



# Evaluation of the Veterans Treatment Court (VTC) Program

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# TABLE OF CONTENTS

<b>ACKNOWLEDGEMENTS</b> .....	Inside Front Cover	
<b>ABSTRACT</b> .....	2	
<b>INTRODUCTION</b>		
Overview.....	2	
Veterans Treatment Court (VTC).....	3	
Thirteenth Judicial VTC Program Description.....	3	
Current Evaluation Study.....	4	
<b>METHOD</b>		
Participants.....	5	
Procedure.....	5	
Measures .....	5	
Treatment and VTC Information .....	5	
Criminal Justice Involvement.....	5	
Government Performance and Results Act .....	5	
Brief Symptom Inventory.....	5	
Posttraumatic Stress Disorder Checklist .....	5	
Social Support Survey Instrument.....	6	
Circumstances, Motivation, and Readiness.....	6	
Working Alliance Inventory.....	6	
Participant Satisfaction Survey .....	6	
Analyses.....	6	
<b>RESULTS</b>		
Baseline Findings.....	7	
Participant Demographic Characteristics .....	7	
VTC Treatment and Court Information.....	8	
Reasons for Drop-Out .....	8	
Military Status Information .....	9	
Drug of Choice Information.....	10	
Mental Health and Substance Use Information .....	10	
Criminal Justice History Involvement.....	11	
Arrest Charges Prior to VTC Program.....	12	
Outcomes Analyses for Graduates .....	13	
Substance Use Outcomes.....	13	
Mental Health and Social Support Outcomes .....	13	
Therapeutic Alliance Outcomes .....	14	
Participant Satisfaction Outcomes.....	14	
Outcome Analyses for Graduates vs. Non-Graduates .....	14	
Re-arrest Outcomes.....	15	
Substance Use Outcomes.....	15	
Mental Health and Social Support Outcomes .....	16	
Outcome Analyses for Those with Veteran Mentor vs. No Veteran Mentor .....	16	
Baseline Predictors of Graduation and Re-arrest .....	18	
<b>DISCUSSION</b>		
Baseline Findings.....	19	
Outcome Findings.....	19	
VTC Graduates.....	19	
VTC Graduates vs. Non-Graduates.....	20	
Participants with Veteran Mentor vs. No Veteran Mentor ...	20	
Predictors of Graduation and Re-arrest.....	21	
Accomplishments .....	21	
Challenges .....	22	
Conclusions.....	22	
<b>REFERENCES</b> .....		23
<b>APPENDIX A</b> .....		24
<b>TABLES</b>		
Table 1. Ten Key Components of Veterans Treatment Court (VTC) .....	3	
Table 2. Participant Demographic Characteristics.....	7	
Table 3. VTC Treatment and Court Information .....	8	
Table 4. Military Status Information .....	9	
Table 5. Mental Health and Substance Use Information.....	10	
Table 6. Criminal Justice History Involvement .....	11	
Table 7. Arrest Charges Prior to VTC Program .....	12	
Table 8. Substance Use Outcomes for Graduates .....	13	
Table 9. Mental Health and Social Support Outcomes for Graduates .....	14	
Table 10. Substance Use Outcomes for Graduates vs. Non-Graduates.....	15	
Table 11. Mental Health and Social Support Outcomes for Graduates and Non-Graduates .....	16	
Table 12. Hierarchical Logistic Regression with VTC Graduation as Dependent Variable .....	18	
Table 13. Binary Logistic Regression with Re-arrest as Dependent Variable.....	18	
<b>FIGURES</b>		
Figure 1. Reasons for Drop-Out.....	8	
Figure 2. Drug of Choice .....	10	
Figure 3. Re-Arrests between VTC Graduates and Non-Graduates .....	15	
Figure 4. Mental Health Difference Scores between Those with Veteran Mentor and Those with No Veteran Mentor. ....	16	
Figure 5. Social Support Difference Scores between Those with Veteran Mentor and Those with No Veteran Mentor .....	16	

# ABSTRACT

The Thirteenth Judicial Circuit's Veterans Treatment Court (VTC) is a specialized court established to serve veterans currently in the criminal justice system. Veteran's enrolled in VTC must meet the following statutory requirements: must be 18 years of age or older and be (1) a veteran discharged or released under any condition, (2) a service members, (3) an individual who is a current or former United States Department of Defense contractor, or (4) an individual who is a current or former military member of a foreign allied county and suffer from a military service-related mental illness, traumatic brain injury (TBI), substance use disorder, or psychological problem. In 2016, the Substance Abuse and Mental Health Services Administration (SAMHSA) funded Hillsborough County's Thirteenth Judicial Circuit a three-year grant to "Enhance Substance Abuse Treatment Capacity in Veterans Treatment Court (VTC)" in partnership with DACCO Behavioral Health and the University of South Florida's Department of Mental Health Law and Policy (MHLP) that provided program evaluation. This evaluation report describes the following information: (1) overview of recent literature, (2) program description, (3) participant demographics and treatment/court results, (4) participant outcome results, and (5) accomplishments and challenges encountered and how these were addressed.

## INTRODUCTION

### Overview

Since the inception of Drug Courts in the early 1990s, specialized problem-solving courts focusing on providing treatment and a heightened level of judicial review for program participants have expanded in number and scope (National Association of Drug Court Professionals [NADCP], 2019). Minimally, the overarching aim of problem-solving courts is to simultaneously address and rectify the legal issues as well as addiction and mental health needs of participants in these programs. The goal of these problem-solving courts is to facilitate long-term improvements for participants through reduced subsequent contact with the criminal justice system and enhanced mental health and substance use outcomes. Research on the drug court model has been both extensive and promising and indicates that, compared to traditional measures such as intensive probation, they are effective in reducing recidivism and drug use (Logan & Link, 2019). Drug courts are the most successful criminal justice intervention for offenders with substance use issues. As of 2016, more than 3,300 treatment drug courts were in operation (American University School of Public Affairs, 2016). Past research has demonstrated that these courts have proven to save lives, money, and reduce crime

- Adult drug courts reduce recidivism by as much as 45% (Aos, Miller, & Drake, 2006)
- 75% of drug court graduates remain arrest free, compared to 30% of those released from prisons (Finigan, Carey, & Cox, 2007)
- Juvenile drug courts reduce recidivism by as much as 40% (Marlowe, 2010)
- Drug courts instead of prison can save up to \$13,000 per participant (Aos et al., 2006)
- Family drug courts reduce the likelihood of re-entry into foster care by two-thirds (Marlowe & Carey, 2012)
- Every U.S. state and territory utilizes drug court (American University School of Public Affairs, 2016)



## Veterans Treatment Court (VTC)

One of the most recent innovations in the sphere of specialty treatment courts began in 2008 in Buffalo, NY, with a program designed to help veterans of the United States Armed Forces in the criminal justice system. Veterans treatment courts (VTCs) are one of the fastest growing specialty court types in the U.S. with over 461 VTCs currently existing nationally (Flatley, Clark, Rosenthal, & Blue-Howells, 2017). VTCs follow the model of Drug Courts by providing specialized services to meet the individual needs of program participants in an environment that emphasizes United States military values and culture (Russell, 2009). VTCs offer an opportunity for the Department of Veteran’s Affairs (VA), local support organizations, and local communities to engage veterans and offer treatment as an alternative to time in jail.

Most veterans are strengthened by their military service, but the combat experience has left a growing number of veterans with issues such as post-traumatic stress disorder (PTSD) and traumatic brain injury. One in five veterans has symptoms of a mental health disorder or cognitive impairment. One in six veterans who served in Operation Enduring Freedom and Operation Iraqi Freedom suffer from a substance use issue. Research continues to draw a link between substance use and combat-related mental illness (Tsai, Finlay, Flatley, et al., 2018). If left untreated, mental health disorders can directly lead to criminal justice involvement.

Recognizing this problem, many local communities have developed special VTCs that seek to provide veterans suffering from these issues assistance that will help keep them from slipping into real legal problems. In 2008, the Buffalo Veterans Treatment Court adopted, with slight modifications, the essential tenements of the U.S. Department of Justice publication entitled *“Defining Drug Courts: The Key Components”* (U.S. Department of Justice, 1997). Table 1 defines the Key Components that provide the foundation for the successful operation of VTCs.

**Table 1. Ten Key Components of Veterans Treatment Court**

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

VTCs are supported by the Veterans Justice Outreach (VJO) program that provides direct outreach, assessment, and case management for criminal justice-involved veterans (U.S. Government Accountability Office, Veterans Justice Outreach Program, 2016). VJO staff dedicate much of their work to liaising with local justice system partners and coordinating care for veterans. VJO staff work with courts to determine whether veterans meet eligibility criteria, and then provide ongoing support to connect enrolled participants to treatment in the VA healthcare system and/or other community health systems, as mandated by the judge to fulfill court requirements.

## Thirteenth Judicial VTC Program Description

The Thirteenth Judicial VTC was established in 2013 in order to divert veterans with service-related issues into available veteran treatment programs, providing a therapeutic environment coupled with an emphasis on accountability for the veteran. As part of a coordinated strategy, an appropriate treatment plan that is specific to the needs of the veteran, is determined through assessment and evaluation by the specialty court case managers, the U.S. Department of Veterans Affairs (VA) providers, or other court-approved treatment providers. The coordinated strategy encompasses five phases in which the veteran's advancement from one phase to the next is not automatic and is determined by the court after review of veterans progress in each program phase. The coordinated strategy includes a protocol of incentives and sanctions to encourage the veteran's compliance with the program. The VTC team is comprised of the following:

- VTC Judge
- Specialty Court Case Managers
- Public Defender's (PD) Office
- State Attorney's (SA) Office
- Department of Corrections (DOC)
- Veterans Justice Outreach (VJO) Coordinator
- Treatment Providers
- Veterans Mentors

In 2016, the Thirteenth Judicial Court applied for and received federal funding for three years from SAMHSA to "*Enhance Substance Abuse Treatment Capacity in Veterans Treatment Court (VTC)*" in partnership with DACCO Behavioral Health and the University of South Florida's Department of Mental Health Law and Policy. DACCO Behavioral Health provided four months of residential treatment, three months of intensive outpatient treatment services, and three months of recovery support services treatment implementing evidence-based treatment models including:

- **Motivational Interviewing (MI)** is a standardized and evidence-based communication approach to support behavior change in wellness and addiction treatment arenas (Olsen & Nesbitt, 2010; Wolever et al., 2013). MI has been associated with improved addiction recovery outcomes and decreased numbers of drug-related overdoses (Coffin et al., 2017).
- **Accelerated Resolution Therapy (ART)** is a brief, exposure-based psychotherapy aimed at treating psychological trauma, depression, anxiety, phobias, obsessive-compulsive disorder, and substance use (Hoge & Lies 2015). The program incorporates specific visualization techniques enhanced through use of repaid eye movements.
- **Matrix Model** utilizes a partnership approach between the substance user and the counselor and incorporates family strengthening components to educate family members on addiction (Rawson et al., 1995). NIDA-funded research has demonstrated that alcohol and opiate dependent individuals demonstrated significant reductions in substance use, improvements in psychological indicators, and fewer sexual behaviors associated with HIV transmission when treated using the Matrix Model.

Additional weekly AA/NA self-help groups were part of the treatment plan and attendance of monthly judicial reviews in front of the VTC judge were required to assess compliance with the program. The treatment plan also required random drug screens that were typically twice per week but could be adjusted if needed. If clients were not in compliance, additional measures were put in place (e.g., additional treatment groups, increased drug screens, judicial reviews, etc.).

## Current Evaluation Study

This evaluation study will focus on 89 VTC participants who completed baseline assessments and those participants with subsequent follow-up information at six-months after program admission. Information collected at baseline included demographics, drug of choice, military information, and self-reported trauma symptoms. Treatment and court variables included length of time in treatment, court graduation rates, and criminal justice involvement. Participant six-month follow-up outcomes include substance use change over time, mental health symptomatology, social support inventory, readiness to change, therapeutic alliance, and participant program satisfaction. Additionally, the discussion section will summarize: (1) accomplished goals and objectives, (2) lessons learned implementing the program, (3) challenges encountered and how these were addressed, and (4) sustainability plan beyond the end of the grant.

## METHOD

### Participants

Participants included 89 participants in the Thirteenth Judicial VTC program that were court-ordered to residential or intensive outpatient treatment at DACCO Behavioral Health. The eligibility criteria for VTC includes the following:

- Identified as a veteran including discharged or released under a general discharge
- Charged with a felony or misdemeanor
- Suffering from a military service-related mental illness, traumatic brain injury, substance use disorder, or psychological problem

The screening process is the responsibility of all entities involved, including the court, public defender's office, and state attorney's office. In order to enter VTC, the veteran and/or attorney, must complete an admission application that includes demographic, medical, and military history information. If the veteran appears to qualify, a screening and assessment is conducted by the VJO prior to the first hearing to verify that the defendant meets eligibility criteria.

### Procedure

This study was approved by the institutional review board (IRB) at the University of South Florida. Baseline and six-month follow-up interviews were conducted with participants involved in the VTC program. Upon admission, participants completed a comprehensive intake interview, with research staff, that included several standardized measures. Participants were interviewed six-months later using the measures completed at baseline in addition to a questionnaire assessing client-therapist rapport. Interviews lasted approximately 90 minutes and were conducted in private.

### Measures

**Treatment and VTC Information.** Information was collected on each participant that included number of days in treatment and outcome (successful graduation, unsuccessful discharge) of the VTC program.

**Criminal Justice Involvement.** Information on participants' arrest history was collected from an online database of arrests in Hillsborough County. Researchers recorded all arrests for each participant occurring prior, during, and after each participant's entry into the program. Arrests were categorized as: (1) drug-related crimes, (2) theft-related offenses, (3) fraud-related crimes, (4) driving-related crimes; (5) violent crimes including domestic violence, (6) violation of probation (VOP), (7) failure to obey written promises including bench warrants and court orders, or (7) other (e.g., trespassing or shoplifting).

**Government Performance and Results Act (GPRA; SAMHSA, 2007).** This measure contains questions about past 30-day drug use, family and living conditions, education, employment, income, crime and criminal justice status, mental and physical health problems, as well as demographic information including gender, ethnicity, race, and age. Specific items regarding substance use analyzed were "During the past 30 days how many days have you used any alcohol?" and "During the past 30 days how many days have you used illegal drugs?"

**Brief Symptom Inventory (BSI; Derogatis & Spencer, 1993).** This is a 53-item measure that assesses overall mental health functioning. The BSI is divided into nine subscales that measure symptoms of (1) somatization, (2) obsessive compulsion, (3) interpersonal sensitivity, (4) depression, (5) anxiety, (6) hostility, (7) phobic anxiety, (8) paranoid ideation, and (9) psychoticism. Internal consistency reliabilities were calculated using Cronbach's alpha, ranging from .71 to .85 on separate subscales (Derogatis, & Spencer, 1993). Other studies have calculated internal reliability scores of  $\alpha = .70$  to  $.88$  (Broday & Mason, 1991).

**Posttraumatic Stress Disorder Checklist (PCL; Weathers, Litz, Herman, Huska, & Keane, 1993).** This 17-item self-report scale for PTSD is based on DSM-IV criteria. Respondents indicate how much distress a symptom has caused over the past month. The PCL has produced scores with an internal consistency of  $\alpha = .94$  (Ruggiero, Del Ben, Scotti, & Rabalais, 2003).



**Social Support Survey Instrument (SSSI;** Sherbourne & Stewart, 1991). This is an 18-item brief, multidimensional, self-reported survey of social support. The SSSI consists of four separate subscales: emotional, tangible, affectionate, and positive social interaction. The scales have produced scores with high internal consistency ( $\alpha$  = alphas ranging from .91 to .97).

**Circumstances, Motivation, and Readiness (CMR;** De Leon, Melnick, & Kressel, 1997). The CMR is an 18-item instrument designed to (1) measure motivation and readiness for treatment and (2) predict retention in substance use treatment. Responses to each item are rated on a Likert scale ranging from (1) *Strongly Agree* to (5) *Strongly Disagree*. The instrument consists of a total score and the following four scales: Circumstances 1 (external influences to enter or remain in treatment), Circumstances 2 (external influences to leave treatment), Motivation (internal recognition of the need to change), and Readiness (perceived need for treatment). Prior research produced scores with internal consistencies of .60-.81 for each CMR subscale (De Leon, Melnick, & Hawke, 2000).

**Working Alliance Inventory (WAI;** Horvath & Greenberg, 1989). The WAI is 12-item instrument that assesses clients' perspectives on the therapeutic rapport between clients and service providers. Each item is rated on a 7-point Likert response scale. The WAI contains three subscales measuring: (1) the therapeutic bond, (2) client-provider agreement on therapeutic tasks, and (3) client-provider agreement on therapeutic goals. There is also a composite scale measuring overall working alliance. The instrument has been shown to produce reliable scores (Horvath, 1994). In the current study, the instrument was administered at six-month follow-up. Participant scores produced Cronbach's alpha reliability coefficients of .71-.92 on the three subscales and .94 for the overall working alliance.

**Participant Satisfaction Survey.** The Participant Satisfaction Survey was developed by the researchers to assess the satisfaction of VTC participants. Each participant was asked to rate their satisfaction for the following domains: (1) VTC Judge, (2) Veteran Mentor, (3) Veteran Justice Outreach Coordinator (VJO), and (4) Treatment Staff

## Analyses

Simple descriptive statistics were used to depict participant demographic characteristics and criminal justice involvement. Paired t-tests were employed to detect changes over time for continuous variables related to substance use, mental health and trauma symptomatology, social support, and treatment motivation. Independent t-tests were used to detect changes over time for continuous variables related to substance use, mental health, trauma symptomatology, social support, and treatment motivation in order to compare graduates vs. non-graduates of the VTC program. Descriptive statistics were used to describe participants' working relationship with their counselor at six-month follow-up. All tests were two-tailed and evaluated at the  $p < .05$  significance level.

A hierarchical binary logistic regression with two blocks was used to determine significant predictors of VTC graduation, with veteran mentor as the primary independent variable. Five predictor variables were included in the overall model: 1) baseline BSI score, 2) baseline PCL score, 3) alcohol use in the past 30 days, 4) illicit drug use in the past 30 days, and 5) veteran mentorship. The first block consisted of baseline BSI and PCL scores, and alcohol and illicit drug use in the past 30 days. The second block included veteran mentor as the only predictor variable in order to assess the unique contribution of veteran mentorship to the overall model. A second binary logistic regression was used to determine significant predictors of re-arrest, with arrest outcome as the dependent variable. Five predictors were included in a second regression model: 1) number of arrests prior to enrollment, 2) number of days from arrest until enrollment in VTC, 3) alcohol use in the past 30 days, 4) illicit drug use in the past 30 days, and 5) history of homelessness.

# RESULTS

## Baseline Findings

The baseline analyses reported in this section include those who completed intake interviews (N=89). These include demographic characteristics, treatment, court information, military status, drug of choice, and criminal justice involvement.

**Participant Demographic Characteristics.** Table 2 details demographic characteristics on 89 participants. The average age was 44 years ranging from 21 to 67 years of age. The majority of participants were male (85%), with a lower percentage of female participants (15%). Most participants were White (60%), with 35% African-American, and almost a third (17%) reporting Hispanic ethnicity. The majority of participants reported single status (44%) followed by being divorced (35%) and married (11%). The average number of children was 2.3 with a range from one to seven children. A majority of participants (97%) did graduate high school, with 26% completing some college, and 33% reporting either an Associates or a Bachelor’s degree. About 19% of participants were working either part-time or full-time at the time of intake assessment, with 42% reporting unemployment, and 28% reporting disability. Almost a third of the participants (31%) were in jail 30 days prior to baseline assessment with 26% in residential treatment. Over a third of the participants reported living with someone else (27%) or in their own house/apt (13%).

**Table 2. Participant Demographic Characteristics (N=89)**

Characteristic	N	% or Mean
<b>Age (years)</b>		44 years
<b>Gender</b>		
Male	76	85%
Female	13	15%
<b>Race</b>		
White	53	60%
African-American	31	35%
Other	5	5%
<b>Ethnicity</b>		
Hispanic/Latino	15	17%
<b>Marital Status</b>		
Single	39	44%
Divorced	31	35%
Married	11	12%
Separated	8	9%
<b>Number of children</b>		2.3

Characteristic	N	% or Mean
<b>Level of Education</b>		
Less than high school diploma	3	3%
High school diploma	30	34%
Some college	23	26%
AA degree	23	26%
BA degree	6	7%
Technical degree	4	4%
<b>Employment</b>		
Full or part-time	17	19%
Disabled	25	28%
Retired	10	11%
Unemployed	37	42%
<b>Housing Status</b>		
Jail	27	31%
Residential program	23	26%
Own/rent a place	24	27%
Someone else’s apartment	11	13%
Street	3	3%

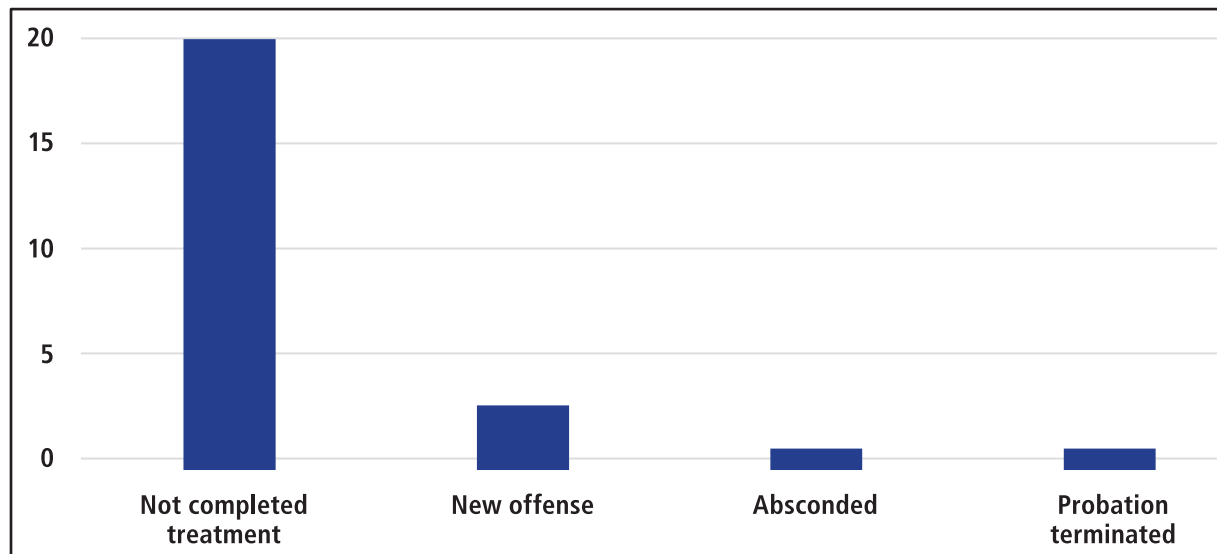
**VTC Treatment and Court Information.** As seen in Table 3, the average length of treatment participation, for the 89 participants, was 238 days (approximately 8 months) with a range from 38 (1.3 months) to 952 days (31.7 months). An optional individualized treatment that was offered is Accelerated Resolution Therapy (ART) which 12% of participants engaged in while under care at DACCO Behavioral Health. Additionally, about 80% of participants were eligible for additional Veteran’s Administration (VA) services. The average length of VTC participation was 341 days (approximately 11.4 months) with a range from 60 (2 months) to 813 days (27.1 months). The average time from arrest into VTC was 177 days (5.9 months) with a range from 19 to 729 days. At the time of this report, 40 participants (45%) have successfully graduated, 24 participants (27%) are still active and enrolled in VTC, and 25 participants (28%) did not successfully graduate from the VTC program. The VTC also offers the opportunity for participants to be paired with a veteran mentor; 81% took advantage and engaged in the mentorship with a “battle buddy” who has had (or currently has) military experience.

**Table 3. VTC Treatment and Court Information (N = 89)**

<i>Characteristic</i>	<i>Average Days (Months)</i>	<i>Range</i>
Length of time in treatment	238 days (8 months)	38 to 952 days (1.3 to 31.7 months)
Length of time in VTC	341 days (11.4 months)	60 to 813 days (2 to 27.1 months)
Arrest to VTC admission	177 days (5.9 months)	19 to 729 days (.6 to 24.3 months)

**Reasons for Drop-Out.** As seen in Figure 1, most participants (n=20) dropped out of treatment due to non-compliance. A small number (n=3) of participants re-offended, one participant absconded, and one had probation terminated.

**Figure 1. Reasons for Drop-Out (N=25)**





**Military Status Information.** As seen in Table 4, the majority of participants reported the Army (55%) as their branch of service followed by Navy (18%), Marines (18%), Air Force (8%), and Coast Guard (1%). A little over half of the participants reported being a combat veteran (52%). Almost a third of participants (31%) reported their rank of service as Corporal, followed by Sergeant (27%), Petty Officer (16%; 1st, 2nd, or 3rd Class), and Private (10%). The majority of participants reported they had not been deployed (47%), with 18 participants (20%) being deployed one time, 16 participants being deployed 2 times (18%), and 12 participants reported being deployed 3 or more times (15%).

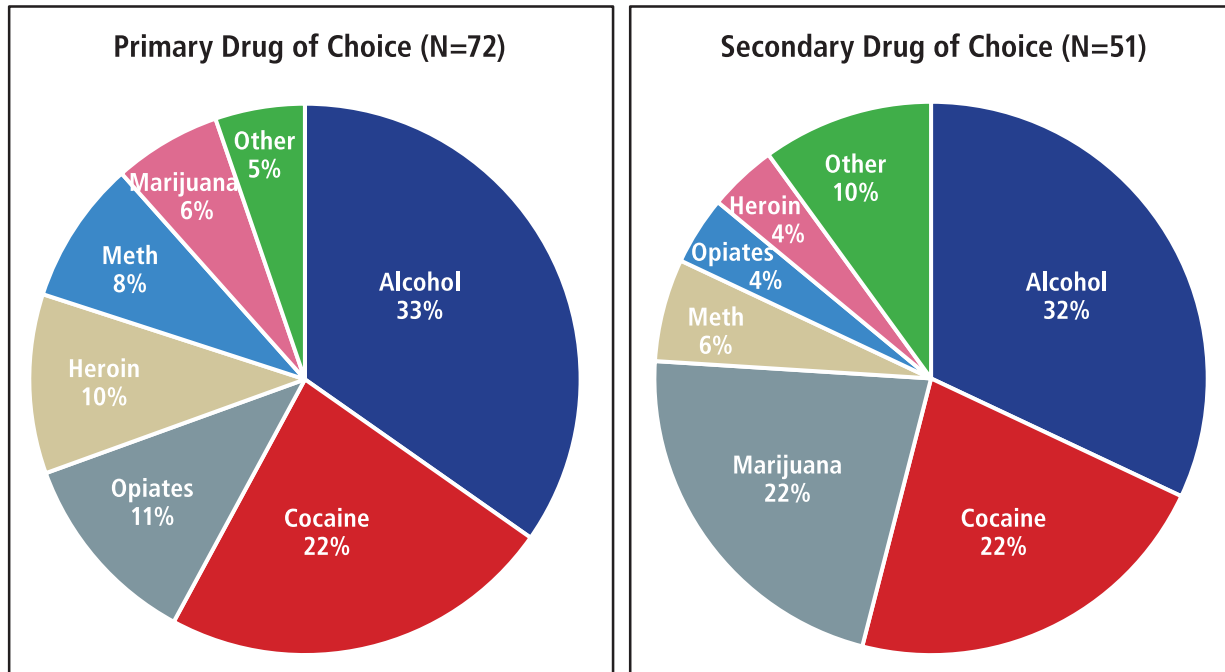
**Table 4. Military Status Information (N = 89)**

<i>Characteristic</i>	<i>N</i>	<i>%</i>
<b>Branch of Service</b>		
Army	49	55%
Navy	16	18%
Marines	16	18%
Air Force	7	8%
Coast Guard	1	1%
<b>Combat Veteran</b>		
Yes	45	52%
No	41	48%
<b>Rank</b>		
Corporal	20	31%
Sergeant	17	27%
Petty Officer	10	16%
Private	7	10%
Other	10	16%
<b>How Many Times Deployed</b>		
0	42	47%
1	18	20%
2	16	18%
3 or more	13	15%



**Drug of Choice Information.** As seen in Figure 2, most participants endorsed alcohol (33%) as their primary drug of choice, followed by cocaine (22%), opiates (11%), and heroin (10%). A similar pattern can be seen for secondary drug of choice, with 51 participants having a second drug of choice. Almost a third of the participants endorsed alcohol (32%), followed by cocaine (22%), marijuana (22%), and methamphetamine (6%). There were 27 participants who had a tertiary drug of choice; marijuana was endorsed as the highest (30%), followed by alcohol (19%) and methamphetamine (15%).

**Figure 2. Drug of Choice**



**Mental Health and Substance Use Information.** As seen in Table 5, the majority of participants reported a past history of posttraumatic stress disorder (PTSD; 74%), anxiety and/or depression (80%), and difficulty with memory (61%). Almost a third of participants (30%) reported a history of suicide attempts and almost two-thirds (65%) reported at least one time in their past when they were homeless. In terms of substance use history, 67% reported history of alcohol abuse and 97% reported past history with drug use. When asked about verbal/physical abuse, 13% had a history of domestic violence with 9% reporting history of child abuse, and 5% reporting both domestic and child abuse.

**Table 5. Mental Health and Substance Use Information (N = 89)**

Characteristic	N	% Yes
<b>Past History of:</b>		
PTSD	66	74%
Anxiety/Depression	71	80%
Difficulty with Memory	54	61%
Suicide Attempts	27	30%
Homelessness	58	65%
Alcohol Abuse	60	67%
Drug Abuse	86	97%
<b>History of Verbal/Physical Abuse</b>		
Domestic	12	13%
Child	8	9%
Domestic and Child	4	5%
Animal	1	1%

**Criminal Justice History Involvement.** Table 6 presents participant’s criminal justice involvement within the Hillsborough County judicial system. All participants had at least one arrest prior to admittance into VTC with a range from one to 44 arrests (Median = 3.0 arrests). The majority of arrests prior to VTC were felonies (82%) with 18% misdemeanors and most had multiple charges within each arrest. Examining the total arrest charges, the top charges across all arrests were warrants/court orders (N=395), possession/delivery/sale/trafficking of controlled substances (N=129), VOP (N=128), theft/burglary/shoplifting/robbery related crimes (N=109), and possession of drug paraphernalia (N=63), and fraudulent crimes (N=62). Almost two-thirds of participants (63%) were sanctioned for contempt of court. Which included not complying with court order, testing positive for alcohol or drugs, or missing treatment sessions.

**Table 6. Criminal Justice History Involvement**

<b>Arrest Charges</b>	<b>1st arrest (N=89)</b>	<b>2nd arrest (N=70)</b>	<b>3rd arrest (N=55)</b>	<b>4th arrest (N=44)</b>	<b>5th arrest (N=39)</b>	<b>6th arrest or more (N=33)</b>	<b>Total</b>
Warrants/Court Orders	31	107	80	61	65	49	395
Possession/Delivery/Sale/Trafficking Controlled Substance	34	40	22	6	13	14	129
Violation of Probation (VOP)	13	17	37	24	26	12	128
Theft/Burglary/Shoplifting/Robbery	56	18	12	9	11	4	109
Possession Drug Paraphernalia	16	11	6	8	11	11	63
Fraudulent Crimes	57	1	4	0	0	0	62
Alcohol-Related Crimes	24	14	3	4	3	3	51
Driving-Related Crimes	19	11	4	3	1	4	42
Violent Crimes	8	6	4	2	0	0	20
Officer-Related Crimes	9	1	2	4	1	2	19
Domestic Violence Crimes	6	4	1	0	1	1	13
Other	13	4	3	1	2	4	27



**Arrest Charges Prior to VTC Program.** Table 7 presents participant’s arrest charges prior to being admitted into the VTC program. As can be seen, participants had multiple charges for the arrest prior to their intake assessment in VTC. Examining the top arrest charges, these included fraudulent crimes (N=55), theft/burglary/shoplifting/robbery related crimes (N=51), possession/delivery/sale/trafficking of controlled substances (N=47), warrants/court order (N=37), possession of drug paraphernalia (N=30), and driving under the influence (N=26).

**Table 7. Arrest Charges Prior to VTC Program**

<i>Arrest into VTC</i>	<i>1st charge</i>	<i>2nd charge</i>	<i>3rd charge</i>	<i>4th charge</i>	<i>5th charge</i>	<i>6th charge or more</i>	<i>Total</i>
Fraudulent Crimes	5	2	3	2	0	43	55
Theft/Burglary/Shoplifting/Robbery	16	7	9	7	3	9	51
Possession/Delivery/Sale/Trafficking Controlled Substance	24	16	5	4	1	1	47
Warrants/Court Orders	8	7	5	5	6	6	37
Possession Drug Paraphernalia	1	10	5	1	1	12	30
Driving Under Influence	19	6	1	0	0	0	26
Driving-Related Crimes	5	1	3	0	2	1	12
Violent Crimes	6	2	0	2	0	0	10
Officer-Related Crimes	0	5	3	1	0	0	9
Violation of Probation	1	2	1	2	1	0	7
Domestic Violence Crimes	2	0	0	0	0	0	2
Other	2	2	4	0	2	1	11



## Outcome Analyses for VTC Graduates

The outcome analyses reported in this section will include those who have successfully graduated from the VTC program (N=40). A paired sample t-test was conducted to test for differences from baseline to six-month follow-up on substance use, mental health, trauma, social support, working alliance inventory, and participant satisfaction.

**Substance Use Outcomes.** Participants reported on using alcohol and illegal drugs in the past 30 days. As can be seen in Table 8, there was a trend for alcohol use reduction from baseline ( $M=.67$ ) to six months ( $M=.003$ ),  $t(35)=1.5$ ,  $p=.15$ . However, illegal drug use decreased significantly from 3.4 days at baseline to 0 days after six-months,  $t(35)=3.0$ ,  $p<.01$ . Of the other substances that participants reported using in the past 30 days, only opiate use was decreased significantly from baseline ( $M=2.3$ ) to six-months ( $M=.00$ ),  $t(35)=2.3$ ,  $p<.05$ . Although not statistically significant, there was a trend for cocaine, marijuana, and methamphetamine use to decrease from baseline to six-month follow-up.

**Table 8. Substance Use Outcomes for Graduates (N=40)**

	Time period					
	Baseline		Six-month		Significance	
	N	M (SD)	n	M (SD)	t(35)	p-value
<b>Number of days in past 30 days using:</b>						
Alcohol	7	.67 (2.6)	2	.03 (.17)	1.5	$p=.15$
<b>Illegal drugs</b>						
Any illicit drug	12	3.4 (5.2)	2	.00 (.00)	3.0	$p<.01$
Opiates	6	2.3 (5.9)	0	.00 (.00)	2.3	$p<.05$
Cocaine	4	.47 (1.5)	0	.00 (.00)	1.9	$p=.06$
Marijuana	4	.94 (3.5)	0	.00 (.00)	1.6	$p=.11$
Methamphetamine	2	1.1 (4.5)	0	.00 (.00)	1.4	$p=.17$

Note: Some missing data; valid percentages displayed.

**Mental Health and Social Support Outcomes.** As can be seen in Table 9, participants reported significant decreases in symptoms on the BSI assessment's global severity index  $t(31)=5.2$ ,  $p<.000$ . Additional statistically significant BSI subscale reductions were found in all nine subscales from baseline to six-month follow-up: depression,  $t(33)=4.5$ ,  $p<.000$ ; psychoticism,  $t(34)=4.3$ ,  $p<.000$ ; somatization,  $t(33)=4.3$ ,  $p<.000$ ; paranoid ideation,  $t(33)=4.1$ ,  $p<.000$ ; panic anxiety,  $t(33)=4.0$ ,  $p<.000$ ; generalized anxiety,  $t(33)=3.8$ ,  $p<.001$ ; obsessive-compulsive,  $t(33)=3.1$ ,  $p<.01$ ; phobic anxiety,  $t(33)=2.9$ ,  $p<.01$ ; and hostility,  $t(33)=2.2$ ,  $p<.05$ .

Participants also reported on the number of days experiencing serious depression, anxiety, or tension in the past 30 days. Results demonstrated that participants significantly decreased depression and anxiety symptoms at six-month follow-up. Depression decreased from 11.7 days at baseline to 5.0 days at follow-up,  $t(34)=3.2$ ,  $p<.01$ . Similarly, anxiety decreased from 13.1 days at baseline to 5.6 at six-month follow-up,  $t(34)=3.4$ ,  $p<.01$ .

Additionally, results showed a significant reduction of trauma symptoms from baseline ( $M=39.1$ ) to follow-up ( $M=31.7$ ),  $t(34)=3.6$ ,  $p<.001$ . At follow-up, the average score did not exceed the severity cut-off of 32, indicative of probable PTSD. In fact, the number of participants that exceeded the cut-off point decreased by almost half, from 64% meeting criteria for probable PTSD at baseline (N = 25) to 38% at six-month follow-up (N=16).

Finally, participants also reported significant improvement in social support from baseline to six-month follow-up. As can be seen in Table 8, participants significantly improved on their overall social support score,  $t(33)=-3.3$ ,  $p<.01$ . Additionally, all subscales were statistically significant from baseline to six-month follow-up including positive social interaction,  $t(33)=-3.2$ ,  $p<.01$ ; emotional social interaction,  $t(33)=-2.7$ ,  $p<.01$ ; affectionate social support  $t(33)=-2.5$ ,  $p<.05$ ; and tangible social support  $t(33)=-2.4$ ,  $p<.05$ .

**Table 9. Mental Health and Social Support Outcomes for Graduates (N=40)**

Variable	Time Period		Significance	
	Baseline M(SD)	Six-Months M(SD)	t(33)=	p
<b>Brief Symptom Inventory (BSI)</b>				
Global severity index	1.1 (0.8)	.48 (0.4)	5.2	p<.000
Depression	1.3 (1.0)	.50 (0.6)	4.5	p<.000
Psychoticism	1.1 (1.1)	.43 (0.6)	4.3	p<.000
Somatization	.71 (0.6)	.32 (0.4)	4.3	p<.000
Paranoid ideation	1.0 (0.9)	.45 (0.6)	4.1	p<.000
Panic Anxiety	1.2 (1.1)	.50 (0.6)	4.0	p<.000
Generalized Anxiety	1.1 (1.1)	.45 (0.7)	3.8	p<.001
Obsessive compulsive	1.4 (1.1)	.75 (0.9)	3.1	p<.01
Phobic Anxiety	.93 (1.2)	.50 (0.6)	2.9	p<.01
Hostility	.63 (0.8)	.35 (0.5)	2.2	p<.05
<b>Number of days in the past 30 days having:</b>				
Serious depression	11.7 (11.8)	5.0 (8.4)	3.2	p<.01
Serious anxiety/tension	13.1 (12.3)	5.6 (9.5)	3.4	p<.01
Troubled by psychological problems	3.8 (1.4)	3.9 (1.93)	-.49	NS
<b>PCL-C total</b>				
	39.4 (17.0)	31.2 (14.0)	4.2	p<.000
<b>Social Support Inventory</b>				
Overall social support	66.6 (21.6)	81.2 (20.7)	-3.3	p<.01
Positive social interaction	10.4 (4.2)	12.9 (3.2)	-3.2	p<.01
Emotional social support	27.3 (9.9)	33.8 (12.3)	-2.7	p<.01
Affectionate social support	10.6 (4.7)	12.9 (3.6)	-2.5	p<.05
Tangible social support	14.7 (5.2)	16.6 (4.5)	-2.4	p<.05

**Therapeutic Alliance Outcomes**

Results from the Working Alliance Inventory (WAI) indicated that participants reported strong relationships with their substance use treatment counselors at six-month follow-up. Participants had an overall high working alliance with their counselor (M=59.2), ranging from 24-82. The subscales were also high with agreement on bond (M=21.2), ranging from 4-28; task (M=19.7) ranging from 10-28; and goal, (M=18.4), ranging from 6-26.

**Participant Satisfaction Outcomes**

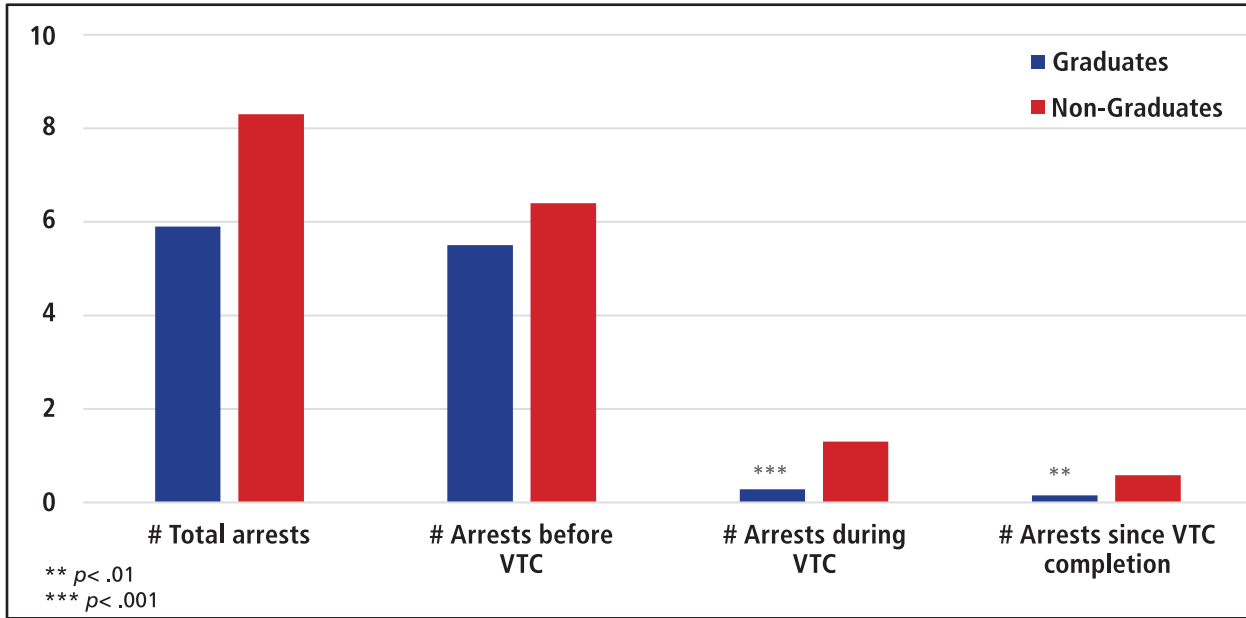
Results from the Participant Satisfaction Survey indicated that participants reported positive satisfaction with the different entities of VTC at six-month follow-up. Participants had an overall high satisfaction with the VTC program (M=137.3), ranging from 24-168. The subscales also had high satisfaction all ranging from 6-42 with the VTC Judge (M=35.1), Veteran Mentor (M=36.2), Veteran Justice Outreach (VJO; M=33.9), and Treatment Counselor (M=32.6).

**Outcome Analyses for Graduates vs. Non-Graduates**

The outcome analyses reported in this section compare those who successfully graduated from the VTC program (N=40) versus those that did not successfully graduate (N=25). An independent sample t-test was conducted to test for differences from baseline to six-month follow-up on re-arrest, substance use, mental health, trauma, social support, working alliance inventory, and participant satisfaction between graduates and non-graduates.

**Re-arrest Outcomes.** As seen in Figure 3, VTC graduates ( $M=5.9$ ) demonstrated less total arrests than non-graduates ( $M=8.3$ ). There were also significant differences between graduates vs. non-graduates for re-arrests during the VTC program,  $t(63)=4.9, p<.001$ ; and after the VTC program,  $t(63)=2.9, p<.01$ . It is important to note that the time after VTC completion varies among participants and may range from one month to two years.

**Figure 3. Re-Arrests between VTC Graduates (N=40) and Non-Graduates (N=25)**



**Substance Use Outcomes.** Participants reported using alcohol and illegal drugs in the past 30 days. As can be seen in Table 10, there were no significant reductions between graduates and non-graduates. Results demonstrated that while VTC graduates significantly decreased their drug use over time, there were no differences between the two groups over reduction in use. In fact, both groups decreased their drug use over time, particularly opiates for graduates ( $M=-2.4$ ) and non-graduates ( $M=-2.7$ ) and methamphetamine for graduates ( $M=-1.1$ ) and non-graduates ( $M=-1.1$ ). Readiness to change and motivation to remain in treatment also were examined but no differences were detected between the two groups.

**Table 10. Substance Use Change Scores for Graduates (N=40) vs. Non-Graduates (N=25)**

	Graduates	Non-Graduates	Significance	
	M (SD)	M (SD)	t(52)	p-value
<b>Number of days in past 30 days using:</b>				
Alcohol	-0.66 (2.7)	-1.3 (3.7)	-0.59	NS
Alcohol 5+ drinks	-0.29 (1.4)	-0.58 (2.0)	-0.64	NS
<b>Illegal drugs</b>				
Any illicit drug	-3.5 (6.7)	-4.2 (7.3)	-0.36	NS
Opiates	-2.4 (6.0)	-2.7 (6.5)	-0.18	NS
Methamphetamine	-1.1 (2.9)	-1.1 (4.6)	.27	NS
Marijuana	-0.97 (3.5)	-1.0 (3.4)	-0.03	NS
Cocaine	-0.49 (1.5)	-0.53 (4.3)	-0.05	NS

Note: Some missing data; valid percentages displayed.



**Mental Health and Social Support Outcomes.** As seen in Table 11, VTC graduates showed significant changes vs. non-graduates on global severity index,  $t(47)=2.3, p<.05$ . Graduates also showed significant changes on four BSI subscales compared to non-graduates: panic anxiety,  $t(52)=2.3, p<.05$ ; generalized anxiety,  $t(52)=2.3, p<.05$ ; depression,  $t(527)=2.2, p<.05$ ; and paranoid ideation,  $t(52)=2.1, p<.05$ . Trauma symptoms did show more reduction for graduates ( $M=-8.2$ ) than non-graduates ( $M=-5.5$ ) but it was not significant. VTC graduates also reported more improvements for overall social support ( $M=14.7$ ) vs. non-graduates ( $M=6.7$ ), and emotional social support for graduates ( $M=6.5$ ) than non-graduates ( $M=1.7$ ).

**Table 11. Mental Health and Social Support Outcomes for Graduates (N=40) and Non-Graduates (N=25)**

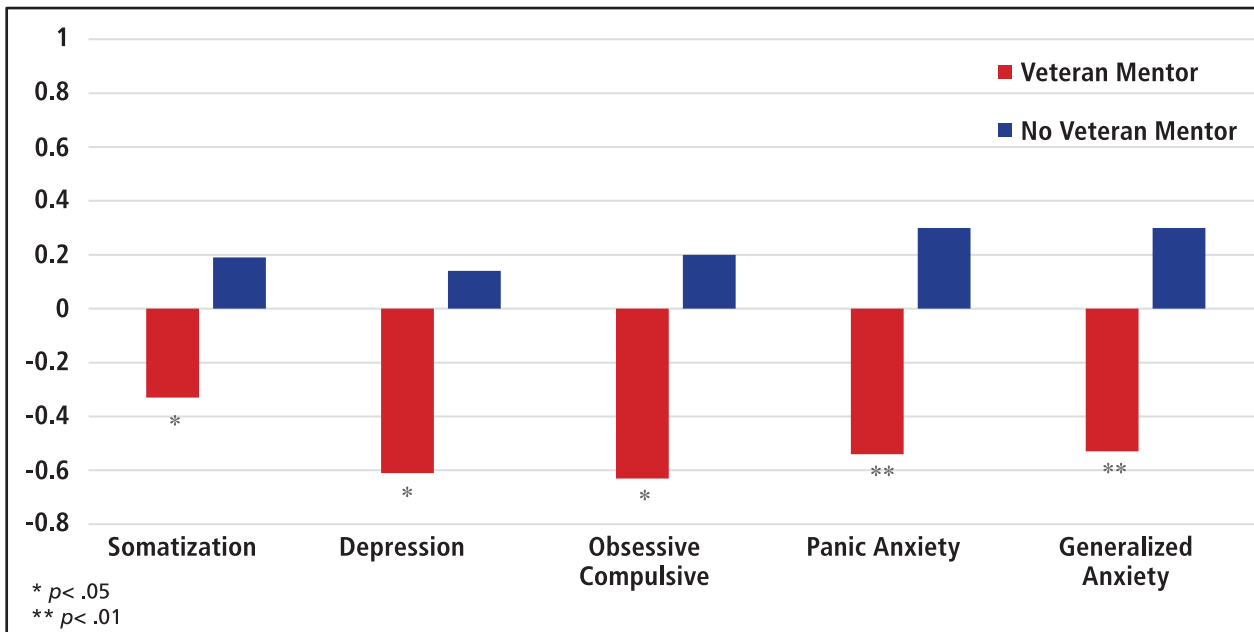
Variable	Graduates	Non-Graduates	Significance	
	M(SD)	M(SD)	t(52)=	p
<b>Brief Symptom Inventory (BSI)</b>				
Global severity index	-.65 (0.6)	-.18 (0.7)	2.3	$p<.05$
Panic Anxiety	-.68 (1.0)	-.04 (0.9)	2.3	$p<.05$
Generalized Anxiety	-.65 (1.0)	-.03 (0.8)	2.3	$p<.05$
Depression	-.77 (1.0)	-.17 (0.9)	2.2	$p<.05$
Paranoid ideation	-.54 (0.8)	-.05 (0.9)	2.1	$p<.05$
Phobic Anxiety	-.48(0.9)	-.37 (0.6)	1.8	$p=.08$
Psychoticism	-.40 (0.5)	-.26 (0.8)	1.7	$p=.10$
Somatization	-.16 (0.8)	.02 (0.4)	1.7	$p=.10$
Obsessive compulsive	-.70 (1.3)	-.25 (0.8)	1.3	NS
Hostility	-.28 (0.7)	-.22 (0.8)	.24	NS
<b>PCL-C total</b>				
	-8.2 (11.4)	-5.5 (13.4)	.77	NS
<b>Social Support Inventory</b>				
	14.7 (25.4)	6.7 (17.1)	-1.2	NS
Emotional social support	6.5 (14.1)	1.7 (7.7)	-1.6	$p=.11$
Positive social interaction	2.5 (4.6)	1.3 (3.6)	-1.0	NS
Affectionate social support	2.3 (5.4)	1.4 (3.9)	.64	NS
Tangible social support	1.9 (4.7)	2.2 (4.3)	.19	NS

## Outcome Analyses for Participants with a Veteran Mentor vs. No Veteran Mentor

The outcome analyses reported in this section compare those with a veteran mentor (N=55) vs. those who did not have a veteran mentor (N=10). An independent sample t-test was conducted to test for differences on re-arrest, substance use, mental health and trauma, and social support.

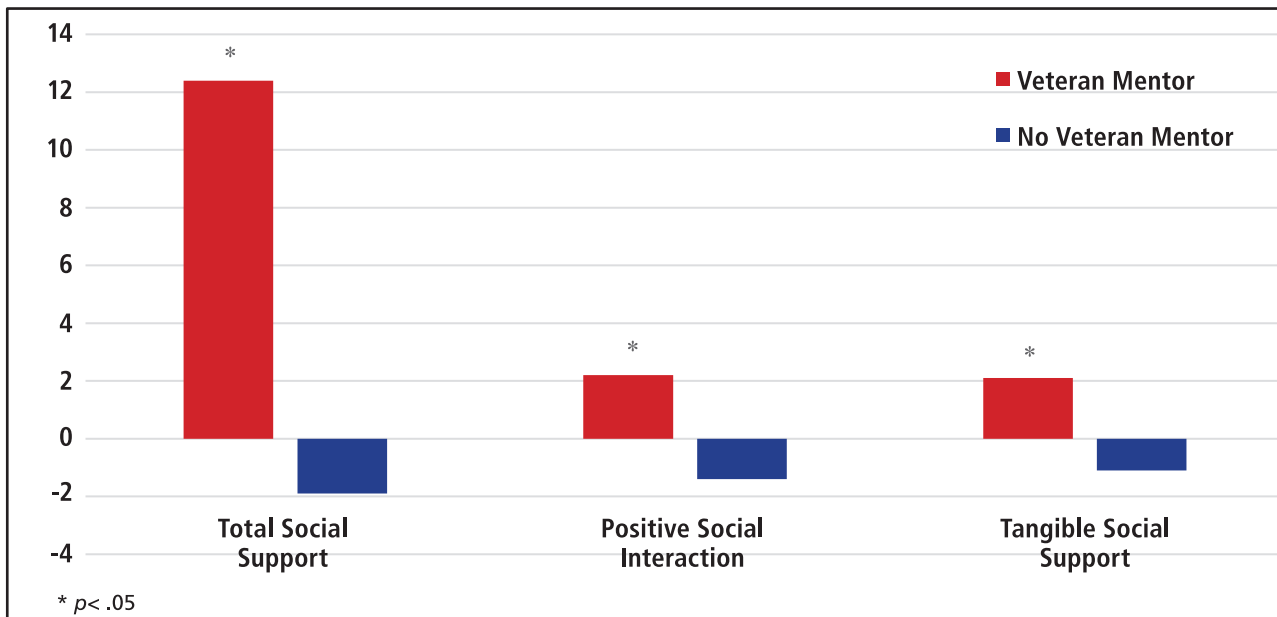
As seen in Figures 4 and 5, there were numerous significant differences on mental health, trauma, and social support for those with a veteran mentor vs. those who did not have one. Those with a veteran mentor demonstrated significant change on four of the nine BSI subscales compared to those who did not have a veteran mentor: somatization,  $t(63)=2.2, p<.05$ ; depression,  $t(63)=2.3, p<.05$ ; obsessive compulsive,  $t(63)=2.2, p<.05$ ; panic anxiety,  $t(63)=2.7, p<.01$ ; and generalized anxiety,  $t(63)=2.8, p<.01$ . Additionally, there was a trend for those with a veteran mentor ( $M=-8.4$ ) to have more reductions in trauma symptomatology vs. those who did not have a veteran mentor ( $M=-.44$ ),  $t(63)=1.9, p=.06$ .

**Figure 4. Mental Health Difference Scores between Those with Veteran Mentor (55) and Those with No Veteran Mentor (N=10)**



Finally, participants also reported differences in change scores for those with a veteran mentor vs. those with not a veteran mentor for overall social support,  $t(64)=-1.8, p=.07$ . Additionally, there were two social support subscales that were statistically significant including positive social interaction,  $t(64)=-2.3, p<.05$ ; and tangible social support  $t(64)=-2.3, p<.05$ .

**Figure 5. Social Support Difference Scores between Those with Veteran Mentor (N=55) and Those with No Veteran Mentor (N=10)**



## Baseline Predictors of Graduation and Re-arrest

The first logistic regression assessed predictors of VTC graduation (see Table 12). Block one of the hierarchical logistic regression was statistically significant,  $\chi^2(63, 4) = 11.03, p < .05$ , Nagelkerke  $R^2 = .217$ . The Hosmer-Lemeshow yielded a nonsignificant value  $\chi^2(8) = 11.92, p = .16$ ; therefore, the model-block was a good fit and accounted for 21.7% of the variance in the dependent variable. Alcohol use in the past 30 days was the only significant predictor within block one (OR = .173,  $p = .029$ ). Those who consumed alcohol in the past 30 days were 5.7 times less likely to graduate from VTC compared to those who did not, when controlling for BSI score, PCL score, and illicit drug use.

The second logistic regression assessed predictors of re-arrest following successful or unsuccessful completion of VTC (see Table 13). The model was statistically significant  $\chi^2(65, 5) = 12.319, p < .05$ , Nagelkerke  $R^2 = .257$ . The Hosmer-Lemeshow yielded a nonsignificant value [ $\chi^2(7) = 7.121, p = .42$ ] indicating that the model was a good fit and accounted for 25.7% of the variance in the dependent variable. Illicit drug use in the past 30 days was the only significant predictor of re-arrest (OR = 5.72,  $p < .05$ ). Those who used illicit drugs in the past 30 days were 5.7 times more likely to get rearrested compared to those who did not, when controlling for history of homelessness, alcohol use, number of times arrested prior to enrollment, and number of days from arrest to enrollment in VTC.

**Table 12. Hierarchical Logistic Regression with VTC Graduation as Dependent Variable**

	B	S.E.	Wald	df	Sig.	Exp(B)	95% C.I. for Exp(B)	
							Lower	Upper
<b>Block 1 (<math>p &lt; .05</math>)</b>								
Illicit Drug Use	.210	.666	.100	1	.752	.811	.220	2.987
Alcohol Use	-1.750	.802	4.780	1	.029	.173	.036	.834
PCL	-.046	.031	2.290	1	.130	.955	.899	1.014
BSI	1.160	.651	3.160	1	.076	3.179	.887	11.389
Constant	1.590	.861	3.430	1	.064	4.920		
<b>Block 2 (<math>p = .051</math>)</b>								
Illicit Drug Use	.213	.668	.102	1	.749	.808	.218	2.992
Alcohol Use	1.740	.819	4.530	1	.033	.175	.035	.871
PCL	.046	2.280	2.276	1	.131	.955	.899	1.014
BSI	1.150	3.100	3.098	1	.078	3.165	.877	11.420
Veteran Mentor	.051	.789	.004	1	.949	1.052	.224	4.938
Constant	1.550	2.000	2.001	1	.157	4.711		

Note. Alcohol and drug use were coded 0 = no and 1 = yes

**Table 13. Binary Logistic Regression with Re-arrest as Dependent Variable**

	B	S.E.	Wald	df	Sig.	Exp(B)	95% C.I. for Exp(B)	
							Lower	Upper
<b>Block 1 (<math>p &lt; .05</math>)</b>								
Arrests prior to enrollment	.065	.044	2.183	1	.140	1.068	.979	1.164
Days from arrest to enrollment	-.002	.003	.605	1	.437	.998	.992	1.003
Alcohol use	-.037	.842	.002	1	.965	.964	.185	5.018
History of homelessness	-.600	.783	.586	1	.444	.549	.118	2.549
Illicit drug use	1.740	.789	4.890	1	.027	5.720	.037	.820
Constant	-.971	1.160	.706	1	.401	.379		

## Discussion

The goal of the Thirteenth Judicial Circuit's VTC program is to provide offenders (who have both misdemeanor and felonious charges) with substance use and mental health treatment, as well as related recovery and wraparound services. The SAMHSA grant program served 89 participants and included a continuum of treatment services including residential, outpatient, and recovery support treatment, mentor assistance, and promoting problem-solving court procedures. The treatment curriculum utilized the Comprehensive Continuous Integrated System of Care (CCISC) model designed to merge mental health and substance use treatment into a comprehensive, integrated model of care. Under this model, several evidence-based treatment curricula were utilized including Motivational Interviewing (MI), Accelerated Resolution Therapy (ART), and Anger Management to address symptoms and behaviors for those presenting with PTSD and anger management problems. Seeking Safety (SS) and Matrix Model concentrates on teaching participants coping skills that not only apply to trauma-related issues but to most real-life situations as well as addressing trauma and substance use simultaneously.

### Baseline Findings

This final evaluation report examined both participant's baseline and outcome information for the VTC program. Participant information examined included demographics, criminal justice involvement, and follow-up outcomes related to re-arrest, substance use, mental health and trauma, social support, therapeutic alliance, and participant satisfaction. Participant demographics suggest mostly white males approximately 44 years old reporting either single or divorced marital status. The majority of participants had either some college or an AA or BA degree, however, only 19% reported working either part-time or fulltime at baseline assessment. About a third were in jail 30 days prior to treatment with 26% residing in residential treatment.

The average length of VTC participation was approximately 11 months that included four months of residential, three months of outpatient, and three months of recovery support. The average length of time from arrest to entering the VTC program was approximately six months. At the time of this report, almost half of the participants (45%) successfully graduated, with 27% participants still enrolled in VTC, and 28% not successfully graduating, primarily due to not completing treatment. All participants had at least one arrest prior to VTC; the average was 3.0 arrests with the majority being felony arrests. Some of the most prevalent arrest charges included fraudulent crimes, burglary-related crimes, possession or sale of controlled substances or drug paraphernalia, and driving under the influence.

At baseline assessment, most participants endorsed alcohol as their primary drug of choice, followed by cocaine and opiates with two-thirds reporting alcohol abuse history and almost all reporting past drug use history. In terms of mental health and trauma, most reported past history of PTSD, anxiety, and depression with almost a third reporting a history of suicide attempts. Finally, almost two-thirds reported a history of homelessness. Additionally, 81% of participants took advantage of the opportunity for a veteran mentor or "Battle Buddy" to help them navigate through the VTC program. The presence and involvement of veteran mentors is one of the fundamental features of this program that sets the VTC model apart from other problem-solving courts.

### Outcome Findings

**VTC Graduates.** As stated in the results section, outcome analyses reported were completed on the 40 participants who successfully graduated from the VTC program. In terms of substance use, results demonstrated that there was a trend for alcohol use reduction, however, illegal drug use did decrease significantly with opiate use as the drug decreasing the most from baseline to six-month follow-up. This is impressive since almost two-thirds of the participants reported being in jail or residential treatment 30 days prior to entering the VTC program.

Mental health symptomatology showed promising outcomes after six-months. This study found higher scores at baseline for mental health symptomatology, with global severity and all nine subscales reducing significantly from baseline to six-month follow-up. At baseline, average participant global severity index scores fell under the 96th percentile of the BSI norms for adult non-patients. This is an interesting finding because it indicates that participants in the program are entering with high levels of mental health problems.



Future research that includes a larger, more diverse sample size may be needed to conclude whether or not this finding is generalizable.

In support for the findings of the BSI, self-reported days of experiencing serious depression and anxiety or tension in the past 30 days were also reduced at six-month follow-up. Although mental health seems to be a prevalent issue in this population, VTCs evidence-based interventions targeting participants' mental health symptomatology appear to be working in this program. Results also indicated a significant decrease in trauma symptoms as documented by the PCL-M. After six months of treatment, the average score on the PCL-M decreased significantly from a score suggesting probable PTSD to a score of 31 that was just below the cut-off clinical score. This result suggests that participants are entering the program with high levels of trauma, however after six months trauma symptoms are significantly reduced.

Participants reported significantly more social support following participation in the VTC program. Specifically, participants reported more tangible and affectionate support as well as enhanced positive social interaction. Participants reported learning how to move from negative social relationships to more positive healthy supportive relationships with friends and family members. In line with these findings, participants also reported strong relationships with their court-appointed counselors at follow-up. Most participants were pleased with the therapeutic bond developed with program staff, and they felt there was a shared client-counselor vision regarding therapeutic tasks and goals. Additionally, most of the participants took the opportunity to work with a veteran mentor who helped them navigate their treatment and court trajectory. This "Battle Buddy" who has or did have military experience has been found to be extremely beneficial and bring their own valuable experience and willingness to serve in a time of need. Justice-involved veterans benefit greatly from the support offered by veteran mentors, as they often require assistance with stabilizing their personal life as well as someone to help navigate the complex veterans benefit system which fellow veterans are well positioned to do.

**VTC Graduates vs. Non-Graduates.** The outcome analyses reported in this section compare those who successfully graduated from the VTC program (N=40) versus those that did not successfully graduate (N=25). These include re-arrest rates, substance use, mental health, trauma, and social support. Several important distinctions were examined between graduates and non-graduates from the VTC program. Analyses demonstrated that graduates had significantly less re-arrest rates than those that did not graduate from the VTC program. Graduates also had less criminal justice involvement prior to admittance into the program than non-graduates.

These were also significant changes in mental health symptomatology. Specifically, graduates decreased scores in psychoticism and depression and had greater reductions in trauma symptomatology than non-graduates. Finally, graduates from the VTC program also reported significant improvement in social support, most notably emotional social support and positive social interaction whereas non-graduates had no significant improvement in social support. Moving to the goal of enhancing family relationships and improving social supports, the number of prosocial activities and relationships tended to increase over the course of program participation—especially for graduates—suggesting many individuals are enhancing the array of positive social supports due to the program. These additional changes in mental health, trauma symptomatology, and social support are very important as participants utilize coping skills upon graduation from the VTC program. Clearly, those who have graduated successfully from the VTC program are utilizing these skills and enhancing their positive social support.

**Participants with Veteran Mentor vs. No Veteran Mentor.** Participants who had a mentor had significant decreases on five of the nine mental health symptomatology subscales compared to those who did not have a veteran mentor. Specifically, somatization, depression, obsessive compulsive, panic anxiety, and generalized anxiety all demonstrated significant decreases from baseline to six-month follow-up compared to those with no veteran mentor. There was also a trend for those with a veteran mentor to have more reductions in trauma symptomatology vs. those who did not have a veteran mentor. Finally, participants with a veteran mentor also reported increases in overall social support, as well as the two subscales measuring positive social interaction and tangible social support.

These results demonstrate the utility of the veteran mentor program, particularly as it relates to mental health issues and positive social support. The strength of the mentor program lies most in the shared

experiences that lay a foundation of trust and facilitate rapid relationship development among mentors and mentees. Most perceive themselves to be members of “the same tribe” that fosters a sense of belonging and accountability. Given these positive results for the mentoring program, future studies should evaluate how the roles of the mentor and mentee are clearly delineated and how potential mentors are properly identified and trained.

**Predictors of Graduation and Re-arrest.** Logistic regression analyses were conducted to assess predictors of VTC graduation and re-arrest. In terms of graduation, results demonstrated that those who consumed alcohol in the past 30 days were almost six times less likely to graduate from VTC compared to those who did not, when controlling for factors such as mental health, trauma, and illicit drug use. The second logistic regression assessed predictors of re-arrest following successful or unsuccessful completion of VTC. Illicit drug use in the past 30 days was the only significant predictor of re-arrest; those who used illegal drugs in the past 30 days were 5.7 times more likely to get rearrested compared to those who did not, when controlling for history of homelessness, alcohol use, number of times arrested prior to enrollment, and number of days from arrest to enrollment in VTC. Taken together, these results suggest that alcohol and drug use are important factors to assess at baseline as potential predictors of graduation success and recidivism.

## Accomplishments

During the administration of this grant, AOC had several accomplishments with Problem Solving Courts in general and specifically with Veteran’s Treatment Court:

- **Needs Assessment:** In 2017, AOC contracted with Dr. Kathleen Moore to complete a Needs Assessment, outlining the needs of the PSC program as a whole. A copy of this Needs Assessment can be found online at <https://www.fljud13.org/Portals/0/Forms/pdfs/drugcourt/Problem%20solving%20court%20needs%20assessment%20final%2010-10-17.pdf> The completion of the Needs Assessment started a process of the Thirteenth Judicial Circuit Court working towards the National Association of Drug Court Professionals (NADCP) best practice standards.
- **Oversight Committee:** In 2018, the Thirteenth Judicial Circuit’s Problem Solving Court Oversight Committee was created, which was memorialized by Administrative Order S-2018-063 (see Appendix A). The Oversight Committee includes the Thirteenth Judicial Circuit Court Chief Judge, VTC Judge, Trial Court Administrator, elected Public Defender, and elected State Attorney. This Committee addresses strategic issues related to the Problem Solving Courts, including VTC.
- **Veterans Treatment Court (VTC) Policy and Procedure Manual:** In 2018, the AOC contracted with Dr. Kathleen Moore to complete the Veterans Treatment Court Policy and Procedure Manual, which can be found online at <https://www.fljud13.org/Portals/0/Forms/pdfs/drugcourt/VTC%20policy%20and%20procedural%20manual%209-18.pdf> This policy and procedure manual describes VTC eligibility criteria, team member roles, VTC phases, and the history of the program.

In addition to the accomplishments made by the AOC, DACCO Behavioral Health had several accomplishments relating to this VTC grant:

- **Adaptation of Treatment Services:** DACCO adapted their services to meet the needs of the veterans involved in this grant, including by providing a veteran-specific dorm in the men’s residential program to facilitate comradery among these participants.
- **Veteran Mentors:** DACCO also worked closely with veteran mentors to try to encourage participant retention in treatment and program compliance.

## Challenges

In addition to the accomplishments of this grant initiative, there were several challenges relating to this VTC grant:

- **Accelerated Resolution Therapy (ART):** During the treatment regimen, ART was only provided to 12 grant participants. There were various reasons for this, including resistance by veterans to engage in this intervention, staff turnover at DACCO Behavioral Health, and veterans transferring to another substance provider before engaging in ART. If more veterans had engaged in this evidenced-based practice, there may have been more of a reduction in PTSD symptoms than were already experienced.
- **Client Enrollment:** The anticipated enrollment over the three-year period of the grant was 120 participants, however, the final re-enrollment of grant participants was 89 veterans. One of the main reasons for this is because referrals and admissions into the VTC program decreased during the three-year period covering the grant. Another factor that affected grant enrollment was that several veterans enrolled in the VTC court program were ineligible to attend treatment at DACCO Behavioral Health, due to their criminal charges or severity of mental health issues.

## Conclusions

The results of this evaluation clearly indicate that the VTC program is effective in reducing alcohol/drug use and mental health symptoms for those participants who successfully graduated from the VTC program. Veterans particularly improved when provided a combination of mental health and trauma-specific treatment as well as VTC mentor services. The importance of trauma-specific therapy and positive peer role models may be important for veterans with combat exposure who have re-integrated into a society unfamiliar with the struggles associated with combat experience. Navigating complex social and mental health systems necessary for recovery is difficult for veterans with PTSD and other mental health conditions. VTCs are designed to integrate therapy, social services, and peer support to help the veteran navigate these systems. Our findings suggest that involvement in VTC services produce sustainable improvements in recovery and PTSD for participants, particularly for those who successfully graduated from the program. These results support this treatment approach for justice-involved veterans involved in the criminal justice system and lend a degree of empirical support to providing substance use and mental health services under the umbrella of a Veterans Treatment Court.



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## Appendix A

### Administrative Order for Problem Solving Courts Oversight Committee

#### IN THE THIRTEENTH JUDICIAL CIRCUIT HILLSBOROUGH COUNTY, FLORIDA

#### ADMINISTRATIVE ORDER S-2018-063

#### PROBLEM-SOLVING COURTS OVERSIGHT COMMITTEE

Florida's problem-solving courts address the root causes of justice system involvement through specialized dockets, multidisciplinary teams, and a non-adversarial approach. Offering evidence-based treatment, judicial supervision, and accountability, problem-solving courts provide individualized interventions for participants, thereby reducing recidivism and promoting confidence and satisfaction with the justice system process.

In 1989, Florida started the national problem-solving court movement by creating the first drug court in the country. In 1992, the Thirteenth Judicial Circuit implemented its first problem-solving court – the Adult Drug Pretrial Intervention Court. Other types of problem-solving court dockets subsequently followed, using the drug court model, and were implemented to assist individuals with a range of problems such as drug addiction, mental illness, domestic violence, child abuse / neglect, and homelessness.

Problem-solving courts offer a specialized court docket and include, but are not limited to, the following elements:

- **Problem-solving team.** A broad-based team of justice system stakeholders including judges, case managers, prosecutors, defense attorneys, treatment professionals, law enforcement officers, corrections personnel, and guardians ad litem.
- **Non-adversarial approach.** A commitment to offering alternatives to the traditional adversarial litigation process.
- **Continuum of individualized treatment services.** An array of evidence-based services designed to identify and meet the unique needs of each participant.
- **Judicial leadership and interaction.** A judge who leads the problem-solving team and monitors the court case using an increased number of hearings for monitoring compliance and progress.

- **Responses to participant compliance.** The use of graduated, individualized, and coordinated responses, both for incentives and sanctions, to promote both public safety and the participants' success.

This circuit's drug court and veterans treatment court have historically operated with separate oversight committees to ensure proper training and implementation of the respective problem-solving courts. In addition to drug court and veterans treatment court, this circuit's other problem-solving courts include juvenile drug court, family dependency treatment court, mental health court, and Marchman Act court. Rather than delegate oversight of the circuit's problem-solving courts to individual committees, it is proper for the efficient and effective administration of justice to create a central oversight committee of all of this circuit's problem-solving courts so that all stakeholders are given a voice about and made aware of issues surrounding the operation of these specialty courts.

By the power vested in the chief judge under article V, section 2(d), Florida Constitution; section 43.26, Florida Statutes; and Florida Rule of Judicial Administration 2.215(b)(2), it is ORDERED:

**1. Establishment of Committee**

The Thirteenth Judicial Circuit Problem-Solving Courts Oversight Committee (Committee) is hereby established. The mission of the Committee is to oversee the circuit's problem-solving courts, to recommend strategies to maintain and improve the quality and effectiveness of these courts' operations, and to ensure access to appropriate resources through the collaborative services of the courts, treatment and the community. In addition, the Committee will be responsible for overall policy development that reflects Best Practices Standards as outlined by the National Association of Drug Court Professionals and the Florida Adult Drug Court Best Practice Standards, as well as, 10 Key Components of Veterans Treatment Courts.

**2. Composition of the Committee**

Upon invitation and consent, the Committee will be comprised of the following members:

- A. The Chief Judge of the Thirteenth Judicial Circuit;
- B. The Trial Court Administrator of the Thirteenth Judicial Circuit;
- C. The presiding judge of each of the following divisions:
  - i. Drug Court;



- ii. Juvenile Drug Court;
  - iii. Family Dependency Treatment Court;
  - iv. Veterans Treatment Court; and
  - v. Mental Health Court.
- D. The Public Defender of the Thirteenth Judicial Circuit plus any designees;
  - E. The State Attorney of the Thirteenth Judicial Circuit plus any designees;
  - F. The Chief Deputy Court Administrator of Court Programs of the Administrative Office of the Courts; and
  - G. The Director of Problem-Solving Courts of the Administrative Office of the Courts;

### 3. **Committee Leadership and Structure**

#### A. **Committee Chair and Executive Chair**

Chief Judge **Ronald N. Ficarrotta** is appointed as the chair of the Committee. As chair, the chief judge may make decisions that pertain to the Committee with consultation of the executive chair. Trial Court Administrator **Gina Justice** is appointed as executive chair of the Committee.

#### B. **Operational Subcommittee**

The Operational Subcommittee is responsible for reviewing and making recommendations on screenings and assessments, wait lists, case staffings, incentives / sanctions, and phases as well as developing specialized dockets or tracks for each of the problem-solving courts. **Julia Schilling**, Administrative Office of the Courts, is appointed as chair of the Operational Subcommittee and **Marie Marino**, Office of the Public Defender, is appointed as co-chair of the Operational Subcommittee.

#### C. **Strategic Planning Subcommittee**

The Strategic Planning Subcommittee is responsible for compiling and analyzing sufficient data from problem-solving courts, treatment providers, and the Clerk of the Circuit Court; reviewing performance measures for problem-solving courts established by the National Center for State Courts; recommending specific performance measures to be used in each of the problem-solving courts; prioritizing the use of resources and setting concrete goals for the future of the circuit's problem-solving courts; developing training programs; and establishing community partnerships. **Jeria Wilds**, Office of the State Attorney, is appointed as chair of the Strategic Planning Subcommittee and **Rocky Brancato**, Office of the



Public Defender, is appointed as co-chair of the Strategic Planning Subcommittee.

D. Treatment Service Providers Subcommittee

The Treatment Service Providers Subcommittee is responsible for identifying best practices for screening and assessment tools, including co-occurring tools. In addition, treatment service providers will be responsible for identifying national evidence-based treatment practices, including for co-occurring disorders and trauma-informed care. Each treatment provider will maintain a participant database and written drug testing policy that will be submitted to the Administrative Office of the Courts annually. All court reports will include any incentives and sanctions so that the judge may reinforce on the record. The Treatment Service Providers Subcommittee will solicit input from and disseminate information to community-based treatment providers that are utilized in the circuit's problem-solving courts. **Julia Schilling**, Administrative Office of the Courts, is appointed as chair of the Treatment Service Providers Subcommittee.

E. Drug Court Subcommittee

The Drug Court Subcommittee is responsible for overseeing operations in the Drug Court and making recommendations to improve the quality and effectiveness of Drug Court's operations. The Honorable **Vivian T. Corvo** is appointed as chair of the Drug Court Subcommittee.

F. Juvenile Drug Court Subcommittee

The Juvenile Drug Court Subcommittee is responsible for overseeing operations in the Juvenile Drug Court and making recommendations to improve the quality and effectiveness of Juvenile Drug Court's operations. The Honorable **Vivian T. Corvo** is appointed as chair of the Juvenile Drug Court Subcommittee.

G. Family Dependency Treatment Court Subcommittee

The Family Dependency Treatment Court Subcommittee is responsible for overseeing operations in the Family Dependency Treatment Court and making recommendations to improve the quality and effectiveness of Family Dependency Treatment Court's operations. The Honorable **Jack E. Espinosa, Jr.** is appointed as chair of the Family Dependency Treatment Court Subcommittee.

H. Veterans Treatment Court Subcommittee

The Veterans Treatment Court Subcommittee is responsible for overseeing operations in the Veterans Treatment Court and making recommendations to improve the quality and effectiveness of Veterans Treatment Court's operations.



The Honorable **Michael J. Scionti** is appointed as chair of the Veterans Treatment Court Subcommittee.

I. Mental Health Court Subcommittee

The Mental Health Court Subcommittee is responsible for overseeing operations in the Mental Health Court and making recommendations to improve the quality and effectiveness of Mental Health Court's operations. The Honorable **Ronald N. Ficarrotta** is appointed as chair of the Mental Health Court Subcommittee.

J. Marchman Act Court Subcommittee

The Marchman Act Court Subcommittee is responsible for overseeing operations in the Marchman Act Court and making recommendations to improve the quality and effectiveness of Marchman Act Court's operations. The Honorable **Jack E. Espinosa, Jr.** is appointed as chair of the Marchman Act Court Subcommittee.

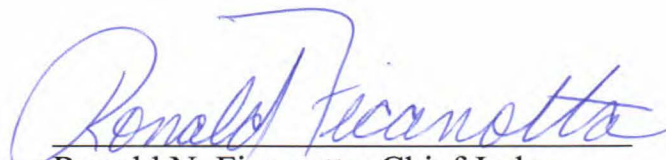
4. Meetings

The Committee will meet quarterly to review the operations of the problem-solving courts in the Thirteenth Judicial Circuit. The respective subcommittees will meet at least quarterly at the discretion of the subcommittee chair.

5. Effective Date

This administrative order is effective January 1, 2019.

ENTERED in Tampa, Hillsborough County, Florida, on December 27, 2018.

  
Ronald N. Ficarrotta, Chief Judge

Original to: Pat Frank, Clerk of the Circuit Court

Copy to: All Presiding Judges of Problem-Solving Courts  
Andrew H. Warren, State Attorney  
Julianne Holt, Public Defender  
Gina Justice, Trial Court Administrator  
K. Angela Smith, Chief Deputy Court Administrator of Court Programs, AOC  
Julia Schilling, Director of Problem-Solving Courts, AOC

Page 5 of 5 – Administrative Order S-2018-063 (*Problem Solving Courts Oversight Committee*)



