Final Report of the Evaluation of the Community Reporting
Engagement Support and Treatment Center (CREST)

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EXECUTIVE SUMMARY

The Department of Mental Health and Addiction Services (DMHAS) contracted with Central Connecticut State University to evaluate The Connection, Inc.’s Community Reporting Engagement Support and Treatment Program (CREST). CREST is a day reporting program for pretrial and convicted offenders who have a serious mental illness or co-occurring psychiatric and substance abuse problem. It is an intensive day reporting, monitoring, recovery support, and skill building program for up to 30 clients in New Haven. The services provided at CREST are coupled with clinical services offered by the DMHAS-operated Connecticut Mental Health Center (CMHC). CREST began receiving clients in July of 2007 and will continue to be DMHAS-funded through June of 2010.

Research Questions and Design

This evaluation focused on three primary questions. First, was the program implemented according to its prescribed treatment model and did it follow the DMHAS contract? Second, what were the program results for those clients participating in CREST? Third, for those clients successfully completing CREST, were they able to continue to be successful and not have future contact with the criminal justice system?

The evaluation incorporated both qualitative and quantitative methods within the research design. The qualitative methods consisted of on-site program observations and informal discussions with CREST and DMHAS staff. The purpose of the qualitative analysis was to understand how CREST was being implemented and to identify any barriers that may have affected this implementation. This analysis enabled us to determine program fidelity, that is, was CREST being operated in a manner that allowed for maximum client benefit.

The quantitative aspect of the evaluation utilized a secondary analysis of existing data. These data were used for determining program utilization rates completion rates, and rearrest rates after clients had left CREST. Specifically, we collected data from The Connection, Inc.’s management information system on clients referred to CREST between July 2007 and March 1, 2009. Some data were available on all clients referred to CREST while other data was only available for those who were admitted.

Summary of Outcomes

Referral and selection process. A well planned and coordinated referral and selection process is necessary for any program to be successful. This process must have a defined target population along with collaboration and buy-in with criminal justice agencies. We found that CREST succeeded in having a defined target population and not accepting large numbers of clients who were not fit for this program. Even though CREST was below capacity and there was pressure to admit as many clients as possible, CREST appeared to primarily select only those referrals who met the admission criteria.

We are concerned over the low number of referrals from particular criminal justice entities. CSSD bail staff only provided four referrals while DOC parole officers only referred nine parolees. The large number of offenders in Connecticut with serious mental illness has been well documented at both the pre-trial and post-prison release aspects of the criminal justice
system. Based on this, we expected many more referrals from bail and parole. It is important to point out that DMHAS and CREST staff made several attempts to engage these entities.

**Program fidelity.** In a recent review of the literature on intensive case management in diversion programs for mentally disordered offenders, Loveland and Boyle (2007) note that one of the few conclusions that can be culled from the few existing studies in this area is that services must be “intensive and comprehensive, including housing, psychiatric, vocational, and addiction treatment services” (p. 145). A strength of the CREST program is that it attempts to address these needs: 1) housing and vocational needs are addressed through a housing coordinator and a vocational counselor on staff; 2) psychiatric needs are addressed through CMHC staff, and the CREST staff facilitate group programming such as Start Now and IMR; and, 3) substance abuse needs are addressed through group programming such as Relapse Prevention and Growing Spiritually, on site 12 Step activities, toxicology screens and referrals for intensive treatment. Basic needs such as food, hygiene are also addressed on site.

**Program outcomes.** During the study period there were 57 discharges from CREST. Of these, 56% \((n=32)\) completed the program and 44% \((n=25)\) did not. While there is no established benchmark for success, we found CREST’s completion rate to be similar to other recent evaluations of mental health offenders. CREST was able to engage clients for a long period of time. For instance, while the program was initially supposed to last for four months, CREST completers attended the program an average of 183 days (six months). The majority of completers \((78\%)\) were in CREST for four months to one year. This suggests the program was successful in engaging and retaining clients. Even program noncompleters averaged three months of attendance. Overall, this suggests that the program was successful in engaging clients.

There were only 20 clients who had been successfully discharged from CREST for more than six months and 5 who had been successfully discharged for over 1 year. Because of these low numbers and the lack of a control group, we cannot draw any definitive conclusions regarding CREST’s long term affects on involvement with the criminal justice system. We are, however, encouraged by the results in following all of the clients who were successfully discharged. As of March 1, 2009, only 6 of the 32 clients have been rearrested \((15\%)\), with one being sentenced to prison. The program components most related to long term success are participation in the Start Now and positive reinforcers (gift certificates for achieving specific goals while in CREST).

**Overall Conclusions**

The evaluation of CREST leads us to three overall conclusions. First, CREST was a well planned and properly implemented program. Our observations found that CREST components were relevant to theory and research on individuals with serious mental illness. Second, the number of appropriate referrals was relatively low given the presumed need for mental health programs that target offenders. The DMHAS and CREST staffs made substantial efforts to engage various criminal justice agencies but appeared to struggle to obtain appropriate referrals. Third, CREST was able to have positive effects on participants and had a program completion rate similar to other court-based mental health programs.
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INTRODUCTION

The Department of Mental Health and Addiction Services (DMHAS) contracted with Central Connecticut State University to evaluate The Connection, Inc.’s Community Reporting Engagement Support and Treatment Program (CREST). CREST is a day reporting program for pretrial and convicted offenders who have a serious mental illness or co-occurring psychiatric and substance abuse problem. CREST began receiving clients in July of 2007 and will continue to be DMHAS-funded through June of 2010.

Need for Programs Targeting Offenders with Serious Mental Illness

The role of the DMHAS in the Connecticut criminal justice system continues to increase as the number of offenders with mental health issues increases. A 2004 report published by Lieutenant Governor Kevin Sullivan stated that the number of prisoners with mental illnesses comprised 16% of the inmate population and had increased 40% from 2000 to 2004 (CITE). In addition, the 2008 State of Connecticut Recidivism Study (Office of Policy and Management, 2008) found that 19% of inmates released into the community at the end of their prison sentence had a serious mental illness (1,369 out of 6,925 released inmates). The Recidivism Study also found that 60% of these 1,369 inmates were rearrested within two years of their release, with 22% receiving a new prison sentence.

The Sullivan report (2004) also reported that serious mentally ill offenders who had co-occurring substance abuse problems were more likely to be reincarcerated due to a lack of community alternatives. To better address the needs of offenders with serious mental illness, the DMHAS Forensic Services Division was tasked with coordinating and implementing evaluation and treatment services for offenders with serious mental illness and substance use disorders and to serve components of the criminal justice system, especially the courts (DMHAS, 2009). Their range of services extends across the entire criminal justice system from pre-trial to after offenders complete their prison sentence and are released back into the community.

The Community Reporting Engagement Support and Treatment Center (CREST) was developed in response to a Request for Proposals released by DMHAS to implement a day reporting center that combined intensive support, clinical services, and supervision for adults with serious mental illness. The program is operated by a nonprofit organization (The Connection, Inc.) and is an intensive day reporting, monitoring, recovery support, and skill building program for up to 30 clients in New Haven. The services provided at CREST are coupled with clinical services offered by the DMHAS-operated Connecticut Mental Health Center (CMHC).

Overview of CREST

CREST is a Mental Health Day Reporting (MHDRC) program for adults age 18 and older who live in New Haven. The program began accepting clients in July 2007 and is open to individuals coming into contact or involved in the criminal justice system that have psychiatric or co-occurring psychiatric and substance use problems. Clients can be referred by any criminal justice entity or offender service provider but it was expected that most referrals would come
from Court Support Service Division (CSSD) bail commissioners (pre-trial), DMHAS jail diversion staff (pre-trial), CSSD jail reinterview staff (pre-trial), public defenders (primarily pre-trial), probation officers (post-conviction), parole officers (post-prison), and halfway houses (post-prison).

CREST’s overall objective is to provide its clients with a positive sense of direction, help them decrease their criminal behavior, and aid them in obtaining the proper level and type of treatment. The CREST strategy involves addressing the criminogenic needs that have been commonly found to be associated with ongoing criminal behavior. These include:

- Psychiatric instability and poor coping skills
- Lack of adequate housing
- Substance abuse or dependence
- Lack of adequate education
- Lack of employment skills
- Dysfunctional family and peer relationships
- Antisocial attitudes and values

To address these needs, CREST provides an array of services that combine the use of detailed assessments, referrals and coordination for mental health and substance abuse treatment, psychoeducational programs, and assistance in fulfilling their basic needs (e.g., life skills, transportation, clothing, etc.). CREST’s specific services and program components consist of:

- Assessments (risk/need)
- Vocational Counseling
- Housing/Transitional Planning
- Random Drug/Alcohol Screening
- Compliance with the Criminal Justice System
- Cognitive Skills Training
- Daily Living Skills Training
- Substance Abuse Education
- Crisis Intervention
- Transportation Services

Under the DMHAS contract, CREST is funded to provide services that include nonclinical intake and assessment, referral, coordination, transportation, weekly drug screens, daily living training, and social activities. More specifically, the contract required that CREST:

1. As part of the day reporting component, provide monitoring and recovery support services for a minimum of 30 persons, and will operate seven (7) days per week from 8:30 am to 4:30 pm, and a minimum of (3) three evenings per week until 8:00 p.m.

2. Collaborate with the Department’s Local Mental Health Authority (LMHA), Connecticut Mental Health Center (CMHC), in all aspects of services provided to the clients by both parties.

3. Provide, at a minimum, weekly drug tests on all program participants, and follow standard DOC and CSSD requirements for urine drug screens.
4. Provide or access transportation for program participants for court dates, treatment/services, religious/spiritual services, and other recovery-relevant client activities.

5. Develop and implement a system of client sanctions, including a system of rewards for positive behavior and program compliance that incorporates a 4 to 1 reward to sanction ratio.

6. Provide a safe and secure environment for all program participants, including both physical and emotional safety. Critical incident reports shall be forwarded to the referring agent and to the state agency liaisons (DMHAS, DOC, and CSSD) within 24 hours of occurrence.

The contract also specified four outcome criteria. These are:

1. CREST has the capacity for up to 30 clients at any given time. Their utilization rate for the program should be at least 90% (or 27 clients).

2. At least 75% of clients will maintain or increase their level of functioning between time of admission and time of discharge or will maintain or increase their level of functioning over a six month period as measured by the Modified Global Assessment of Functioning Scale (MGAF).

3. No more than 30% of discharged clients will have left due to reasons of non-compliance and/or against clinical advice.

4. At least 75% of respondents to the DMHAS consumer survey will rate services positively in the domains of access to services, quality of services, outcomes, participation in treatment planning and overall satisfaction with services.

The present evaluation considers these outcome criteria but also looks at program implementation (e.g., is CREST being operated according to its design?), factors associated with clients’ completion or noncompletion (e.g., are there reasons why some clients complete CREST and others do not?), and clients’ criminal justice involvement after completion of CREST (e.g., what happens to completers once they leave CREST?). The following document presents a description of the CREST program, prior research on offenders with serious mental illness, and the methodology used in the evaluation. These sections will be followed by qualitative findings of the operation of CREST and the findings of the outcome evaluation. The final section will discuss these findings in terms of program and policy implications and provide recommendations for future services and research for offenders with severe mental illness.
Offenders with Severe Mental Illness: The Scope of the Problem

The overrepresentation of persons with severe mental illness (SMI) in the criminal justice system has been well documented. Rates of SMI are significantly higher in the prison, probation, and parole populations than in the general population (Fazel, & Daniels, 2002; Teplin, 1994; Teplin, Abram, & McClelland, 1996; Trestman, Ford, Zhang, & Wiesbrock, 2007). In addition, research indicates that more than half (and perhaps as many as three quarters) of offenders with SMI also have co-occurring substance use disorders (Abram & Teplin, 1991; Hartwell, 2004; Teplin, Abram, & McClelland, 1996). Thus, prisons, parole, and probation agencies must manage a large number of offenders who present with complex symptoms and disorders that are often resistant to treatment.

Not surprisingly, the criminal justice outcome of offenders with SMI tends to be poor: Two thirds of offenders with SMI are rearrested within 18 months of their release from custody (Feder, 1991). Offenders with SMI who are on parole or probation are at greater risk for recidivism and supervision violations than other probationers and parolees (Lurigio, Rollins, & Fallon, 2004). Offenders with SMI who are on parole or probation are also more likely to be homeless than other probationers and parolees (McCoy, Roberts, Hanrahan, Clay, & Luchins, 2004). Outcomes for offenders with SMI and a co-occurring substance abuse disorder are even worse than that of offenders with SMI who do not have a substance use disorder. Compared to offenders with only SMI, offenders with SMI and a co-occurring substance use disorder have higher rates of recidivism & probation violations a greater risk for violence (Steadman, Mulvey, Monahan, Robbins, Grisso, Roth, & Silver, 1998; Swartz, Swanson, Hiday, Borum, Wagner, & Burns, 1998), and higher rates of homelessness and psychiatric hospitalization (Hartwell, 2004).

The limited research into the causes and contributors of the poor criminal justice outcome of offenders with SMI suggests that psychological symptoms, substance abuse, criminal justice factors, and a lack of basic needs are involved (Hartwell, 2004; Watson, Hanrahan, Luchins, & Lurigio 2004). Through interviews with offenders with SMI, McCoy and colleagues (2004) identified a number of factors associated with recidivism in this population. The top three were 1) poverty (offenders with SMI described committing crime for subsistence as well as committing crime following the psychological decompensation that occurred after their lack of access to medication and treatment), 2) homelessness (offenders described being arrested for civil order violations such as trespassing that were directly linked to their homelessness), and 3) substance abuse (offenders described committing offenses directly linked to substance use such as crimes committed under the influence and crimes in order to obtain money to support their addiction). Similarly, Watson et al., (2004) noted that offenders with SMI are often brought into contact with the criminal justice system due to their severe psychological symptoms, and their recidivism is often linked with a lack of treatment services and housing.

In a review of evidence based supervision practices for probationers and parolees with SMI, Skeem and Eno Louden (2006) hypothesized that the high rate of supervision failure among probationers and parolees with SMI was due to an interaction of psychological factors and criminal justice supervision factors. Among the psychological factors were the 1) impact of
severe psychiatric symptoms on the offenders’ compliance with the conditions of supervision, 2) impaired life skills associated with SMI, and 3) limited coping abilities of many offenders with SMI. Among the supervision factors were 1) poor officer-client relationships, 2) a lack of available treatment options for offenders with SMI, and 3) the use of punitive supervision strategies with SMI offenders.

The above research suggests that improving the criminal justice outcome of offenders with SMI will involve targeting multiple problem areas, of which mental health is only one concern: mental health treatment, substance abuse treatment and help meeting basic needs are all indicated. With respect to the criminal justice supervision, officers working with offenders with SMI may need to be specially trained to interact productively with this population and be prepared to modify supervision practices in a manner that is more effective for this unique population. A review of the literature indicates that attempts to meet one or more of the various needs of offenders with SMI and thereby improve their outcome has been implemented in a variety of specialized programs and programs, and it is to these programs that this review next turns.

Strategies to Improve the Outcome of Offenders with SMI

Strategies to improve the outcome of offenders with SMI in the community have included prebooking and postbooking diversion programs. Prebooking programs are police-based and involve the offender being diverted into mental health treatment in lieu of arrest. A review of these programs is beyond the scope of this evaluation. Postbooking programs, which may be jail based or court based, generally involve the offender being diverted into mental health treatment in lieu of conviction or incarceration. There are a wide variety of postbooking diversion strategies, such as mental health courts (MHC), specialized probation and parole units, Assertive Community Treatment teams (ACT) and intensive case management (ICM). As the mission of these programs is roughly analogous to that of the CREST program, they are reviewed below.

Mental health courts: The first MHCs were established in the late 1990s with a mission to divert offenders with SMI into treatment in lieu of incarceration, and an ultimate goal of reducing recidivism and jail/prison overcrowding (Redlich, Steadman, Monahan, Petrila, & Griffin, 2005). While the procedures and processes of MHCs vary from jurisdiction to jurisdiction, they share a common philosophy: A nonadversarial approach based on the principles of therapeutic jurisprudence. MHCs also share common components: A judge that monitors the offenders’ progress in treatment and a team approach such that the prosecutor and defense attorney work collaboratively with the judge and treatment providers to act in the best interests of the client. Some MHCs follow a preadjudicative model in which offenders plead guilty and their prosecution is held in abeyance while the offender attends treatment. Other MHCs follow a postadjudicative model in which offenders are referred to the MHC after processing by traditional court and are offered to have their sentences replaced with treatment. In either model, offenders typically must agree to enter a period of treatment of 6 months to a year, and monitoring by the court. Upon successful completion of the program, their charges are dismissed or their sentence is dismissed (Redlich et al., 2005).
Due to their relatively recent introduction, a substantial body of literature on the effectiveness of MHCs has yet to accrue. However, the small body of research into their effectiveness has suggested that MHCs are associated with reduced recidivism, especially among those offenders who complete the program. An evaluation of an MHC based in San Francisco, California found that participation in the MHC was associated with a 26% reduction in the probability of a new charge, and a 55% reduction in the probability of a new violent charge 18 months after entry into the program compared to a comparison group. Successful completion of the MHC was associated with a 39% reduction in the probability of a new charge, and a 54% reduction in the probability of a new violent charge (McNiel & Binder, 2007). An evaluation of an MHC in rural North Carolina found MHC noncompleters had a rearrest rate similar to that of a treatment-as-usual comparison group, while MHC completers had a rearrest rate less than one fourth that of the treatment-as-usual comparison group 12 months after entry into the program (Moore & Hiday, 2006).

Specialized mental health parole and probation units: A recent survey found 137 specialized mental health parole and probation units had been established in the United States (Skeem, Emke-Francis, & Eno Louden, 2006). While jurisdictions differ in the organization and operation of these units, five features are prototypical of this strategy: 1) officers are assigned only mental health cases, 2) officers have reduced case loads (averaging 45 clients), 3) officers are provided with 20-40 hours of training in mental health issues per year, 4) officers are expected to be intimately involved in their client’s treatment engagement (e.g., coordinating with their client’s treatment providers, remaining apprised of their client’s treatment progress, and assisting their client in accessing social services), and 5) officers are expected to rely on engagement and problem solving with clients rather than admonitions and threats in working through problems with their client’s noncompliance with treatment and supervision (Skeem et al., 2006). Overall, the approach of specialized mental health units can be viewed as one that relies on greater attention to and engagement with, SMI clients compared to traditional probation.

Research into specialized mental health probation units has not yet been able to provide reliable answers to questions regarding their impact on SMI probationer outcomes. This is due to both the limited number of studies on specialized mental health probation units as well as the limitations of the research designs that existing studies have employed. Survey and focus group research with SMI probationers, probation officers, and probation supervisors suggest that these units are perceived by all three groups as an improvement over traditional supervision approaches. Outcome research suggests that specialized mental health probation units increase the amount of mental health treatment that SMI probationers receive, but do not reduce the number of technical violations or new arrests (Skeem & Eno Louden, 2006). This limited, but encouraging, body of research has suggested that mental health probation units are a “promising approach” (Skeem & Eno Louden, 2006). A greater number of well controlled studies will determine if this “promising approach” is ultimately deemed an “empirically supported practice.”

Assertive Community Treatment (ACT): ACT teams targets offenders with SMI leaving custody, attempting to provide a stable transition into the community. ACT teams are unique in that they provide multimodal care in the field rather than the office, meeting offenders with SMI in their homes or even in homeless shelters. ACT teams can provide psychiatric treatment, crisis intervention, and medical care as well as social services such as assistance in locating housing
and employment, and assistance with self-care; helping clients problem solve and cope with the difficulties with everyday living (Lurigio, 2000). This blend of relevant services delivered in the field appears to be effective in improving the quality of life of clients. ACT teams have been found to reduce hospitalization and increase stable housing (Drake, McHugo, Clark, Teague, Xie, Miles, & Ackerson, 2003) as well as retain offenders in mental health treatment (McCoy, Roberts, Hanrahan, Clay, & Luchins, 2004). The impact of ACT on criminal justice involvement has not been adequately evaluated, and while a review found that the few studies which had examined the issue found mixed results (Marshall & Lockwood, 1998), other studies have found significant decreases in arrests and incarceration (Lamberti, Weisman, & Faden, 2004; McCoy, Roberts, Hanrahan, Clay, & Luchins, 2004).

**Case management:** In their report, “Intervention Strategies for Offenders with Co-occurring Disorders: What Works?” Peters and Hills (1997) note that “Case management services are frequently considered the ‘core’ set of services provided for offenders with co-occurring disorders. Case managers often negotiate contact across various different service systems, and link together services that are not addressed in other treatments, including housing, vocational rehabilitation, community mental health services, and evaluation of eligibility for Medicaid/SSI or other financial entitlements. Case managers also help coordinate and monitor scheduled appointments and provide important linkages to community supervision officers” (pp. 36-37). Thus, while not treatment per se, case management as a therapeutic agent of change for offenders with SMI is evident, and case management components have been incorporated into a variety of court-based diversion programs and reentry programs for offenders with SMI. The role of case management in diversion programs has varied from a complementary component to a core component (Loveland & Boyle, 2007).

Research into the effectiveness of case management services with offenders with SMI has been limited and drawing conclusions from the existing body of literature is further hampered by the variety of case management programs. For example, a recent review of case management with offenders with SMI found 1) intensive case management (ICM) (i.e., low case loads) used as a component within ACT programs, 2) intensive case management programs that were modeled after ACT, but without the provision of all ACT services, and 3) nonintensive case management used to link offenders with other providers (Loveland & Boyle, 2007). The review also noted that ICM programs that had a substance abuse treatment component or which addressed the coordination of mental health and criminal justice services tended to have an impact on recidivism, while more general ICM programs did not impact recidivism.
EVALUATION METHODOLOGY

The present evaluation employed both qualitative and quantitative research methods in assessing the CREST program’s implementation, completion rate, and follow-up. The following section will summarize the research design and measures used to address these issues.

Research Questions and Design

This evaluation focused on three primary questions. First, was the program implemented according to its prescribed treatment model and did it follow the DMHAS contract? Second, what were the program results for those clients participating in CREST? Third, for those clients successfully completing CREST, were they able to continue to be successful and not have future contact with the criminal justice system?

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Referral data. The data available for all referrals were:

- CREST referral date
- Demographic information (age, gender, race/ethnicity, marital status, education level obtained, employment, living situation, income source)
- Referral source
- Legal status at the time of referral and at the time of discharge

Intake data. After clients were initially screened and admitted, a more detailed intake process was performed by CREST staff consisting of several assessments. These were:

- CREST admission date
- DSM-IV Axis I and Axis II diagnoses and Axis V GAF scores
- Adult Substance Use Survey-Revised (ASUS-R) scores
- Level of Service Inventory-Revised (LSI-R) scores
- Whether client is functionally literate
- Recovery strengths
- Drug preference
- Number of days used drugs in 30 days prior to CREST referral
Program data. Program data were available from CREST after clients were discharged from the program (either successfully or unsuccessfully). These data consisted of:

- Discharge date
- Discharge type and reason
- Legal status at discharge
- Services provided while at CREST
- Positive reinforcements given out
- Results of drug tests while at CREST

It was the intent of CREST staff to reassess clients upon their successful discharge. These re-assessments included the DSM-IV Axis I, Axis II, and Axis V, ASUS-R, and LSI-R. Also, staff were to note any changes in recovery strengths, employment, income, and living situation. We were unable to analyze these data given the small number of clients that were reassessed at discharge.

Criminal history data. We collected arrest and court data on all individuals that were referred to CREST. To obtain these data, we matched clients to their arrest records. These data included:

- Dates of all arrests, court dispositions, and sentences (if convicted) prior to CREST referral; offenses and level of seriousness (offense type and class)
- Dates of all arrests, court dispositions, and sentences after CREST referral; Offenses and level of seriousness.

DMHAS Defined Measure of Program Success

The evaluation assessed two measures of program success that were defined by DMHAS. These were:

1. Program Completion – whether clients who were admitted to CREST were successfully discharged from the program. A successful program discharge consisted of a client completing all of the program components of CREST and being clinically discharged. A client was also considered a successful discharge if he/she were assessed by CREST staff and referred to a higher level of care.

2. Legal Success – CREST is ultimately an alternative to incarceration program, in that it serves the criminal justice system by keeping clients out of prison. A legal success is defined as discharging a client into the community. Even if a client is unsuccessfully discharged from CREST, he/she may still be considered a legal success if he/she remains under some form of community supervision by the criminal justice system. For example, a CREST client who is on probation may receive a probation violation and be unsuccessfully discharged from CREST but may not be resentenced to prison for the violation. This person would be considered a legal success.
QUALITATIVE OBSERVATIONS

A significant aspect of this evaluation was a qualitative analysis that centered on a description of the daily operation of CREST. In this part of the evaluation, meetings with CREST staff and visits to the CREST facility were conducted to understand the nature and functioning of the CREST program. Observations focused on the physical space where the program is housed, staff and client characteristics, assessment practices, and program activities. Strengths of the program are noted. The initial recommendations for the program’s improvement are provided, along with discussion of changes in the program since the recommendations were shared with CREST.

The CREST Facility

CREST is situated in a residential section of New Haven, within walking distance of Yale University. The program is located in a building called the Learning Barn, which sits on the campus of Fellowship Place, an organization that provides psychosocial services to individuals who are homeless. The series of buildings that comprise Fellowship Place surround CREST. There are small patches of open space on the campus for clients to smoke and sit outside.

The entrance to the Learning Barn opens to a large room with high ceilings. This principal room serves as the center of most CREST activities. The room contains a reception desk where clients check in, a large table surrounded by comfortable chairs for group programming, cabinets for storage, a TV/DVD, a kitchen, washer/dryer, and bookshelves. The room alternately serves as the place for group programming, staff meetings, client check in/check out, client lounge, and cafeteria (as some client meals are served there). The room exudes a welcoming atmosphere as it is brightly lit, clean, and well furnished. The kitchen is stocked with food. The TV/DVD is in good working order. A dry erase board attached to the wall lists the day’s schedule. Another dry erase board attached to the wall marks the progress of each client on their weekly goals. Another section of wall space contains photos of staff and clients.

A client bathroom and three small staff offices can be accessed only by entering the principal room. The offices are shared by the Program Manager, case managers, and several Connecticut Mental Health Center (CMHC) staff. Individual sessions with clients are conducted in the offices. Located in another section of the Learning Barn is a one room attic that is also occupied by CREST. The attic provides additional office space for administrative tasks and staff meetings. The attic is unsuitable for group programming due to its small size. It is equally unsuitable for individual sessions with clients due to its isolation.

Staff Characteristics

Staffing the CREST site is a responsibility shared by The Connection and Fellowship Place. There are six full time staff. Three are provided by each agency. The Connection staffs the following three positions: Program Manager, Lead Clinical Case Manager, and Case Manager/Criminal Justice Liaison. The current Program Manager has a master’s degree in psychology, as does the current Lead Clinical Case Manager. One of these two master’s level
staff are on site whenever CREST is open. Both worked in community corrections’ programs prior to their positions at CREST. The current Case Manager/Community Justice Liaison has a bachelor’s degree and worked in a community corrections program prior to her employment at CREST.

The three positions staffed by Fellowship Place are the Housing Coordinator, Vocational Specialist, and Engagement/Outreach Specialist. The Housing Coordinator identifies potential housing options for clients and assists them in the application process. The woman presently occupying the position has an associate’s degree in human services and provided services to the homeless at Fellowship Place’s drop in center prior to her position at CREST. The Outreach and Engagement Specialist provides support for groups, facilitates activities, maintains supplies, escorts clients to meals, and provides transportation for clients into the community. The woman presently occupying the position has a high school degree and provided services to the homeless at Fellowship Place’s drop in center prior to her position at CREST. There has been little staff turnover since the inception of the program, which is unusual for a community corrections program and suggests strong staff cohesion and job satisfaction.

The CREST staff has undergone training in basic listening and communication skills. This training has emphasized motivational interviewing. More specialized skill-based trainings have included cognitive-behavioral treatment techniques, suicide prevention, and techniques for working with court mandated clients. Educational-based trainings have included dual diagnosis and psychosis. Specialized training in teaching life skills and employment skills was provided to the Vocational Specialist. Staff that facilitate a group program called Start Now have attended a training program specifically for this group.

In addition to the Connections/Fellowship CREST staff, two full time staff (a clinical psychologist and a social worker) and two part time staff (two social workers) from CMHC are on site, providing clinical services. The clinical psychologist evaluates clients referred to the program to ensure they meet program criteria, serves as clients’ interim mental health provider until a community provider can be arranged, assists in running some group programming, and participates in case review meetings. The full time social worker also assists in running some group programming and participates in case review meetings. Both provide clinical consultation for the case managers as well as crisis intervention. The two part time social workers have been hired within the past year to develop and run evening and weekend group programming.

Client Characteristics

The target clients of the CREST program are DMHAS-eligible individuals with serious mental illness from the New Haven area, who are involved with the criminal justice system. Clients may have a co-occurring substance use disorder, but the severity of their substance use must be secondary to their severe mental illness. In addition, clients may not be sex offenders or offenders with a history of arson or a pattern of violence (a condition that was necessary to be able to site the program in a neighborhood with residences).

CREST clients are at various stages in the criminal justice process (pre-trial, probation, parole) and are referred to CREST from variety of sources such as jail diversion, probation/parole, and public defender social workers. The size of the program is capped at 30
clients. The program accepts men and women age 18 and older, but men between the ages 25 and 45 have made up the majority of the clients. Clients suffer from a range of significant and chronic mental disorders including schizophrenia, schizoaffective disorder, and bipolar disorder. The vast majority of clients also have a substance use disorder. Most of the clients receive their psychiatric treatment from the CMHC. Clients have significant problems in living such as homelessness, poor physical health, lack of financial stability, lack of transportation, and unemployment. Few clients have a stable residence. Most reside in homeless shelters or transitional housing. Few clients are employed and many are disabled due to their mental illness.

Assessment Practices

Clients referred to CREST are interviewed by the CMHC clinical psychologist to determine if they are appropriate for the program. If accepted into CREST, they meet with a case manager and undergo an extensive intake process. A semi-structured interview is used to obtain psychosocial data. A variety of instruments are used to obtain risk and need information. These include the Level of Service Inventory-Revised (LSI-R; an instrument that assesses risk for recidivism and potential needs for services), the Adult Substance Use Survey- Revised (ASUS-R; an instrument that assesses substance abuse, mood disorder, and antisocial behavior), the Mental Health Screening Form-Third Edition (MHSF-III; a brief screen of severe psychological symptoms), the CAGE (a brief substance abuse screening), and a functional literacy test.

The assessment process also includes contact with the client’s criminal justice referral agent, and mental health provider if there is one. If there is no current mental health provider, the assessment includes referral to appropriate mental health services. Information from the CMHC clinical psychologist, assessment instruments, and other sources are used to develop individual service plans for clients. For example, if a client has a significant housing need identified, an individual service plan may call for the client to meet with the Housing Coordinator, explore safe and suitable housing options, and fill out appropriate housing applications. As part of clients’ individual service plans, they are classified into one of three levels that specify the frequency of their reporting to CREST. Clients classified as Level I report to CREST 1-3 days a week. Clients classified as Level II report 3-5 days a week. Clients classified as Level III report 5-7 days a week.

Program Activities

The CREST program is open seven days a week, with morning check in at 8:30 AM and afternoon check in at 12:30 PM. Clients are generally assigned to either morning or afternoon check in but some clients remain at CREST all day. Ordinarily, the program runs until 4 PM, but three days a week, the program is open until 8 PM. Clients are expected to remain in the program for 90 days, but can remain longer if ordered by the court or deemed appropriate by the staff.

The services and programs offered at CREST reflect the diversity of problems that CREST clients confront, most strikingly, basic needs. Many basic necessities are provided to clients: Breakfast and lunch are provided to clients seven days a week. Dinner is provided three nights a week. There is a shower available for clients as well as a washer/dryer. Transportation
to and from appointments can be provided by CREST staff. Weekly trips are made to social
security, the DMV, SAGA, and city hall to assist clients who are trying to obtain basic
identification, health insurance, and disability benefits. Staff also actively assist clients with
obtaining housing, which is a primary client need.

Group programming occurs in the morning, afternoon, and three evenings a week. Some
of the group programs are manual based, and thereby provide a standardized curriculum. Among
the manual based programs at CREST are:

1) *Start Now*: A cognitive behavioral coping skills group (facilitated by a CMHC social
worker and a CREST case manager),

2) *Growing Spiritually*: A program to assist those with substance abuse disorders develop
a relationship with a higher power to assist in their recovery (facilitated by the Program
Manager),

3) *Relapse Prevention*: A cognitive behavioral substance abuse program (facilitated by a
CREST case manager),

4) *Illness Management and Recovery*: A psychoeducational program for individuals with
a severe mental illness (facilitated by the CMHC clinical psychologist and a CREST case
manager),

5) *Thinking for a Change*: A cognitive behavioral group focused on changing antisocial
attitudes (facilitated by the Program Manager),

6) *Open Discussion Group*: A group to encourage peer support (facilitated by Program
Manager),

7) *Health and Well-Being*: A psychoeducational group on various health issues relevant
to CREST clients such as STDs, HIV, and diabetes (facilitated by the Housing
Coordinator),

8) *Life Skills*: Education in basic living skills such as money management, cooking,
coping (facilitated by the Housing Coordinator),

9) *Self Reflection*: A group to increase mindfulness (facilitated by the CMHC clinical
psychologist),

10) *Vocational Planning*: A group that works on resumes, identifying obstacles to
employment, mock interviews, construction of cover letters (normally facilitated by the
CREST vocational specialist).

CREST clients are also eligible to attend some Fellowship Place programming such as
structured arts and crafts activities. In addition to the formal group programming, CREST holds
a 12 Step meeting at the facility once a week, and transports clients to a 12 Step meeting in the
community once a week. A half hour of each day is devoted to completion of chores. Clients are assigned basic responsibilities around the facility such as cleaning the tables and floors. Periodically, other activities such as board games (e.g., Bingo, Pictionary) are brought out to facilitate socialization.

**Reward and Disciplinary Procedures**

Clients meet individually with their case manager at least once a week to review their schedule, establish their goals for the week, and review progress on the prior week’s goals. The goals are blend of court mandated goals (e.g., produce negative urine drug screens, attend appointments) and program specific goals (e.g., complete applications for housing, maintain personal hygiene). Clients who meet all of their weekly goals are awarded a $10 gift card to stores such as Wal-Mart and Walgreens. A chart hanging in the principal room of the facility lists those clients who have earned a gift card for the week. Once a week, gift cards are presented during Community Meeting (a special meeting for all CREST clients). The presentation of the cards at the meeting is intended to reinforce the clients’ positive behaviors. Clients who do not meet their goals are not awarded a gift card, although clients may be awarded a $5 gift card for partial completion of goals.

The disciplinary procedure for clients’ disruptive behaviors ideally involves a verbal warning from the staff the first time, a written warning the second time, and suspension or termination from the program after a third incident. Common disruptive behaviors by clients are inappropriate jokes and violations of the smoking policy. A client can be terminated from the program for a single disruptive behavior provided the behavior is judged significantly dangerous to staff or other clients. There were two such occasions during the program’s first year: One client was terminated for threatening to harm staff and another was terminated for making a bomb threat at CREST.

**Strengths of the Program**

1) **Provision of basic necessities:** The CREST program appears to have thoughtfully considered the variety of problems in living encountered by its clients and made an effort to address them. Providing basic necessities such as food, transportation, a shower, a place to wash and dry clothes, as well as assistance in obtaining housing, identification, health insurance, and disability benefits enable the target population to participate in mental health treatment. It seems unlikely that CREST clients would be able to attend to their mental health care if such necessities were not provided.

2) **CMHC staff on site:** With CMHC staff on site at the CREST program, CREST staff benefit from consultation with mental health providers, and from the ability of these providers to facilitate group programming, recognize deterioration, defuse agitation, and effectively communicate with clients with challenging psychological conditions. The integration of CHMC staff seems essential to the ultimate success of CREST and it seems likely that the CMHC staff is one reason there have been few serious incidents of harm since the inception of the program.

3) **CMHC staff providing transitional care:** The clients served by the CREST center are traditionally those who have difficulty establishing and maintaining a course of mental health treatment. The ability of CMHC staff at CREST to facilitate clients’ entry into treatment at the
CMHC and provide transitional care is likely improving treatment engagement and reducing noncompliance among CREST clients.

4) Use of manual-based psychoeducational group programs: The CREST program has adopted several standardized group programs. While the use of manual-based programs does not ensure an effective presentation of the material, the use of such programs does help to ensure that clients are exposed to relevant material and provides a means of ensuring consistency in the nature of the material presented to clients.

5) Use of standardized assessment instruments: The CREST program assessment battery includes standardized instruments, several of which are also in use by Connecticut’s Court Support Services Division and Department of Correction. The advantage of using standardized instruments is that they have been empirically validated, and the specific adoption of instruments in use by other state agencies facilitates the sharing of client information between agencies.

6) Positive reinforcement of program goals: The use of the voucher system and the weekly presentation of the vouchers positively reinforce productive behavior on the part of the clients. The use of such a system is more likely to achieve productive goals than one based on negative reinforcement or punishment.

Recommendations for Program Improvement from August 2008

1) Obtain more space for group programming: One drawback to the CREST facility is the lack of suitable space for group programming. The principal room is the only room of sufficient size for group programming, but the room also serves a multitude of other functions. In addition, access to the staff offices and bathroom is only possible through the principal room. The result is that group programming faces regular interruptions by staff and other clients. This distracts the clients and the staff facilitating the group.

As the census for the program grows, the issue of space is going to become more problematic. Once the program reaches its target census of 30 there will be about 15 clients attending the morning programming and 15 attending the afternoon programming, a size that may be unmanageable and disruptive given the limitations of the space. The room used for group programming can probably comfortably accommodate about 10 clients. Conducting a group with 15 low functioning clients with severe mental illness in such a small space susceptible to so many disruptions seems unlikely to produce positive results. Furthermore, once the program reaches its target census of 30 it may be advisable to hold more than one group at a time. Given that group sizes for high functioning outpatients generally hover around 8-14 clients, it would make sense to have groups for the low functioning, severely mentally ill clients of CREST at a relatively small size. Thus, the prospect of running two groups simultaneously, not presently possible given the space limitations, may one day become a necessity.

There are other spaces in Fellowship Place buildings suitable for group programming, but these are only available to CREST on a space-available basis, not on a permanent basis that would allow regularly scheduled group programming. Ideally, the principal room can function as reception, check in, kitchen, and lounge, while group programming is conducted in a separate room affording more privacy and fewer disruptions. CREST would benefit from a room
specifically designated for group programming. This will limit disruptions to group participants, increase cohesion among group members, and allow facilitators to engage with the group without distraction.

2) Enhance the security protocol: A second drawback to the CREST facility is the lack of a suitable security system or security protocol for staff. At present, CREST does not have a security guard or metal detector. Security cameras are positioned throughout the principal room, but they do not record and they are not actively monitored, making them largely useless. There are no alarms in staff offices and no protocols in place in the event of a hostile situation with the exception of a whistle that has recently been provided to staff to wear around their neck. The combination of the small number of staff, potential for danger from clients, and lack of an appropriate security protocol make staff vulnerable to harm. CREST staff would benefit from a more thoughtful security protocol such as installation of a metal detector or “panic buttons” in the offices along with established procedures and training among staff for dealing with threatening situations.

3) Create discharge criteria: The CREST program was intended to serve clients for 90 days but in actual practice, clients remain beyond 90 days and no specific criteria guide discharge decision-making. The program would benefit from the development of specified discharge plans based on psychosocial and/or clinical criteria. For example, discharge criteria for a client could be developed at intake based upon the various pieces of the client’s individual service plan. This would not have to be a rigid system as a client’s discharge criteria could be revised depending upon changes in their stability, needs, and legal status. In addition to providing guidance on when to discharge clients, discharge criteria would serve as a marker of client progress, clarify overall client objectives, and provide clients and staff with a timeline for establishing those contacts and referrals for post CREST interventions and services.

Establishing and monitoring discharge criteria can also serve as a measure of program effectiveness. For example, one means of gauging program effectiveness could be to examine the percentage of clients that meet 100% of their discharge criteria, 90% of discharge criteria, etc. Establishing and monitoring discharge criteria can also serve as a means of learning which services the program is providing effectively and which need improvement.

4) Create a quality assurance procedure for group programming and case management: One problem that can develop with manualized programs is “drift,” the tendency for staff to gradually modify programs according to their own preferences and adhere less and less to the training guidelines when they initially learned the program. It is recommended that CREST staff develop a means for assessing their adherence to their manualized group programming to help prevent drift. This may take a variety of forms. For example, groups can be periodically audio taped or observed by a supervisor and reviewed using criteria that would indicate adherence to the program manual and objectives. Quality assurance procedures should also be developed for nonmanualized programs and involve some form of observation and review to ensure the programs are meeting established objectives. Quality assurance can also be implemented for individual case management through a periodic audio taping of sessions that are later reviewed by a supervisor.
5) **Implement regularly scheduled educational seminars:** Due to the complex mental health problems faced by the CREST clients it is recommended that CREST staff have regularly scheduled educational seminars (perhaps an hour a month). The purpose of the seminars would be to educate the staff on specialized and technical topics relevant to the case management of the CREST population and supplement, but not replace, the existing training provided to staff such as the Hearing Voices program and the DMHAS Behavioral Management Strategies program. The seminars could feasibly be conducted by CMHC staff. Some specific seminar topics that would be immediately relevant for CREST staff include community reinforcement, contingency management, mood stabilizing medications, atypical antipsychotic medications, thought disorders, mania and hypomania, and personality disorders.

6) **Hire a Co-Manager:** CREST may benefit from an additional master’s level staff member. If the program is going to be open 7 days a week over practically 80 hours and have a constant master’s level staff member on site, then the present system in which either the Program Manager or Lead Clinical Case Manager provide supervision for the facility is probably untenable on a long term basis. Co-Managers, splitting coverage of the week with a period of overlap, would make sense as a long term plan for CREST’s operation. The Lead Clinical Case Manager would be able to provide coverage in the event of emergencies, vacations, etc, and provide greater flexibility than is presently possible. A Co-Manager would also be valuable in supervising some quality assurance procedures (mentioned in recommendation #4) and monitoring clients’ progress in meeting discharge criteria procedures (mentioned in recommendation #3).

7) **Concerns regarding the program census should be the concerns only of the Program Directors and not of the staff:** The CREST program is capped at 30 clients, but the program’s daily census has yet to consistently reach that number. Referrals to CREST were few during the first six months of the program’s operation, and while the number of clients in the program gradually increased, the number of clients in the program has hovered in the low twenties for much of the past year. The failure to reach the target census of 30 clients was a significant source of anxiety among staff and considerable staff energy appeared to be expended in brainstorming methods to increase the census. Remediating a low census, which will undoubtedly be necessitated from time to time, should be a topic of discussion and brainstorming among senior agency personnel. Pressure felt by case managers and clinical staff to increase the census may lead to clients who are clinically inappropriate being accepted into the program and clients being maintained in the program longer than is beneficial.

**Program Modifications Following the Above Recommendations**

In the year since the recommendations were initially presented (Mitchell & Cox, 2008), there have been changes in CREST that pertain to the recommendations: 1) Perhaps most importantly, reliable additional group space has been obtained from Fellowship Place, permitting greater privacy and fewer disruptions to group programming, 2) Security has been improved through the purchase of metal detector wands, 3) Education of the staff on clinical issues relevant to the CREST population has been enhanced through a clinical psychologist consultant, and 4) the census at CREST increased.
OUTCOME ANALYSIS AND FINDINGS

While the qualitative analysis found that CREST was being operated according to its program model and was providing an array of services to clients, the outcome analysis looked at program effects. This analysis centered on (1) describing the number and characteristics of clients who were referred and selected to CREST; (2) determining the number of clients who were successfully discharged from CREST and whether any client characteristics (e.g., demographics, assessment data, or criminal history) were associated with program completion; and, (3) following clients after they were successfully discharged from CREST. The following section reports our findings from these analyses.

Program Referral and Selection

As of March 1, 2009, there were 135 referrals to CREST. The largest source of referrals (55%; \( n = 74 \)) came from CSSD’s Office of Adult Probation. The second largest source of referrals was the DMHAS’ Jail Diversion program (19%; \( n = 26 \)). The third largest source of referrals was The Connection’s Sierra Center (10%; \( n = 13 \)). Parole was the fourth largest source of referrals (6%; \( n = 8 \)). No other agency was responsible for more than 2% of CREST referrals.

The 135 referrals to CREST do not represent 135 unique clients: Eight clients were referred to the program twice. Thus, we distinguish between the number of referrals (\( N = 135 \)), and the number of clients (\( N = 127 \)). Of the 135 referrals, 63% (\( n = 85 \)) resulted in an admission to the program. The remaining 37% of referrals were deemed inappropriate for the program. Of the 85 referrals that resulted in admission, four were clients admitted to the program twice, leaving 81 unique clients. Of the 4 clients admitted twice: One was discharged due to noncompliance after the first admission, and is still participating in the program following the second admission; one was successfully discharged twice; one was successfully discharged after the first admission and is still in the program following the second admission; one was discharged due to noncompliance after the first admission and was successfully discharged after the second admission.

The 81 unique clients admitted to the program had an average age of 36 (\( SD = 8.99 \)), and ranged in age from 19 to 54. Seventy eight percent (\( n = 63 \)) were male. With respect to ethnic background, 60% (\( n = 49 \)) were African American, 17% (\( n = 14 \)) were Caucasian, 5% (\( n = 4 \)) were Hispanic, and the remainder were of another ethnic background or did not disclose their ethnic background. With respect to marital status, 18% (\( n = 15 \)) of participants were married or in a civil union at the time of their admission to CREST.

On a variety of psychosocial indicators, CREST clients were low functioning at admission to the program. Only 32% (\( n = 26 \)) had obtained a GED or high school degree, and 15% (\( n = 12 \)) were functionally illiterate as assessed by a functional literacy test. Only 15% (\( n = 12 \)) had permanent housing, and only one client was employed. The primary source of income for 40% (\( n = 32 \)) of the clients was social security, and 27% (\( n = 22 \)) reported no source of income.
CREST clients presented with severe mental illness diagnoses: All of the clients had a major Axis I diagnosis: 64% (n = 52) were diagnosed with some type of psychotic disorder (e.g., paranoid schizophrenia, undifferentiated schizophrenia, schizoaffective disorder), and 28% (n = 23) with a major mood disorder (e.g., bipolar disorder, major depressive disorder). A majority of CREST clients had a co-occurring substance use disorder (83%, n = 67), the most common being polysubstance dependence (27%, n = 22) followed by cocaine dependence (23%, n = 19). In addition to their Axis I condition, 25% (n = 20) had a personality disorder diagnosis and these primarily consisted of antisocial personality disorder (11%, n = 9) and personality disorder not otherwise specified (9%, n = 7). A small percentage of clients (5%, n = 4) were diagnosed with mild mental retardation or borderline intellectual functioning.

Overall, CREST clients’ history of involvement with the criminal justice system was significant: Every client had been incarcerated at least once, and the average number of incarcerations was 4.95 (SD = 3.04). The average number of arrests was 14 (SD = 8.51). The average number of convictions was 9.32 (SD = 5.97). In terms of offense severity, the highest percentage of clients were arrested for Class A misdemeanors (28%, n = 29) and Class D felonies, (21%, n = 28), followed by Class C felonies (14%, n = 19), and Class B misdemeanors (14%, n = 19). The most common offense type was assault (22%, n = 30) followed by public disturbances (13%, n = 18), property offenses (18%, n = 24), and drug offenses (12%, n = 16). Seven clients (5%) were arrested for sex offenses.

The mean Level of Service Inventory-Revised score was 35.82 (SD = 6.13), which would fall in the High range under the current case classification system used by CSSD’s Office of Adult Probation. Of the 72 clients for whom LSI data were available, 93% (n = 67) had scored in the High range, 4% (n = 3) were in the Medium range, and 3% (n = 2) in the Low range.

**Program Completion**

DMHAS required two outcome measures for CREST: program completion (defined as completing program components and being successfully discharged or assessed and referred to a higher level of care) and legal success (not being incarcerated after being admitted to CREST). Of the 85 admissions to CREST, 28 were still in the program as the time of this report. Of those whose disposition to the program were evident, 44% (n = 25) did not successfully complete the program and 56% (n = 32) completed the program. Of those who did not successfully complete the program, 84% (n = 21) were noncompliant, 8% (n = 2) were arrested on a new charge, and 8% (n = 2) were incarcerated on their referring charge. When assessing the number of clients that were legally successful, 50 clients were considered successful (88%) and 7 were incarcerated while attending CREST (12%).

CREST completers attended the program an average of 183 days compared to 79 for noncompleters. The majority of completers (78%) were in CREST for four months to one year (Table 1). CREST was initially designed to engage clients for four months before discharging them. However, the DMHAS did allow CREST to keep clients longer than four months if program capacity was under 30 clients. Most noncompleters attended CREST for less than three months (64%).
Table 1. Time in Program by Completion*

<table>
<thead>
<tr>
<th>Completion Period</th>
<th>Did Not Complete</th>
<th>Successful Discharge</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 month or less</td>
<td>4 (16%)</td>
<td>1 (3%)</td>
<td>5</td>
</tr>
<tr>
<td>2-3 months</td>
<td>12 (48%)</td>
<td>4 (13%)</td>
<td>16</td>
</tr>
<tr>
<td>4-6 months</td>
<td>8 (32%)</td>
<td>15 (47%)</td>
<td>23</td>
</tr>
<tr>
<td>7-12 months</td>
<td>1 (4%)</td>
<td>10 (31%)</td>
<td>11</td>
</tr>
<tr>
<td>Over 1 year</td>
<td>0</td>
<td>2 (6%)</td>
<td>2</td>
</tr>
<tr>
<td>Total</td>
<td>25 (100%)</td>
<td>32 (100%)</td>
<td>57</td>
</tr>
</tbody>
</table>

*Percentages are column percents.

As mentioned earlier, CSSD-Probation was the predominant referral source followed by DMHAS-Jail Diversion and the Sierra Center (Table 2). There was little variation in the completion rates across the three predominant referral sources (64% of DMHAS’ Jail Diversion referrals completed CREST, 63% of Sierra Center referrals completed, and 54% of CSSD’s probation referrals completed). Only 1 of the 6 parolees admitted to CREST was successfully discharged.

Table 2. Program Completion by Referral Source

<table>
<thead>
<tr>
<th>Referral Source</th>
<th>Did Not Complete</th>
<th>Successful Discharge</th>
<th>Percent Successfully Discharged*</th>
<th>Still in CREST</th>
<th>Total Referred</th>
</tr>
</thead>
<tbody>
<tr>
<td>CSSD – Probation</td>
<td>12</td>
<td>14</td>
<td>54%</td>
<td>16</td>
<td>75</td>
</tr>
<tr>
<td>CSSD – Pretrial</td>
<td>0</td>
<td>1</td>
<td>100%</td>
<td>1</td>
<td>4</td>
</tr>
<tr>
<td>DMHAS-Jail Diversion</td>
<td>5</td>
<td>9</td>
<td>64%</td>
<td>6</td>
<td>26</td>
</tr>
<tr>
<td>Parole</td>
<td>5</td>
<td>1</td>
<td>17%</td>
<td>0</td>
<td>9</td>
</tr>
<tr>
<td>Sierra Center</td>
<td>3</td>
<td>5</td>
<td>63%</td>
<td>3</td>
<td>13</td>
</tr>
<tr>
<td>Other</td>
<td>0</td>
<td>2</td>
<td>100%</td>
<td>2</td>
<td>8</td>
</tr>
<tr>
<td>Total</td>
<td>25</td>
<td>32</td>
<td>50%</td>
<td>28</td>
<td>135</td>
</tr>
</tbody>
</table>

*These percentages are not statistically significant at p.<.05.

CREST Treatment Components Provided for Completers

Table 3 presents the type and amount of services received by clients. The table only shows those services that are directly related to mental health or substance use issues. Most of the clients who completed CREST (25 out of 32) participated in the Start Now program (a cognitive behavioral coping skills group facilitated by a CMHC social worker and a CREST case manager). The two most commonly used treatment components were substance use treatment and positive reinforcers in the form of gift cards. For substance use, clients averaged 30 sessions while at CREST with one client receiving 114 sessions. Gift cards are awarded on a weekly basis for clients who completed or partially completed a goal. Clients who completed CREST averaged 16 gift cards while at CREST and received an average of $187 (since CREST’s inception to March 1, 2009, a total of 639 positive reinforcers were awarded for a total of $7,290). Clients who did not complete CREST also received these services but at a much lower number given their limited time in the program.
Table 3. Treatment Components for CREST Completers

<table>
<thead>
<tr>
<th>Component</th>
<th>Number of Clients Receiving</th>
<th>Minimum Sessions</th>
<th>Maximum Sessions</th>
<th>Average per Client</th>
</tr>
</thead>
<tbody>
<tr>
<td>Start Now</td>
<td>25</td>
<td>1</td>
<td>26</td>
<td>7</td>
</tr>
<tr>
<td>Substance Abuse</td>
<td>32</td>
<td>4</td>
<td>114</td>
<td>30</td>
</tr>
<tr>
<td>Staff Contact</td>
<td>32</td>
<td>1</td>
<td>84</td>
<td>25</td>
</tr>
<tr>
<td>Positive Reinforcers</td>
<td>29</td>
<td>3</td>
<td>57</td>
<td>16</td>
</tr>
<tr>
<td>Value Reinforcers</td>
<td>29</td>
<td>$20</td>
<td>$650</td>
<td>$187</td>
</tr>
</tbody>
</table>

Changes in Living Situation and Employment for CREST Completers

Living situation and employment status were assessed at the time of program admission and discharge for those clients successfully discharged from CREST. For living situation, twelve of the 30 (40%) successfully discharged clients were homeless or had temporary housing (shelters) at the time of program admission (Table 4). At the time of their discharge, six out of the twelve had permanent housing (3 clients) or were in residential programs (3 clients).

Table 4. CREST Completers’ Living Situation at Admission and Discharge

<table>
<thead>
<tr>
<th></th>
<th>Admission</th>
<th>Homeless</th>
<th>Trans/Temp</th>
<th>Sierra Center</th>
<th>Residential</th>
<th>Permanent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Homeless</td>
<td>2</td>
<td>1 (50%)</td>
<td>0</td>
<td>0</td>
<td>1 (50%)</td>
<td>0</td>
</tr>
<tr>
<td>Trans/Temp</td>
<td>10</td>
<td>1 (10%)</td>
<td>3 (30%)</td>
<td>1 (10%)</td>
<td>2 (20%)</td>
<td>3 (30%)</td>
</tr>
<tr>
<td>Sierra Center</td>
<td>9</td>
<td>0</td>
<td>4 (44%)</td>
<td>0</td>
<td>4 (44%)</td>
<td>1 (11%)</td>
</tr>
<tr>
<td>Residential</td>
<td>3</td>
<td>0</td>
<td>1 (33%)</td>
<td>0</td>
<td>1 (33%)</td>
<td>1 (33%)</td>
</tr>
<tr>
<td>Permanent</td>
<td>6</td>
<td>0</td>
<td>1 (17%)</td>
<td>0</td>
<td>1 (17%)</td>
<td>4 (67%)</td>
</tr>
<tr>
<td>Total</td>
<td>30</td>
<td>2 (7%)</td>
<td>9 (30%)</td>
<td>1 (3%)</td>
<td>9 (30%)</td>
<td>9 (30%)</td>
</tr>
</tbody>
</table>

For employment, almost all of CREST completers were unemployed (20) or receiving disability (7) at the time of CREST intake (Table 5). Of the 20 clients unemployed at intake, one client had a full-time job, three had part-time jobs, seven were receiving disability, and 9 remained unemployed at the time of their successful discharge.

Table 5. CREST Completers’ Employment at Admission and Discharge

<table>
<thead>
<tr>
<th></th>
<th>Admission</th>
<th>Unemployed</th>
<th>Disability</th>
<th>Part-time</th>
<th>Full-time</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unemployed</td>
<td>20</td>
<td>9 (45%)</td>
<td>7 (35%)</td>
<td>3 (15%)</td>
<td>1 (5%)</td>
</tr>
<tr>
<td>Disability</td>
<td>7</td>
<td>1 (14%)</td>
<td>5 (71%)</td>
<td>1 (14%)</td>
<td>0</td>
</tr>
<tr>
<td>Part-Time</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>1 (100%)</td>
<td>0</td>
</tr>
<tr>
<td>Full-time</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Total</td>
<td>28*</td>
<td>10 (36%)</td>
<td>12 (43%)</td>
<td>5 (18%)</td>
<td>1 (4%)</td>
</tr>
</tbody>
</table>

*The employment status of two clients was unknown.
Differences between CREST Completers and Noncompleters

Tables 6 through 9 present differences between CREST completers and noncompleters across demographics, personal background problems, assessment scores, and criminal history. These analyses reveal no statistically significant differences between those clients who were successfully discharged from CREST and those that did not complete the program. There are some interesting differences although they were not statistically significant. For example, 60% of males who were admitted to CREST were successfully discharged while only 42% of females completed (there were only 12 females in the program so this difference is not statistically significant due to this small number).

Table 6. Demographics and Personal Background of Completers

<table>
<thead>
<tr>
<th>Demographics*</th>
<th>Percent Completed</th>
<th>Number Completed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gender</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Males</td>
<td>60%</td>
<td>27</td>
</tr>
<tr>
<td>Females</td>
<td>42%</td>
<td>5</td>
</tr>
<tr>
<td>Marital Status</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Not Married</td>
<td>61%</td>
<td>27</td>
</tr>
<tr>
<td>Married</td>
<td>50%</td>
<td>5</td>
</tr>
<tr>
<td>Personal Background at Intake*</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Restraining Order</td>
<td>54%</td>
<td>7</td>
</tr>
<tr>
<td>History of Suicide</td>
<td>25%</td>
<td>1</td>
</tr>
<tr>
<td>History of Property Destruction</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>GED</td>
<td>55%</td>
<td>12</td>
</tr>
<tr>
<td>Functional Literacy</td>
<td>57%</td>
<td>31</td>
</tr>
<tr>
<td>Dual Diagnosis</td>
<td>56%</td>
<td>25</td>
</tr>
<tr>
<td>Psychotic Disorder</td>
<td>63%</td>
<td>22</td>
</tr>
<tr>
<td>Personality Disorder</td>
<td>67%</td>
<td>10</td>
</tr>
</tbody>
</table>

*Chi-Square values are not statistically significant at p.<.05

Living situation does appear to affect program completion (Table 6). There were 23 clients admitted to CREST with stable housing (permanent, Sierra Center, or residential). Of these, 19 completed CREST (83%). In comparison, 13 of the 33 admitted clients who did not have stable housing were successfully discharged (39%).

Table 7. Living Situation at Intake by Program Result

<table>
<thead>
<tr>
<th></th>
<th>Total</th>
<th>Non-Compliance</th>
<th>Arrested</th>
<th>Successful Discharge</th>
</tr>
</thead>
<tbody>
<tr>
<td>Homeless</td>
<td>9</td>
<td>7 (78%)</td>
<td>0</td>
<td>2 (22%)</td>
</tr>
<tr>
<td>Trans/Temp</td>
<td>25</td>
<td>11 (44%)</td>
<td>3 (12%)</td>
<td>11 (44%)</td>
</tr>
<tr>
<td>Sierra Center</td>
<td>9</td>
<td>0</td>
<td>0</td>
<td>9 (100%)</td>
</tr>
<tr>
<td>Residential</td>
<td>6</td>
<td>1 (17%)</td>
<td>1 (17%)</td>
<td>4 (66%)</td>
</tr>
<tr>
<td>Permanent</td>
<td>8</td>
<td>2 (25%)</td>
<td>0</td>
<td>6 (75%)</td>
</tr>
<tr>
<td></td>
<td>57</td>
<td>21</td>
<td>4</td>
<td>32</td>
</tr>
</tbody>
</table>
While not statistically significant, there were some differences between completers and noncompleters for ASUS-R and LSI-R scores (Table 8). For instance, Noncompleters had a higher mood adjustment score than completers (13.88 to 11.04) and also a higher LSI-R risk score (37.69 to 35.45).

Table 8. ASUS-R and LSI-R Scores for Completers and NonCompleters*

<table>
<thead>
<tr>
<th></th>
<th>Completers</th>
<th>NonCompleters</th>
</tr>
</thead>
<tbody>
<tr>
<td>AOD Involvement 1</td>
<td>10.31</td>
<td>10.94</td>
</tr>
<tr>
<td>Disruption 1</td>
<td>28.96</td>
<td>26.19</td>
</tr>
<tr>
<td>AOD Last 6 Months</td>
<td>18.42</td>
<td>20.06</td>
</tr>
<tr>
<td>AOD use benefits</td>
<td>11.92</td>
<td>12.12</td>
</tr>
<tr>
<td>Social non-conforming</td>
<td>11.96</td>
<td>12.06</td>
</tr>
<tr>
<td>Legal non-conforming</td>
<td>17.46</td>
<td>19.12</td>
</tr>
<tr>
<td>Legal non-conforming last 6 months</td>
<td>7.15</td>
<td>6.94</td>
</tr>
<tr>
<td>Mood adjustment</td>
<td>11.04</td>
<td>13.88</td>
</tr>
<tr>
<td>Global AOD-psycho social disruption</td>
<td>62.58</td>
<td>63.06</td>
</tr>
<tr>
<td>Defensive</td>
<td>10.81</td>
<td>9.25</td>
</tr>
<tr>
<td>Motivation</td>
<td>11.23</td>
<td>13.06</td>
</tr>
<tr>
<td>Strengths</td>
<td>12.91</td>
<td>13.32</td>
</tr>
<tr>
<td>ASUS-R Rater</td>
<td>11.23</td>
<td>11.69</td>
</tr>
<tr>
<td>LSI-R Score at Intake</td>
<td>35.45</td>
<td>37.69</td>
</tr>
</tbody>
</table>

Mean differences are not statistically significant at $p < .05$

We also compared clients’ criminal history for completers and noncompleters in terms of number of arrests, convictions, and prison sentences in clients’ lives and the severity of their most recent criminal offense prior to CREST admission (Table 9). There were no statistically significant differences for these.

Table 9. Criminal History of Completers and Noncompleters*

<table>
<thead>
<tr>
<th></th>
<th>Completers</th>
<th>NonCompleters</th>
</tr>
</thead>
<tbody>
<tr>
<td>Arrests in Lifetime</td>
<td>14.7</td>
<td>14.4</td>
</tr>
<tr>
<td>Convictions in Lifetime</td>
<td>9.5</td>
<td>9.6</td>
</tr>
<tr>
<td>Prison Sentences in Lifetime</td>
<td>3.9</td>
<td>5.6</td>
</tr>
<tr>
<td>Current Offense Severity</td>
<td>1.5</td>
<td>1.1</td>
</tr>
</tbody>
</table>

*Mean differences are not statistically significant at $p < .05$

Follow-up for CREST Clients’ Successfully Discharged

Table 10 presents the follow-up for clients who were successfully discharged from CREST. The ideal time frame for a follow-up component is typically 12 to 24 months after discharge. However, due to the small number of program participants and completers this was not possible. We simply followed all program completers as long as possible (from their discharge date to the end of data collection – March 1, 2009).
Table 10. CREST Clients’ Post Discharge Arrests

<table>
<thead>
<tr>
<th>Client</th>
<th>Days after Discharge Without an Arrest</th>
<th>Days after Discharge Until Arrest</th>
<th>Disposition</th>
<th>Sentence</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>507</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>494</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>471</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4</td>
<td></td>
<td>439</td>
<td>Pending</td>
<td></td>
</tr>
<tr>
<td>5</td>
<td></td>
<td>348</td>
<td>Guilty</td>
<td>Unconditional Discharge</td>
</tr>
<tr>
<td>6</td>
<td></td>
<td>120</td>
<td>Nolle</td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>353</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8</td>
<td>348</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9</td>
<td>342</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10</td>
<td>333</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>11</td>
<td>324</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>12</td>
<td>319</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>13</td>
<td></td>
<td>256</td>
<td>Pending</td>
<td></td>
</tr>
<tr>
<td>14</td>
<td></td>
<td>58</td>
<td>Guilty</td>
<td>$150 Fine</td>
</tr>
<tr>
<td>15</td>
<td>264</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>16</td>
<td>228</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>17</td>
<td>207</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>18</td>
<td>202</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>19</td>
<td>200</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>20</td>
<td></td>
<td>57</td>
<td>Guilty</td>
<td>185 days in prison</td>
</tr>
<tr>
<td>21</td>
<td>118</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>22</td>
<td>81</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>23</td>
<td>32</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>24</td>
<td>32</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>25</td>
<td>30</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>26</td>
<td>30</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>27</td>
<td>30</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>28</td>
<td>30</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>29</td>
<td>30</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>30</td>
<td>30</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>31</td>
<td>29</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>32</td>
<td>12</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Of the 20 clients who had been discharged at least six months prior to the follow-up, 6 were rearrested (30%). Table 10 also provides the court verdict and sentence for these arrests. Three arrestees were convicted but only one was sentenced to a prison term (185 days). Two arrestees have yet to have their cases disposed of, and one arrestee had his or her case nolled.

To explore the factors associated with rearrest after discharge, we ran bivariate correlations and chi-square tests between ASUS-R scores, total LSI-R score, age at program entry, gender, personal characteristics (whether client has a psychotic disorder, personality
disorder diagnosis, history of property destruction, history of suicide, GED, functional literacy), program components received (positive drug tests, Start Now services, Substance use services, staff contacts), and criminal history (total arrests in lifetime, total convictions in lifetime, total prison sentences in lifetime, total sentenced time in prison in lifetime, number of arrests in year prior to CREST enrollment, severity of the offense prior to CREST enrollment).

While the number of statistically significant correlations was limited due to the low number of clients in the study (n=32), there was one statistically significant finding. The more sessions clients attended of Start Now, the less likely they were arrested after completion of CREST \((r = -0.46)\). There were three other correlations that were .30 or higher but were not statistically significant. Clients who had a history of suicide were more likely to be arrested \((r = 0.31)\), clients who were functionally literate were less likely to be arrested \((r = -0.31)\), and clients who received a high number of gift certificates for positive reinforcements were less likely to be arrested \((r = -0.30)\).

Follow-up for CREST Clients' Unsuccessfully Discharged

We also present follow-up data on CREST clients who were unsuccessfully discharged for either a new arrest while attending CREST or for not following the CREST program (non-compliance)(Table11). A total of 25 clients were unsuccessfully discharge from CREST (21 were non-compliant, 2 were arrested while in CREST, and 2 pre-trial clients were sentenced to prison while in CREST). Eleven out of the 21 (52%) non-compliant discharges were arrested after leaving CREST. Of these, all 11 were convicted and four received prison sentences. It is also important to point out that 17 of the 25 unsuccessful clients were discharged within 90 days after their admission to CREST.
Table 11. Post Discharge Arrests for Unsuccessfully Discharged Clients

<table>
<thead>
<tr>
<th>Client</th>
<th>Days in CREST</th>
<th>Reason for Discharge</th>
<th>Arrested after Discharge</th>
<th>Disposition</th>
<th>Sentence</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>62</td>
<td>Arrest</td>
<td>Yes</td>
<td>Guilty</td>
<td>3.5 years in prison, 2 years probation</td>
</tr>
<tr>
<td>2</td>
<td>106</td>
<td>Non-Compliant</td>
<td>No</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>31</td>
<td>Non-Compliant</td>
<td>Yes</td>
<td>Guilty</td>
<td>Unconditional Discharge</td>
</tr>
<tr>
<td>4</td>
<td>37</td>
<td>Non-Compliant</td>
<td>Yes</td>
<td>Guilty</td>
<td>5 years in prison, 3 years probation</td>
</tr>
<tr>
<td>5</td>
<td>28</td>
<td>Non-Compliant</td>
<td>No</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>71</td>
<td>Non-Compliant</td>
<td>Yes</td>
<td>Guilty</td>
<td>320 days in prison, 2 years probation</td>
</tr>
<tr>
<td>7</td>
<td>90</td>
<td>Non-Compliant</td>
<td>Yes</td>
<td>Guilty</td>
<td>Pending</td>
</tr>
<tr>
<td>8</td>
<td>22</td>
<td>Non-Compliant</td>
<td>Yes</td>
<td>Guilty</td>
<td>18 months probation</td>
</tr>
<tr>
<td>9</td>
<td>30</td>
<td>Non-Compliant</td>
<td>Yes</td>
<td>Guilty</td>
<td>Pending</td>
</tr>
<tr>
<td>10</td>
<td>59</td>
<td>Non-Compliant</td>
<td>No</td>
<td></td>
<td></td>
</tr>
<tr>
<td>11</td>
<td>48</td>
<td>Pre-Trial Reincarceration</td>
<td>Yes</td>
<td>Guilty</td>
<td>Pending</td>
</tr>
<tr>
<td>12</td>
<td>109</td>
<td>Non-Compliant</td>
<td>No</td>
<td></td>
<td></td>
</tr>
<tr>
<td>13</td>
<td>97</td>
<td>Non-Compliant</td>
<td>Yes</td>
<td>Guilty</td>
<td>Pending</td>
</tr>
<tr>
<td>14</td>
<td>21</td>
<td>Non-Compliant</td>
<td>Yes</td>
<td>Guilty</td>
<td>5 months probation</td>
</tr>
<tr>
<td>15</td>
<td>161</td>
<td>Arrest</td>
<td>Yes</td>
<td>Guilty</td>
<td>6 months in prison</td>
</tr>
<tr>
<td>16</td>
<td>97</td>
<td>Non-Compliant</td>
<td>Yes</td>
<td>Guilty</td>
<td>1 year probation</td>
</tr>
<tr>
<td>17</td>
<td>63</td>
<td>Non-Compliant</td>
<td>No</td>
<td></td>
<td></td>
</tr>
<tr>
<td>18</td>
<td>70</td>
<td>Non-Compliant</td>
<td>No</td>
<td></td>
<td></td>
</tr>
<tr>
<td>19</td>
<td>160</td>
<td>Non-Compliant</td>
<td>No</td>
<td></td>
<td></td>
</tr>
<tr>
<td>20</td>
<td>217</td>
<td>Non-Compliant</td>
<td>No</td>
<td></td>
<td></td>
</tr>
<tr>
<td>21</td>
<td>39</td>
<td>Non-Compliant</td>
<td>No</td>
<td></td>
<td></td>
</tr>
<tr>
<td>22</td>
<td>49</td>
<td>Non-Compliant</td>
<td>Yes</td>
<td>Guilty</td>
<td>Pending</td>
</tr>
<tr>
<td>23</td>
<td>72</td>
<td>Reincarceration</td>
<td>No</td>
<td></td>
<td></td>
</tr>
<tr>
<td>24</td>
<td>66</td>
<td>Non-Compliant</td>
<td>Yes</td>
<td>Guilty</td>
<td>6 years in prison, 3 years probation</td>
</tr>
<tr>
<td>25</td>
<td>123</td>
<td>Non-Compliant</td>
<td>No</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Summary of Outcomes

The outcome evaluation centered on three components: the referral and selection process, program completion, and follow up on clients after successful discharge.

Referral and selection. There were 135 referrals from July 1, 2007 to March 1, 2009. The majority of referrals were from CSSD’s probation officers and DMHAS’ jail diversion staff. There were an extremely low number of referrals from CSSD’s bail staff (only four referrals with one admitted) and DOC’s parole officers (only nine referrals with six admitted). We would have expected that the volume of clients served by bail and parole would translate into a larger number of referrals.
The data indicate that the clients accepted into the CREST program are from a high risk/high need population. CREST clients are high risk in that they present with significant risk factors for recidivism such as extensive criminal histories, substance abuse, mental disorders, and lack of employment, education, and housing. The average LSI-R score among CREST clients fell well above the cut off for classification as "High" risk for recidivism under the current CSSD guidelines. CREST clients are high need in that they present with significant service needs, from basic needs such as food and housing to ongoing psychiatric treatment, substance abuse treatment, and life skills training. This suggests that the selection process results in the acceptance of the client population that the program was intended to serve.

Program completion. During the study period there were 57 discharges from CREST. Of these, 56% (n=32) completed the program and 44% (n=25) did not. It is difficult to assess the success of the program completion rate because there was no opportunity to randomly assign clients to a control condition, nor is any established "gold standard" completion rate for a program such as CREST. Two recent evaluations of mental health courts found completion rates of 62% (McNiel & Binder, 2007; Moore & Hiday, 2006). In the absence of a control group, one possible benchmark for CREST is a comparison with the completion rate of mental health courts because they have a similar mission and serve a similar population as CREST. Two recent evaluations of mental health courts found completion rates of 62% (McNiel & Binder, 2007; Moore & Hiday, 2006). Based on this benchmark, the completion rate of CREST can be seen as similar to those of other mental health diversion programs, but this is at best a crude benchmark because MHCs have greater leverage in retaining clients through criminal justice sanctions, and a sufficient the body of literature has yet to accrue on the typical program completion rate of MHCs.

The data indicate that CREST clients attended the program for an extended period of time. For instance, while the program length was initially expected to be four months, CREST completers attended the program an average of 183 days (six months). The majority of completers (78%) were in CREST for four months to one year. Even program noncompleters averaged three months of attendance. Overall, this suggests that the program was successful in engaging clients.

Identifying meaningful differences between program completers and noncompleters was hampered by the small sample size. For example, while 60% of male clients completed the program compared to 42% of female clients, any conclusions based on this difference in raw percentages must be tempered by the fact that only 12 female clients had been discharged from the program. Another hindrance in identifying meaningful differences between program completers and noncompleters was the lack of variability in some of the variables. For example, all but four clients discharged from the program had an LSI in the high range and all but nine had a co-occurring substance abuse disorder. The high risk/high need nature of the vast majority of CREST clients may have created a ceiling effect, precluding the identification of meaningful differences on these variables.

Follow-up after discharge. We cannot draw any definitive conclusions regarding CREST’s long term affects on client behavior due to the small number of CREST clients who have been discharged and in the absence of a control group. We are encouraged by the results in following all of the clients who were successfully discharged. As of March 1, 2009, 6 of the 30
clients who had been discharged for at least six months had been arrested (30%). The program components most related to post program success are participation the Start Now and positive reinforcers (gift certificates for achieving specific goals while in CREST).
CONCLUSIONS AND RECOMMENDATIONS

As part of Connecticut’s prisoner re-entry initiative, the Department of Mental Health and Addiction Services funded the Community Reporting Engagement Support and Treatment Center (CREST). This New Haven-based program is operated by The Connection, Inc. and is an intensive day reporting, monitoring, recovery support, and skill building program for individuals coming into contact or involved in the criminal justice system that have psychiatric or co-occurring psychiatric and substance use disorders. The services provided at CREST are coupled with clinical services offered by the DMHAS-operated Connecticut Mental Health Center (CMHC).

Our evaluation of CREST consisted of two broad criteria. First, we assessed the program using DMHAS’ contractually defined outcome criteria. These were:

1. CREST has the capacity for up to 30 clients at any given time. Their utilization rate for the program should be at least 90% (or 27 clients).
2. At least 75% of clients will maintain or increase their level of functioning between time of admission and time of discharge or will maintain or increase their level of functioning over a six month period as measured by the Modified Global Assessment of Functioning Scale (MGAF).
3. No more than 30% of discharged clients will have left due to reasons of non-compliance and/or against clinical advice.
4. At least 75% of respondents to the DMHAS consumer survey will rate services positively in the domains of access to services, quality of services, outcomes, participation in treatment planning and overall satisfaction with services.

Second, we used process and outcome evaluation methods to assess (1) the referral and selection process, (2) program implementation and fidelity, (3) program completion (along with factors associated with clients’ completion or noncompletion, and (4) what happened to clients successfully discharged from the program.

DMHAS Outcome Criteria

CREST capacity. Over the evaluation period the number of CREST participants ranged from 3 in July 2007 (the first month of program operations) to 37 in January 2009. The utilization rate was below 90% for the first 15 months of the program (July 2007 to September 2008). From October 2008 through February 2009 CREST has been at almost 100% at capacity. The initially low utilization rate appears to be a result of a small number of referrals from CSSD’s pretrial staff and DOC parole officers more than a lack of effort by the DMHAS and CREST to promote the program. We were impressed by the efforts put forth by DMHAS and The Connection Inc. in making criminal justice agencies aware of CREST throughout the study period.

Level of functioning while at CREST. The contract required that 75% of clients either improve or maintain their level of functioning as measured by the MGAF. There were intake and discharge MGAF scores for 46 CREST clients. Of these, the average MGAF score
significantly increased from intake to discharge. The average MGAF score at intake was 49.20 (SD=7.17) compared to 52.57 at discharge (SD=9.33) (this average difference was statistically significant at \( p < .05 \)). Overall, 76% of CREST participants had MGAF scores that either increased (50%) or remained stable (26%).

**Non-compliance rates.** Throughout the evaluation period 85 individuals were admitted into CREST and 57 had been discharged. Out of the 57 discharges, 21 were discharged for being non-compliant or against clinical advice (a 37% non-compliance rate). CREST was above the DMHAS-defined non-compliance rate, and the completion rate was similar to two recent evaluations of mental health courts (McNeil & Binder, 2007; Moore and Hiday, 2006).

**DMHAS customer survey.** Our evaluation of CREST was independent of DMHAS’ internal survey of clients who had been discharged from their programs.

**Process and Outcome Criteria**

**Referral and selection process.** A well planned and coordinated referral and selection process is necessary for any program to be successful. This process must have a defined target population along with collaboration and buy-in with criminal justice agencies. We found that CREST succeeded in having a defined target population and not accepting large numbers of clients who were not fit for this program. Even though CREST was below capacity and there was pressure to admit as many clients as possible, CREST appeared to primarily select only those referrals who met the admission criteria.

We must restate our concern over the low number of referrals from particular criminal justice entities. CSSD bail staff only provided four referrals while DOC parole officers only referred nine parolees. The large number of offenders in Connecticut with serious mental illness has been well documented at both the pre-trial and post-prison release aspects of the criminal justice system. Based on this, we expected many more referrals from bail and parole. It is important to point out that DMHAS and CREST staff made several attempts to engage these entities.

**Program fidelity.** In a recent review of the literature on intensive case management in diversion programs for mentally disordered offenders, Loveland and Boyle (2007) note that one of the few conclusions that can be culled from the few existing studies in this area is that services must be “intensive and comprehensive, including housing, psychiatric, vocational, and addiction treatment services” (p. 145). A strength of the CREST program is that it attempts to address these needs: 1) housing and vocational needs are addressed through a housing coordinator and a vocational counselor on staff; 2) psychiatric needs are addressed through CMHC staff, and the CREST staff facilitate group programming such as Start Now and IMR; and, 3) substance abuse needs are addressed through group programming such as Relapse Prevention and Growing Spiritually, on site 12 Step activities, toxicology screens and referrals for intensive treatment. Basic needs such as food, hygiene are also addressed on site.

**Program outcomes.** It is difficult to make overall assessments of CREST’s effectiveness due to the lack of an appropriate comparison group and the small number of CREST discharges during the evaluation period. Ideally, we would have been able to randomly admit half of the
appropriate referrals to CREST and denied CREST services to the other half (Draine and Solomon, 1999). Another commonly used evaluation method that is less than ideal would have been to match CREST participants to a similar group of individuals who did not participate in CREST. We were unable to use this technique because of the number of referral sources. To explain further, 40 CREST clients were probationers, 2 clients were from bail referrals, 20 were DMHAS jail diversion referrals, 11 were Sierra Center referrals, and 4 were from other entities. To create a sufficiently matched comparison group, we would have needed to find 40 similar probationers, 2 similar bail clients, 20 similar jail diversion clients, 11 similar Sierra Center participants.

During the study period there were 57 discharges from CREST. Of these, 56% \((n=32)\) completed the program and 44% \((n=25)\) did not. While there is no established benchmark for success, we found CREST’s completion rate to be similar to other recent evaluations of mental health offenders. CREST was able to engage clients for a long period of time. For instance, while the program was initially supposed to last for four months, CREST completers attended the program an average of 183 days (six months). The majority of completers (78%) were in CREST for four months to one year. This suggests the program was successful in engaging and retaining clients. Even program noncompleters averaged three months of attendance. Overall, this suggests that the program was successful in engaging clients.

There were only 20 clients who had been successfully discharged from CREST for more than six months and 5 who had been successfully discharged for over 1 year. Because of these low numbers and the lack of a control group, we cannot draw any definitive conclusions regarding CREST’s long term affects on involvement with the criminal justice system. We are, however, encouraged by the results in following all of the clients who were successfully discharged. As of March 1, 2009, only 6 of the 32 clients have been rearrested (15%), with one being sentenced to prison. The program components most related to long term success are participation in the Start Now and positive reinforcers (gift certificates for achieving specific goals while in CREST).

Overall Conclusions

The evaluation of CREST leads us to three overall conclusions. First, CREST was a well planned and properly implemented program. Our observations found that CREST components were relevant to theory and research on individuals with serious mental illness. Second, the number of appropriate referrals was relatively low given the presumed need for mental health programs that target offenders. The DMHAS and CREST staffs made substantial efforts to engage various criminal justice agencies but appeared to struggle to obtain appropriate referrals. Third, CREST was able to have positive effects on participants and had a program completion rate similar to other court-based mental health programs.

Recommendations

It is recommended that in one year the recidivism rate of CREST clients be examined. This extended time period should allow for a suitable number of discharged clients to accrue. At that point, the recidivism rate of CREST clients referred by probation can be compared with a matched sample of probationers or compared with the results of other studies with similar

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populations, which can provide a rough benchmark. It would be useful to not only examine the rate of recidivism, but also the nature of the recidivism (e.g., felony/misdemeanor; violent/nonviolent) and the frequency with which CREST clients reoffend pre and post discharge.

We also recommend that the DMHAS continue to experiment with different ways to engage and collaborate with criminal justice agencies. Faculty in the Department of Criminology and Criminal Justice at Central Connecticut State University have evaluated four DMHAS funded programs that have collaborated with different criminal justice agencies (Young Offender Model, Transitional Case Management, The Chrysalis Center, and CREST). DMHAS had difficulties filling program slots in each of these programs despite using different strategies and collaborating with different criminal justice agencies (the Young Offender Model placed DMHAS staff in Hartford Superior Court to obtain court referrals, Transitional Case Management involved working with staff from the Department of Correction’s Addiction Services Unit to recruit offenders prior to their prison release, the Chrysalis Center was a day reporting program similar to CREST but operated in Hartford).

The DMHAS’ struggles to be received into the criminal justice community are not unique to Connecticut. In fact, the difficulties mental health agencies have had in serving offender populations has often been discussed in the literature (see Draine & Solomon, 1999; Thompson, Reuland, & Souweine, 2003; Wilson & Draine, 2006). DMHAS’ membership and participation in the Criminal Justice Policy and Advisory (CJPAC) is one example of its efforts to better engage criminal justice agencies. This committee was created by Public Act 06-193 of state and local agencies and is tasked to develop policy recommendations for the General Assembly and Governor concerning criminal justice issues, namely those related to prison overcrowding and offender populations. We recommend that the DMHAS undertake a rigorous needs assessment and gap analysis with criminal agencies to determine what mental health services are most widely needed and then use its’ CJPAC membership to discuss how to best address these needs.
REFERENCES


Draine, J., & Solomon, P. Describing and evaluating jail diversion services for persons with serious mental illness. Psychiatric services, 50, 56-61.


