This survey is intended to get individual feedback from the participants of the Mendocino County Collaborative Courts regarding program services and participant needs. The individual responses will be maintained confidentially and reported in a general aggregate format. Results are intended to be used in guiding program decisions and development.

Thank you for your time!

|  |
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| 1. Which collaborative court do you participate?
 |
| Family Dependency Drug Court (FDDC) |  |  |
| Adult Drug Court (ADC) |  |  |
| Behavioral Health Court (BHC, aka 11a court) |  |  |
|  |  |  |
| 1. Today’s Date
 |
|  |  |  |
|  |  | MM/DD/YY |
|  |  |  |
| 1. When did you start the program?
 |
|  |  |  |
|  |  | MM/DD/YY |
|  |  |  |
| 1. What is your gender?
 |
| Male |  | Female |  |
|  |  |  |
| 1. What is your race? Check one please.
 |
| African American/Black |  | Caucasian/White |  | Asian |  |
| Bi-Racial |  | Other |  |  |  |
|  |
| 1. Are you Hispanic?
 |
| Yes |  | No |  |
|  |  |  |
| 1. Are you currently employed?
 |
| Yes |  | No |  |
|  |  |  |  |
| 1. Have you ever been on probation and/or parole?
 |
| Yes |  | No |  |
|  |  |  |  |
| 1. What is your highest level of education?
 |
| Some high school |  | HS Diploma |  | GED |  |
| Some College |  | Completed College Degree |  |  |  |
|  |  |  |  |  |  |
| 1. Have you ever been in substance abuse treatment before?
 |
| Yes |  | No |  |
|  |  |  |  |
| 1. Have you ever been in mental health treatment before?
 |
| Yes |  | No |  |
|  |  |  |  |
| 1. Are you currently taking medications for a diagnosed mental health illness?
 |
| Yes |  | No |  |
|  |  |  |  |
| 1. Identify which of the following services are needed by you as a participants of the collaborative court (Please check all that apply). If needed, identify if it is available.
 |
| Adult Services | Needed |  | Available |
| Substance Abuse Treatment  |  |  |  |
| Mental Health Treatment  |  |  |  |
| Primary Medical Care |  |  |  |
| Dental Services |  |  |  |
| Child Care Services |  |  |  |
| Transportation Services |  |  |  |
| Parenting Services |  |  |  |
| Housing Assistance |  |  |  |
| Employment Assistance |  |  |  |
| Domestic Violence Services |  |  |  |
| Continuing Care/Recovery Support Services |  |  |  |
| Trauma Services |  |  |  |
| Family Planning Services |  |  |  |
| Legal Services |  |  |  |
| Child Welfare Services/Support |  |  |  |
| Probation |  |  |  |
| Peer Mentors |  |  |  |
| Other |  |  |  |
| Other please specify |  |  |
| Children’s Services | Needed |  | Available |
| Substance Abuse Treatment Services |  |  |  |
| Substance Abuse Prevention Services |  |  |  |
| Child Development Services |  |  |  |
| Mental Health Treatment  |  |  |  |
| Primary Pediatric Health Care |  |  |  |
| Dental Services |  |  |  |
| Educational Services |  |  |  |
| Neurological Services |  |  |  |
| Other |  |  |  |
| Other please specify |  |  |  |
|  |  |  |  |
| 1. Are services easily accessible (hours, location, language)?
 |
| Yes |  | No |  |
|  |  |  |  |
| If not easily accessible, what are the challenges? |
| Hours | Yes |  | No |  |
| Location | Yes |  | No |  |
| Language | Yes |  | No |  |
| Other | Yes |  | No |  |
| Other please specify |  |  |  |  |
|  |  |  |  |
| 1. Identify which of the following services needed by participants are NOT easily accessible and why.
 |
| Adult Services | Hours |  | Location |  | Language |
| Substance Abuse Treatment for adults |  |  |  |  |  |
| Mental Health Treatment  |  |  |  |  |  |
| Primary Medical Care |  |  |  |  |  |
| Dental Services |  |  |  |  |  |
| Child Care Services |  |  |  |  |  |
| Transportation Services |  |  |  |  |  |
| Parenting Services |  |  |  |  |  |
| Housing Assistance |  |  |  |  |  |
| Employment Assistance |  |  |  |  |  |
| Domestic Violence Services |  |  |  |  |  |
| Continuing Care/Recovery Support Services |  |  |  |  |  |
| Trauma Services |  |  |  |  |  |
| Family Planning Services |  |  |  |  |  |
| Legal Services |  |  |  |  |  |
| Child Welfare Services/Support |  |  |  |  |  |
| Probation |  |  |  |  |  |
| Peer Mentors |  |  |  |  |  |
| Other |  |  |  |  |  |
| Other please specify |  |  |
| Children’s Services | Hours |  | Location |  | Language |
| Substance Abuse Treatment Services |  |  |  |  |  |
| Substance Abuse Prevention Services |  |  |  |  |  |
| Child Development Services |  |  |  |  |  |
| Mental Health Treatment  |  |  |  |  |  |
| Primary Pediatric Health Care |  |  |  |  |  |
| Dental Services |  |  |  |  |  |
| Educational Services |  |  |  |  |  |
| Neurological Services |  |  |  |  |  |
| Other |  |  |  |  |  |
| Other please specify |  |  |  |  |  |
|  |  |  |  |

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| --- |
| 1. Do you currently have a spouse/significant other who needs any of the services listed below?
 |
| Yes |  | No |  |
|  |  |  |  |
| 1. If needed by spouse/significant other, please check all that apply and identify if it is available.
 |
| Adult Services | Needed |  | Available |
| Substance Abuse Treatment  |  |  |  |
| Mental Health Treatment  |  |  |  |
| Primary Medical Care |  |  |  |
| Dental Services |  |  |  |
| Child Care Services |  |  |  |
| Transportation Services |  |  |  |
| Parenting Services |  |  |  |
| Housing Assistance |  |  |  |
| Employment Assistance |  |  |  |
| Domestic Violence Services |  |  |  |
| Continuing Care/Recovery Support Services |  |  |  |
| Trauma Services |  |  |  |
| Family Planning Services |  |  |  |
| Legal Services |  |  |  |
| Child Welfare Services/Support |  |  |  |
| Probation |  |  |  |
| Peer Mentors |  |  |  |
| Other |  |  |  |
| Other please specify |  |  |
|  |
| 1. Please provide any additional information that would assist in improving services to participants of the collaborative court.
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