

ASSERTIVE COMMUNITY TREATMENT: A REENTRY MODEL FOR SERIOUSLY MENTALLY ILL OFFENDERS*

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This is the tenth article in a series about effectively dealing with mentally ill offenders in the criminal justice system. This article highlights two pilot projects using Assertive Community Treatment (ACT) as a new approach to transitioning prison offenders with a serious mental illness back to the community at the conclusion of their incarceration. ODRC, the Hamilton County Mental Health Board, and the Cuyahoga County Mental Health Board are collaborating on this innovating reentry model that may impact judicial decisions on early-release.

I. WHAT IS ASSERTIVE COMMUNITY TREATMENT?

Almost 10 (9.5) percent of the Ohio prison population has a serious mental illness. When offenders complete their sentence and are released, they are often unable to link up with services and find themselves reincarcerated, caught up in a vicious cycle. The ACT Model is a plan for comprehensive community-based mental health treatment. The original concept for ACT began in Wisconsin about 23 years ago. Psychiatrist Len Stein and Psychologist Mary Ann Test believed that psychiatric hospital staff should treat patients who had received long term and intensive inpatient services in a community setting. They called the plan The Program of Assertive Community Treatment (PACT). The ACT model, with minor staffing modifications, is called Assertive Community Treatment (ACT).

In the community, ACT provides services with a full clinical mental health staff including a psychiatrist, nurses, substance abuse specialists, and case managers. The team encourages consumers to stay involved in their treatment and assertively works in homes, neighborhoods, and places of employment as needed to provide services and promote recovery. Similar to a hospital unit, staff holds daily team meetings and provides services throughout the day and evening seven days per week.

ACT is for persons with severe illnesses who have frequent relapses and hospitalizations and/or find it difficult to maintain recovery treatment activities. Family members are involved directly and early on. The

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multidisciplinary team seeks family suggestions about how to help the consumer. The psychiatrist and other team members meet with the family to teach them about their loved one's mental illness and its treatment, and to offer practical suggestions for interacting with the consumer.

II. KEY FEATURES OF ACT

- Comprehensive service provided by a team in the community which includes a psychiatrist, nurse, substance abuse specialist and case managers.
- The team includes a ratio of 1 staff per 10 consumers.
- 24 hour coverage is provided.
- Assertive engagement.
- The provision of medications including atypical antipsychotic medications.
- The provision of substance abuse treatment including dual diagnosis group.
- The provision of supportive and cognitive-behavioral therapy including structuring time and handling activities of daily living.
- Supported employment, both paid and volunteer work.
- Support for resuming education.
- Support, education and skill teaching to family members.
- Direct support to help consumers meet all of their needs, i.e., housing, transportation, etc.

III. BUT DOES IT WORK?

Twenty years of research has demonstrated that the ACT model is more effective than traditional intervention in reducing days spent in hospitals and in promoting improved clinical stability, independent living, and client satisfaction. ACT is recommended as a best practice by the Schizophrenia PORT study by John's Hopkins University and the University of Maryland. ACT is a scientifically studied, evidence-based best practice. The *Mental Health: Report of the Surgeon General* summarizes the value of ACT, noting that it reduces hospital use, promotes continuity of outpatient care, and increases community tenure and residence stability. The Surgeon General's report also notes that ACT is most cost-effective when targeted to individuals with the greatest service need, particularly those with a history of multiple hospitalizations.

IV. PILOT PROJECTS

The Ohio Department of Rehabilitation and Correction (ODRC) recognizes that a disproportionate number of seriously mentally ill offenders released from prison are reincarcerated within a relatively short period of time following reentry to the community. In July of 2002, ODRC's Division of Parole and Community Services awarded grants to

the Hamilton and Cuyahoga County Mental Health Boards to establish ACT Teams for seriously mentally ill offenders being released from prison. ODRC is the first state-operated department of corrections to implement this innovative reentry model.

In July of 2002, ODRC awarded \$400,000 to these two pilot projects. The ODRC funds are used for housing, clothing, medication, transportation, transitional support services, and ACT Team personnel. Moreover, two parole officers from the Ohio Adult Parole Authority are part of the ACT teams. The addition of the parole officers to the teams is an innovative modification to the traditional ACT Team Model. The work completed by the parole officers has been beneficial as they help bridge the gap between the state criminal justice system and local community mental health providers. The Alcohol Drug Addiction and Mental Health Boards also contribute local funding to cover the costs of implementation.

Both pilot project teams serve offenders who have schizophrenia, schizoaffective, or bipolar disorders that are released from prison and being supervised by the Ohio Adult Parole Authority. Ninety days prior to an offender's release from prison, an ACT Team member completes a treatment assessment at the prison or via video teleconferencing. This process enhances the continuity of mental health treatment. All offender/consumer participation in the pilot project is voluntary.

To date, a total of fifty offenders/consumers have participated in the two pilot projects. The first offenders were served by the Act Teams in July, 2002, and average admission to both teams has been five offenders per month. The average length of stay in prison has been eight years. Ages range from 19 to 68. The range of charges for consumers in the project include: abduction, aggravated robbery, assault, attempted arson, arson, burglary, felonious assault, sexual battery, murder, and voluntary and involuntary manslaughter. Program participants live in a variety of housing options including: halfway houses, families, independent apartments, and three-quarter way houses.

V. CONCLUDING THOUGHTS

While a formal outcomes study is underway, preliminary data reveals decreased usage of jail, prison, and psychiatric beds days. In fact, since the inception of the pilot study, one offender has been returned to prison for 60 days as a result of a parole violation.

Funding has been secured for 2004 for both pilot projects. For more information on these projects or for technical assistance and consultation please contact Debbie Nixon-Hughes, Chief Bureau of Mental Health Services, Ohio Department of Rehabilitation and Correction at (614) 728-1932.