilize the test, please put a zero.)
    a. _____ Average cost basic panel (1)
    b. _____ Basic panel with spice (2)
    c. _____ Basic panel with alcohol (3)
    d. _____ Other (please specify) (4)

15. Approximately at what cost does drug testing become cost-prohibitive to the client? (Please specify a single number, not a range. Please use your best judgment to estimate this amount.)

16. Are the screenings observed by a staff member?
    a. Yes (1)
    b. No (2)
    c. Typically yes, but limited to when a gender-appropriate person is available (3)

17. What is the typical frequency of drug and alcohol testing per week?
    a. 1 (1)
    b. 2 (2)
    c. 3 (3)
    d. 4+ (4)

18. Are the drug tests random?
    a. Yes (1)
    b. No (2)

19. What tools are used to test for alcohol? (Select all that apply)
    a. Urinary Analysis (1)
    b. Breathalyzer (2)
    c. N/A (no alcohol testing) (3)

20. Does your program have the ability to test for Spice/K2?
    a. Yes (1)
    b. No (2)

21. Which drugs are included in your typical drug panel? (Select all that apply.)
    a. Marijuana (1)
    b. Cocaine (3)
    c. Opioids/Opiates (5)
    d. Oxycodone (OxyContin/Vicodin) (14)
    e. Morphine (16)
    f. Heroin (2)
    g. Methadone (4)
    h. Suboxone (7)
    i. Buprenorphine (12)
    j. Barbiturates (13)
    k. Benzodiazepines (6)
    l. Methamphetamines (8)
    m. Amphetamines (9)
    n. PCP/Phencyclidine (10)
    o. MDMA/Ecstasy (15)
    p. Other (Please specify) (11) _____

22. Does your program have a written policy for initiating Baker Acts and/or Marchman Acts by staff?
    a. Yes (1)
    b. No (2)

23. What is/are the program policies regarding Baker Acts and/or Marchman Acts?

24. Approximately how many Baker Act cases does your program initiate annually?

25. Approximately how many Marchman Act cases do you initiate annually?

26. Approximately how many clients are sent to jail from the treatment program annually for unrelated (to the problem-solving court) charges?

27. What is the approximate average length of incarceration for these clients?
    a. Fewer than 6 months (1)
    b. 6-12 months (2)
    c. 1-2 years (3)
    d. 2+ years (4)
    e. Unknown (5)

28. Does your program offer Medication Assisted Treatment (MAT)?
    a. Yes (1)
    b. No (2)

29. What medication is utilized for MAT? (Select all that apply.)
    a. Methadone (1)
    b. Vivitrol (2)
    c. Suboxone (3)
    d. Buprenorphine (4)

30. Which of the following services does your agency offer? (Select all that apply.)
    a. GED/Educational (1)
    b. Vocational/Job Placement (2)
    c. Mental Health Services (3)
    d. Housing (5)
    e. Other (4) _____
    f. N/A (7)

31. Does your program measure client satisfaction with the aforementioned services (i.e., education, vocational, mental health, housing, or other services)?
    a. Yes (1)
    b. No (2)

32. How does your agency connect with other services? (Select all that apply.)
    a. Psych Referrals (1)
    b. Interagency Referrals (2)
    c. Other (3) _____
    d. N/A (4)

33. Which type of referrals are utilized? (Select all that apply.)
    a. Paper (1)
    b. Electronic (2)
    c. Phone (3)
    d. In-person (4)
    e. Other (5) _____
    f. N/A (6)

34. Are appointments scheduled for/on behalf of clients?
    a. Yes (1)
    b. No (2)

35. Which of the following does your program coordinate access for clients? (Select all that apply)
    a. Housing (1)
    b. Transportation (2)
    c. Food Banks (3)
    d. Educational/Vocational Classes (4)
    e. Legal services (6)
    f. Benefits (i.e., Medicare/Medicaid, identification, health insurance) (9)
    g. Other (Please specify) (8) _____
    h. N/A (11)

36. Please briefly explain how these services are coordinated for clients.

37. If a client absconds or goes MIA, what is the protocol? Please provide the written procedure.

38. How does your agency define co-occurring/comorbid conditions?

39. Does your agency maintain client information?
    a. Yes (1)
    b. No (2)

40. Is client information maintained on an electronic database?
    a. Yes (1)
    b. No (2)

41. Is this electronic database encrypted?
    a. Yes (1)
    b. No (2)

42. Is client information maintained in a locked filing cabinet?
    a. Yes (1)
    b. No (2)

43. Is this filing cabinet kept inside a locked room with limited accessibility?
    a. Yes (1)
    b. No (2)

44. Does your organization utilize electronic records management?
    a. Yes, all electronic (1)
    b. No, all paper (2)
    c. Somewhat, paper and electronic records are used (3)

45. How many employees do you have that actively work with your problem-solving court clients (across all locations)?
    a. 0-10 (1)
    b. 11-20 (2)
    c. 21-30 (3)
    d. 31-50 (4)
    e. 50+ (5)

46. What is your average client to clinical staff ratio? (X:1; X = number of clients)
    a. _____ Problem-Solving Court clients per staff member (1)

47. What percent of staff are: (Total sum must equal 100)
    a. _____ Male (1)
    b. _____ Female (2)
    c. _____ Transgender (3)

48. What percent of staff are: (Total sum must equal 100):
    a. _____ White (1)
    b. _____ Black or African American (2)
    c. _____ American Indian or Alaska Native (3)
    d. _____ Asian (4)
    e. _____ Native Hawaiian or Pacific Islander (5)
    f. _____ Other (6)

49. Does your program offer staff training on cultural competency?
    a. Yes (1)
    b. No (2)

50. Is the cultural competency training specific to the populations served or general? Please specify.

51. What type of staff training(s) does your program provide, which align the needs of the programs target populations? (Please select all that apply.)
    a. In-person Trainings (1)
    b. Trauma-Informed Care (2)
    c. Online Webinars (3)
    d. Continuing Education (4)
    e. Agency Policies and Procedures (5)
    f. Other (Please specify) (6) _____

52. On average, how many times per year do staff members receive training relevant to their position?
    a. 1 (1)
    b. 2 (2)
    c. 3 (3)
    d. 4+ (4)

53. Are staff members cross-trained for mental health and substance abuse services?
    a. Yes (1)
    b. No (2)

54. Does your organization have a dedicated court liaison?
    a. Yes (1)
    b. No (2)

55. Does the court liaison attend court hearings?
    a. Yes (1)
    b. No (2)
56. How often does your dedicated court liaison attend court hearings?
    a. Daily (1)
    b. Weekly (2)
    c. As needed (3)

57. Any additional comments?

Appendix A2: Treatment Provider Qualtrics Survey Court Specific Questions

1. Is your program CARF certified?
    a. Yes (1)
    b. No (2)

2. Is your program JACHO certified?
    a. Yes (1)
    b. No (2)

3. Is your program DCF licensed?
    a. Yes (1)
    b. No (2)

4. What is the current census of enrolled clients in all Adult Drug Court programs with your agency?

5. Does your program utilize peer support services?
    a. Yes (1)
    b. No (2)

6. Are these peer support services formal (paid) or informal (unpaid)?
    a. Formal (1)
    b. Informal (2)
    c. Both (3)

7. How many Adult Drug Court dedicated residential beds do you have (i.e. residential beds specifically for Adult Drug Court clients that cannot be filled by any other means)?
    a. _____ Male (1)
    b. _____ Female (2)
    c. _____ Transgender (3)

8. Does the availability/number of beds include beds in multiple counties?
    a. Yes (1)
    b. No (2)
    c. Not Applicable (3)

9. What is the average duration of treatment for Adult Drug Court clients?
    a. 1 Month (1)
    b. 2 Months (2)
    c. 3 Months (3)
    d. 4-6 Months (4)
    e. 6-12 Months (5)
    f. 12-18 Months (6)
    g. 18+ Months (7)

10. Does your treatment program provide various levels of care for Adult Drug Court?
    a. Yes (1)
    b. No (2)

11. What levels of care are provided? (Select all that apply)
    a. Residential (3)
    b. Intensive Outpatient (1)
    c. Outpatient (2)
    d. Aftercare/Recovery Support (4)
    e. Detox (5)

12. Please list what Aftercare/Recovery Support services are in place and the duration of these services.

13. Are there plans to provide additional levels of care, if needed?
    a. Yes (1)
    b. No (2)

14. What are the additional levels of care?

15. Does the program provide case management services?
    a. Yes (1)
    b. No (2)

16. Have all case managers received at least a Bachelor's degree at an accredited university?
    a. Yes (1)
    b. No (2)

17. How often do the case managers meet with clients in Residential?
    a. Daily (1)
    b. 2-3 times a week (2)
    c. 4-6 times a week (3)
    d. Once a week (4)
    e. Bi-weekly (5)
    f. Monthly (6)
    g. Other (7) _____

18. How often do the case managers meet with clients in Intensive Outpatient?
    a. Daily (1)
    b. 2-3 times a week (2)
    c. 4-6 times a week (3)
    d. Once a week (4)
    e. Bi-weekly (5)
    f. Monthly (6)
    g. Other (7) _____

19. How often do the case managers meet with clients in Outpatient?
    a. Daily (1)
    b. 2-3 times a week (2)
    c. 4-6 times a week (3)
    d. Once a week (4)
    e. Bi-weekly (5)
    f. Monthly (6)
    g. Other (7) _____

20. How often do the case managers meet with clients in Aftercare?
    a. Daily (1)
    b. 2-3 times a week (2)
    c. 4-6 times a week (3)
    d. Once a week (4)
    e. Bi-weekly (5)
    f. Monthly (6)
    g. Other (7) _____

21. Does the program provide transportation services for clients?
    a. Yes (1)
    b. No (2)

22. Which transportation services are provided? (Select all that apply)
    a. Bus Pass (1)
    b. Agency-provided (i.e., bus or van) (2)
    c. Reimbursement (3)
    d. Transportation services are only available for court appearances (4)
    e. Other (please specify) (5) _____

23. Does the program provide treatment status updates to court for clients enrolled in treatment?
    a. Yes (1)
    b. No (2)

24. What do these updates consist of?

25. Does the program provide medication management for Mental health conditions?
    a. Yes (1)
    b. No (2)

26. Does the program provide medication management for Medical health conditions?
    a. Yes (1)
    b. No (2)

27. Does the program provide medication management for the following Medical health conditions?
    a. Diabetes (1)
    b. Seizures (2)
    c. Asthma (3)
    d. Tuberculosis (4)
    e. Blood Pressure (5)
    f. Hepatitis (6)
    g. Heart Disease (7)
    h. Head Injury/TBI (8)
    i. HIV/AIDS (9)
    j. Other (please specify) (10) _____

28. Does the program provide licensed nursing staff to clients who are prescribed medications?
    a. Yes (1)
    b. No (2)

29. What is the minimum qualification to be a nurse for the agency? (i.e. LPN, RN, BSN, etc.)

30. Are there any limitations on medication management? Please explain.

31. How much funding does your program receive per residential bed PER DAY for Adult Drug Court?

32. Please list the most recent fiscal year for which you have data available and have used for this survey.

33. What percent of Residential funding is received from the following sources for Adult Drug Court:
    a. _____ DOC (1)
    b. _____ Grants (2)
    c. _____ County (3)
    d. _____ CFBHN (4)
    e. _____ Self-pay (5)
    f. _____ Private Insurance (6)
    g. _____ Choice Provider (7)
    h. _____ Other (8)

34. Is self-pay on a sliding scale?
    a. Yes (1)
    b. No (2)

35. What percent of Intensive Outpatient funding is received from the following sources for Adult Drug Court: (Total sum must add to 100)
    a. _____ DOC (1)
    b. _____ Grants (2)
    c. _____ County (3)
    d. _____ CFBHN (4)
    e. _____ Self-pay (5)
    f. _____ Private Insurance (6)
    g. _____ Choice Provider (7)
    h. _____ Other (8)

36. Is self-pay on a sliding scale?
    a. Yes (1)
    b. No (2)

37. What percent of Outpatient funding is received from the following sources for Adult Drug Court: (Total sum must add to 100)
    a. _____ DOC (1)
    b. _____ Grants (2)
    c. _____ County (3)
    d. _____ CFBHN (4)
    e. _____ Self-pay (5)
    f. _____ Private Insurance (6)
    g. _____ Choice Provider (7)
    h. _____ Other (8)

38. Is self-pay on a sliding scale?
    a. Yes (1)
    b. No (2)

39. Does the program have any additional funding sources?
    a. Yes (1)
    b. No (2)

40. Please explain where additional funding is obtained.

41. What are the average annual fees for the client associated with participation in the program (i.e. urinalysis, screening, assessment, or treatment fees)? Please be as specific as possible.

42. What percent of your clients are: (Total sum must equal 100)
    a. _____ Male (1)
    b. _____ Female (2)
    c. _____ Transgender (3)

43. What percent of clients are: (Total sum must equal 100)
    a. _____ Asian (1)
    b. _____ American Indian or Alaska Native (2)
    c. _____ Black or African-American (3)
    d. _____ Native Hawaiian or Pacific Islander (4)
    e. _____ White (5)
    f. _____ Other (6)

44. What percent of clients identify as Hispanic/Latino?

45. What percent of clients are court ordered to treatment?

46. What percent of clients fall under these age groups? (Total sum must equal 100)
    a. _____ Under 18 (1)
    b. _____ 18 - 25 (2)
    c. _____ 26 - 40 (3)
    d. _____ 41-64 (4)
    e. _____ 65+ (5)

47. Approximately what percent of clients are English language learners or English as a second language?
    a. 0-10% (1)
    b. 11-30% (2)
    c. 31-50% (3)
    d. 51-70% (4)
    e. 71% + (5)

48. How many hours per week of multilingual interpreter services are provided?

49. What is the average reading level of clients enrolled in Adult Drug Court programs? (i.e. 8th grade)

50. Do you provide services to the following special populations? (Select all that apply)
    a. Migrant Farm Workers (1)
    b. Indigent (2)
    c. Military (3)
    d. Developmental/Intellectual Disabilities (4)
    e. Physical Disabilities (5)
    f. Undocumented Immigrants (6)
    g. Non-English Speaking (7)
    h. LGBTQ (8)
    i. Co-Occurring Mental Health and Substance Abuse (9)
    j. HIV/AIDS (10)
    k. Pregnant Women (11)
    l. Deaf/Hard of Hearing (12)
    m. Vision Impaired (13)
    n. Other (please specify) (14) _____

51. Among Adult Drug Court clients, are there restrictions in eligibility for persons diagnosed with specific mental disorders?
    a. Yes (1)
    b. No (2)

52. Please explain why is your agency unable to accept these clients.

53. Do you accept clients who have been diagnosed with the following disorders? (Select all that apply)
    a. Schizophrenia/Schizoaffective Disorder (1)
    b. Bipolar I & II (2)
    c. Psychosis (3)
    d. TBI (4)
    e. Dementia (5)

54. Must clients currently be stabilized on medication in order to be accepted into the program?
    a. Yes (1)
    b. No (2)

55. Is priority given to clients perceived as high risk for recidivism?
    a. Yes (1)
    b. No (2)

56. Generally speaking, is priority given to clients who are perceived as a high need for treatment?
    a. Yes (1)
    b. No (2)

57. Does Adult Drug Court conduct any type of screening or assessment with clients before admission to the program?
    a. Yes (1)
    b. No (2)

58. What type of initial screening or assessment is provided?

59. Do you use the screening or assessment information from Adult Drug Court?
    a. Yes (1)
    b. No (2)

60. What information does your agency receive regarding the client from Adult Drug Court?

61. Do you find that you need to supplement this information?
    a. Yes (1)
    b. No (2)

62. When necessary, why do you supplement this information?

63. Do you conduct your own screening or assessment regardless of the information received from Adult Drug Court?
    a. Yes (1)
    b. No (2)

64. Are drug test results included in the information received from Adult Drug Court?
    a. Yes (1)
    b. No (2)

65. How many current Memorandum of Understanding (MOU) contracts does your agency currently have?
    a. 1 (1)
    b. 2 (2)
    c. 3 (3)
    d. 4 (4)
    e. 5 (5)
    f. 6 (6)
    g. 7+ (7)

66. Please specify which agencies/organizations your agency has a MOU contract with.

67. Are any of these MOU's related to grants?
    a. Yes (1)
    b. No (2)

68. How often do staffing meetings between your agency and Adult Drug Court occur?
    a. At least weekly (1)
    b. Every other week (every two weeks, twice monthly) (2)
    c. More than once per month, but less than biweekly (3)
    d. About once per month (4)
    e. Less often than once per month (5)

69. How often do staffing meetings occur within your organization?
    a. At least weekly (1)
    b. Every other week (every two weeks, twice monthly) (2)
    c. More than once per month, but less than biweekly (3)
    d. About once per month (4)
    e. Less often than once per month (5)

70. How often do staffing meetings occur with collaborating organizations?
    a. At least weekly (1)
    b. Every other week (every two weeks, twice monthly) (2)
    c. More than once per month, but less than biweekly (3)
    d. About once per month (4)
    e. Less often than once per month (5)
    f. N/A (6)

71. Are ad hoc or informal methods of communication used frequently in between staffings?
    a. Yes (1)
    b. No (2)

72. How frequent are informal methods of communication used between your agency and Adult Drug Court?
    a. At least daily (1)
    b. At least 3x per week (2)
    c. 1-2x per week (3)
    d. Once per week or less (4)

73. What is the highest level of education obtained by the individual(s) conducting client SCREENINGS? (Not an assessment tool.)
    a. High school/GED (1)
    b. Associate's/Vocational training (2)
    c. Bachelor's (3)
    d. Master's or higher (4)
    e. N/A -- No screening tools are utilized (5)

74. Do staff members who conduct client screenings receive training at least annually?
    a. Yes (1)
    b. No (2)

75. Are clients screened for both mental and substance use disorders?
    a. Yes (1)
    b. No (2)

76. What screening instruments are used?

77. Does the program also utilize screening instruments developed by your agency during the intake process?
    a. Yes (1)
    b. No (2)

78. Please specify the screening instrument(s) that your agency has developed and utilizes during the intake process.

79. Does the intake process identify issues related to family members and/or significant others?
    a. Yes (1)
    b. No (2)

80. Does the intake process include a risk assessment?
    a. Yes (1)
    b. No (2)

81. Does this risk assessment include criminogenic factors?
    a. Yes (1)
    b. No (2)

82. Does the intake process include questions about a clients sexual orientation or gender identity?
    a. Yes (1)
    b. No (2)

83. What is the highest level of education obtained by the individual(s) conducting client ASSESSMENTS? (Not a screening tool.)
    a. High school/GED (1)
    b. Associates/ Vocational training (2)
    c. Bachelor's (3)
    d. Master's or higher (4)

84. Do staff members who conduct client assessments receive training at least annually?
    a. Yes (1)
    b. No (2)

85. Are clients assessed in jail?
    a. Yes (1)
    b. No (2)
86. Is a separate instrument used for clients assessed in jail?
    a. Yes (1)
    b. No (2)

87. Which separate instrument does your agency utilize when assessing clients in jail?

88. Are clients assessed for both mental and substance abuse disorders?
    a. Yes (1)
    b. No (2)

89. Does the assessment instrument(s) used utilize ASAM criteria or another standardized instrument to determine level of care needed?
    a. Yes (1)
    b. No (2)
90. Which standardized instrument is utilized for level of care assessment?

91. Does this program also utilize assessment instruments developed by your agency?
    a. Yes (1)
    b. No (2)

92. Does the assessment tool identify issues related to family members and/or significant others?
    a. Yes (1)
    b. No (2)

93. Does the assessment examine the client's personal strengths?
    a. Yes (1)
    b. No (2)

94. Does this assessment include a risk assessment?
    a. Yes (1)
    b. No (2)

95. Which risk assessment is used?

96. Does the risk assessment include criminogenic factors?
    a. Yes (1)
    b. No (2)

97. What is the highest level of education obtained by the behavioral health direct care staff (e.g., behavioral health technician, case manager, therapist, psychiatrist, etc.):
    a. _____ High School/GED (1)
    b. _____ Associate's/Vocational training (2)
    c. _____ Bachelor's degree (3)
    d. _____ Master's degree or higher (4)

98. Does direct care staff receive training at least annually on evidence-based curricula?
    a. Yes (1)
    b. No (2)

99. Are clients placed in treatment immediately following eligibility screening/assessment?
    a. Yes (1)
    b. No (2)

100. What is the average duration of time before clients are placed in treatment?

101. Does the program provide services to prevent early attrition while clients are waiting for treatment?
    a. Yes (1)
    b. No (2)

102. What services does the program provide while clients wait for treatment?

103. Are specialized treatment approaches used for the following? (Please select all that apply):
    a. Participants who have a co-occurring mental illness and substance use disorder? (1)
    b. Participants who have a history of trauma/PTSD? (2)
    c. Military (active duty and/or veterans)? (3)
    d. Participants who are juveniles/young adults? (4)
    e. Gender specific treatment needs? (5)

104. Are specialized treatment approaches used for the following? (Please select all that apply):
    a. Military -- Combat (1)
    b. Military -- Sexual Assault (2)

105. Are specialized treatment approaches used for the following? (Please select all that apply):
    a. Gender identity (1)
    b. Sexual orientation (2)

106. Are manualized instruments used for treatment services?
    a. Yes (1)
    b. No (2)

107. What instruments are used?

108. Have you modified treatment curricula?
    a. Yes (1)
    b. No (2)

109. Which of the following evidence-based approaches are provided in the program?
    a. Contingency Management (1)
    b. Motivational Enhancement Therapy/Motivational interviewing (2)
    c. Relapse prevention (3)
    d. Cognitive Behavioral Therapy (4)
    e. Family Psychoeducation (5)
    f. Other (please specify) (6) _____

110. Approximately what percent of clients are diagnosed with substance use disorder (include substance abuse, substance dependence, and SUD)?

111. What is the average duration of substance abuse treatment?

112. Does substance abuse treatment include the following elements? (Select all that apply):
    a. Cognitive restructuring (1)
    b. Criminal thinking (2)
    c. Problem solving (3)
    d. Self-control/management strategies (4)
    e. Skill-building (5)

113. Does substance abuse treatment focus on criminogenic needs in addition to substance use disorders?
    a. Antisocial attitudes/personality (1)
    b. Antisocial peers (2)
    c. Family/Marital problems (3)
    d. Education (4)
    e. Employment (5)
    f. Leisure skills (6)

114. Approximately what percent of clients are diagnosed with a mental disorder?

115. Which mental disorders do you treat?
    a. Depression (1)
    b. Psychosis (2)
    c. Anxiety (3)
    d. Bipolar (4)
    e. Other (please specify) (5) _____

116. Is there a psychiatrist on staff?
    a. Yes (1)
    b. No (2)

117. Is the psychiatrist employed:
    a. Full time (1)
    b. Part time (2)
    c. Other (please specify) (3) _____

118. Does treatment address the participant's trauma history and current symptoms of trauma?
    a. Yes (1)
    b. No (2)

119. Are participants treated for co-occurring mental disorders?
    a. Yes (1)
    b. No (2)

120. Do clients with co-occurring mental disorders receive the same treatment as clients diagnosed with only substance use disorder?
    a. Yes (1)
    b. No (2)

121. What treatment is used?

122. What is the average duration of mental health treatment?

123. Approximately what percent of clients are diagnosed with co-occurring mental and substance use disorders?

124. Does the program include peer support provided by trained peer support specialists?
    a. Yes (1)
    b. No (2)

125. Does the treatment program utilize a phase structure?
    a. Yes (1)
    b. No (2)

126. Briefly describe each phase AND the duration of each phase.

127. Approximately what percent of clients receive individual therapy?

128. What is the average amount of time spent per week in individual therapy for the following clients?
    a. _____ Residential (1)
    b. _____ Intensive Outpatient (2)
    c. _____ Outpatient (3)
    d. _____ Aftercare (4)

129. Approximately what percent of clients receive group therapy?

130. What is the average amount of time spent per week in group therapy for the following clients?
    a. _____ Residential (1)
    b. _____ Intensive Outpatient (2)
    c. _____ Outpatient (3)
    d. _____ Aftercare (4)

131. What types of group therapy are provided?

132. Are clients required to attend support groups?
    a. Yes (1)
    b. No (2)

133. Does your facility offer the following support groups on location for Adult Drug Court clients?
    a. SMART Recovery (1)
    b. AA/NA/CA (2)
    c. Rational Recovery (3)
    d. Celebrate Recovery (4)
    e. Other (5) _____

134. Does treatment incorporate elements of recovery-oriented systems of care?
    a. Yes (1)
    b. No (2)

135. Does the recovery management plan address long-term recovery goals for the period after the completion of Adult Drug Court?
    a. Yes (1)
    b. No (2)

136. Is there a focus on outpatient treatment, with residential treatment reserved for those who have experienced multiple relapses or who are at risk for harm to self or harm to others?
    a. Yes (1)
    b. No (2)

137. Does the program provide home-based services?
    a. Yes (1)
    b. No (2)

138. What home-based services are provided? Please explain.

139. Is fidelity to evidence-based treatments monitored on a regular basis?
    a. Yes (1)
    b. No (2)

140. How is fidelity measured and monitored? Please explain.

141. Please write any additional comments here.

Appendix B: Problem-Solving Court Focus Group Interview Questions

1. How would you define your role in problem-solving courts?

2. Does your court have a participant handbook?
   Adult Drug Court
   Family Dependency Treatment Court (FDTC)
   Juvenile Drug Court
   Marchman Court
   Mental Health Court
   Veteran Treatment Court (VTC)

3. How often is offender progress and compliance shared? Daily, weekly, monthly, only at court?
   Adult Drug Court
   Family Dependency Treatment Court (FDTC)
   Juvenile Drug Court
   Marchman Court
   Mental Health Court
   Veteran Treatment Court (VTC)

4. Do you think your court is successful at reducing recidivism?
   Adult Drug Court
   Family Dependency Treatment Court (FDTC)
   Juvenile Drug Court
   Marchman Court
   Mental Health Court
   Veteran Treatment Court (VTC)

5. What type of resources does it require for your program/organization to support problem solving courts (# of staff, operational supports, data management, etc.)?
   Adult Drug Court
   Family Dependency Treatment Court (FDTC)
   Juvenile Drug Court
   Marchman Court
   Mental Health Court
   Veteran Treatment Court (VTC)

6. Are there conflicts with staffing recommendations? If so, how are these conflicts dealt with?
   Adult Drug Court
   Family Dependency Treatment Court (FDTC)
   Juvenile Drug Court
   Marchman Court
   Mental Health Court
   Veteran Treatment Court (VTC)

7. How do you distinguish between graduating from treatment and graduating from drug court? How does the offender understand the difference?
   Adult Drug Court
   Family Dependency Treatment Court (FDTC)
   Juvenile Drug Court
   Marchman Court
   Mental Health Court
   Veteran Treatment Court (VTC)

8. In your opinion, how effective or ineffective are the sanctions and incentives mandated by the problem-solving courts?
   Adult Drug Court
   Family Dependency Treatment Court (FDTC)
   Juvenile Drug Court
   Marchman Court
   Mental Health Court
   Veteran Treatment Court (VTC)

9. How would you describe the collaboration between agencies who work within problem-solving courts?
   Adult Drug Court
   Family Dependency Treatment Court (FDTC)
   Juvenile Drug Court
   Marchman Court
   Mental Health Court
   Veteran Treatment Court (VTC)

10. How would you describe the communication between agencies who work within problem-solving courts?
    Adult Drug Court
    Family Dependency Treatment Court (FDTC)
    Juvenile Drug Court
    Marchman Court
    Mental Health Court
    Veteran Treatment Court (VTC)

11. How would you describe the coordination between agencies who work within problem-solving courts?
    Adult Drug Court
    Family Dependency Treatment Court (FDTC)
    Juvenile Drug Court
    Marchman Court
    Mental Health Court
    Veteran Treatment Court (VTC)

12. What are the strengths associated with problem-solving courts?
    Adult Drug Court
    Family Dependency Treatment Court (FDTC)
    Juvenile Drug Court
    Marchman Court
    Mental Health Court
    Veteran Treatment Court (VTC)

13. What are the challenges associated with problem-solving courts (e.g., wait time, continuum of services, treatment for clients with co-occurring disorders, bilingual/hearing impaired, on-site drug testing)?
    Adult Drug Court
    Family Dependency Treatment Court (FDTC)
    Juvenile Drug Court
    Marchman Court
    Mental Health Court
    Veteran Treatment Court (VTC)

14. What are some improvements that could be made to problem-solving courts to better facilitate its' intended purpose?
    Adult Drug Court
    Family Dependency Treatment Court (FDTC)
    Juvenile Drug Court
    Marchman Court
    Mental Health Court
    Veteran Treatment Court (VTC)