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Integrating into the Mental Health System from the Criminal Justice System: Jail Aftercare Services for Persons with a Severe Mental Illness

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ABSTRACT This article describes a mental health evidence based practice, Assertive Community Treatment (ACT). While ACT has scientific support, it has not been rigorously tested for persons with a severe mental illness and repeated forensic involvement. This article provides preliminary evidence that ACT is best suited for reentry into the mental health system by reporting reduced arrests and hospital admissions for an ACT jail aftercare team. ACT both facilitates formal diversion and linkage mechanisms between the criminal and mental health systems and engages and prepares persons with mental illness for integration into the mental health system.

KEYWORDS Jail aftercare, assertive community treatment, mental health evidence based practices

INTRODUCTION

In the past five years, it has been widely reported in local news stories to nationally televised exposes that persons with mental illness are over represented in the nations' jails (Psychiatric News, 2003; Frontline, 2005). The frequent exposes of this problem, coupled with exposes of overcrowding, have made inroads into public consciousness, creating greater recognition of how many persons with mental illness are incarcerated and a greater acceptance for alternatives to incarceration. Concurrently, institutional/criminal justice consciousness was being raised. Federal funding agencies, particularly the Substance Abuse and Mental Health Services Administration (SAMHSA), made jail diversion a funding priority, offering incentives to State or County governments to develop jail diversion initiatives to reduce the number of persons with mental illness in jails. These funding opportunities signaled the importance of the problem to State and local governments and, through grant-specified selection criteria, encouraged multiple stakeholder participation in designing diversion programs.

Public recognition and federal targeting of the problem not only has resulted in more jail diversion programs but also has increased screening and treatment within jails themselves. In terms of jail diversion programs, a wide variety of pre and post booking programs exist. There are more crisis intervention teams to divert before booking and mental health court programs to divert post-booking. Additionally, a 2006 Department of Justice report indicates that mental health screening and treatment is now provided as a matter of policy so that psychotropic medications are prescribed and counseling is done by trained mental health providers in all Federal prisons and most State prisons and jail jurisdictions (Bureau of Justice Report, 2006). What the report does not comment on, however, is the quality of care within the criminal justice system. Despite the reported quantity of services, advocates for prisoners' rights and for the mentally ill consider services ineffective and prison conditions incompatible with therapeutic efforts.

Calls for better assessment, improvement, and monitoring of care have long been made and often made by a rhetorical comparison to the attention paid to the quality of community care (Elliot, 1997). In addition, recent research indicates that many individuals with repeated forensic involvement are not being diverted to a comprehensive set of services best suited to meet their multiple needs (Steadman & Naples, 2005; Broner et al., 2004). As the Council of State Governments (2002) noted, "Without housing that is integrated with mental health, substance

abuse, employment, and other services, many people with mental illness end up being homeless, disconnected from community supports, and thus more likely to . . . become involved with the criminal justice system" (8). In contrast, many diversion programs have come to be measured against the single metric of reduced criminal justice contact. There are few longitudinal studies looking at how individuals fare after diversion. Inadvertently, diversion had, in many cases, become an end in and of itself (Broner et al., 2004).

As a result, research into what mode of service delivery and what kinds of treatments are most effective for this population remain in the early stages of inquiry (Morrissey & Meyers, 2006; Lamberti et al., 2004). This is particularly true of assessing the kinds of mental health treatment diverted individuals receive, particularly the accessibility and effectiveness of evidence based mental health practices for diverted individuals (Steadman, 2006; Watson et al., 2001). This article serves to provide support for one of the oldest community mental health evidence based practices, Assertive Community Treatment (ACT), as a service delivery modality most suited for engaging and preparing persons with criminal justice histories for full participation in the mental health system and for provision of subsequent evidence based practices as needed or desired. In the process, it also contributes to the specification of what a Forensic ACT team might look like, an issue currently being debated in the mental health field (Lamberti et al., 2004).

Over the past 10 years, the community mental health system, taking its lead from somatic medicine/physical health care, has developed and begun to test a set of six "Evidence Based Practices," (EBPs) including ACT, Integrated Dual Disorder Treatment, Supported Employment, and Illness Management and Recovery. Just as evidence based medicine is grounded in three principles, namely that clinical care should be supported by the strongest scientific evidence, attention must be paid to consumer values, preferences, and choice, as well as an ongoing commitment to improving clinical skills, so too is mental health evidence based care (Drake et al. Psychiatric Services, 2001). Despite the by now wide dissemination of these practices, implementation not surprisingly has lagged behind. The Surgeon General reports (Mental Health: A Report of the Surgeon General, 1999) that there typically is a 15-20 year gap between identification of an Evidenced Based Practice and routine implementation in the mental health field. ACT, however, has been implemented for close to thirty years and is viewed by many in the mental health field as a delivery mode that will easily accommodate other

evidence based practices because rather than specifying service content it specifies a structure for services.

The ACT model, developed by Test and Stein (1976) to provide intensive and supportive care from a multi-disciplinary team *in* the community–as opposed to the hospital or to office based care–began with a two-fold goal. The model was designed to help consumers meet their multiple and complex needs as they transitioned from the hospital and to help them post-transition "become integrated into the community" by providing rehabilitation, counseling, and material support. In effect, the model was thought to be able to keep individuals from returning to the hospital by helping them to connect and feel a real sense of belonging to the world outside the hospital. With the refocus of mental health care from hospital based to community based care, substituting the goal of reducing incarceration for the goal of reducing hospitalization appears a natural extension of the ACT model.

The potential of ACT to reduce jail and arrest rates, however, is uncertain. In a review of controlled studies examining assertive community treatment's impact on jail and arrest rates, Bond and colleagues (2000) found that 70 percent of studies showed no effect, and 10 percent showed worsening. One explanation is that many of the reviewed studies did not involve teams who were formally collaborating with the criminal justice system and who were also systematically recruiting forensic involved individuals (Lamberti et al., 2004). On the other hand, there are a handful of naturalistic studies that demonstrate that ACT services successfully integrate individuals into the mental health system and that this integration (increased service use and working alliances) contributes to better functioning and fewer days in jail.

Among these studies is one reporting on the first 18 patients treated using ACT services–called the Arkansas Partnership Program–seventeen consumers remained arrest free and substance free while living in the community an average of 508 days (Cimino & Jennings, 1999). In a study comparing outcomes among 41 patients during the year before and after enrollment in a program called Project Link, the mean number of jail days per patient dropped, and significant reductions were also noted in the number of arrests and hospitalizations, along with improved community functioning as measured with the Multnomah Community Ability Scale (MCAS) (Lamberti et al., 2001).

In a one year follow-up study of the first 30 patients enrolled in the Thresholds Jail Project, the total number of jail days dropped from 2,741 in the previous year to 469 during the first year of enrollment. The total number of hospital days dropped from 2,153 to 321 for the group.

Total savings in jail costs during the one-year study period was $157,000, and total savings in hospital costs was $917,000. Steadman and Naples (2005), conclude from the data collected from six sites (N = 1260) involved in the SAMHSA Jail Diversion Initiative for persons with a serious mental illness that jail diversion reduces jail days and criminal justice costs. The study points out that the data does not indicate quality of services, an integral component to jail diversion. A recent study, by Broner, Lattimore, Cowell, and Schelnger (2004), which examined differences between diverted and non-diverted individuals in terms of service use, among other variables, reported that diversion did not result in greater access to or use of services over the course of the study period. Significantly, increased service use was found in the first three months after diversion, suggesting that assertive outreach and other engagement strategies ought to be continued well into treatment.

Recent experimental and quasi-experimental studies of post-booking jail diversion programs report modest outcomes. One study, comparing non-diversion to 6 jail diversion programs (3 pre and 3 post booking) at 12 months post-diversion, shows reduction in time spent in jail and linkage to community services (Steadman & Naples, 2005). A second quasi-experimental study, again comparing individuals court assigned to a diversion program versus individuals not assigned, showed participants improved on both mental health and substance use outcomes over time, irrespective on which condition they had been assigned (Shafer, Arughtu, & Franczak, 2006). The main effect of time may be attributed to quality of services for both conditions. The more comprehensive and outreach oriented the services the better the outcomes. Diversion and linkage are best viewed as a first step, not ends in and of themselves.

In one of the few longitudinal studies of ACT aftercare for those with criminal justice involvement, five-year outcomes are reported for 83 acquittees found not guilty by reason of insanity (NGRI) placed on conditional release (CR) into the community. During the study period, only five arrests and 60 hospitalizations occurred, and NGRI acquittees were in the community for 83 percent of the time they were eligible for conditional release (Parker, 2004). Insofar as NGRI typically is a defense for more serious crimes, the study does not speak to the effectiveness of forensic informed ACT teams for repeat *misdemeanor* offenders.

Often misdemeanor offenses result from behaviors related to using substances, such as disruptive behavior, including difficulties in negotiating interpersonal conflict, resulting in public nuisance offenses and

dysfunctional coping skills resulting in a variety of drug related offenses (Abrham & Teplin, 1991; Chandler & Spicer, 2006). Estimates suggest that 90% of offenders with a mental illness have had a substance use disorder at some point in their lives, and 62%-72% report having a current substance use problem (Abram & Teplin, 1991; Veysey, Steadman, Morrissey, & Johnsen, 1997). Individuals with co-occurring disorders present particular challenges. They are less likely to cooperate with treatment, including taking medication as prescribed, are more likely to be homeless, and may be more likely to commit violence (Steadman et al., 1998; Swartz et al., 1998). A recent study (Chandler & Spicer, 2006) reports on the limited effectiveness of Integrated Dual Disorder Treatment (IDDT), a multi-component practice targeting substance use of individuals with repeated forensic involvement. Using non-equivalent groups, they speculated that the "portability" of IDDT is limited for persons with criminal justice involvement returning to urban areas and that fairly high fidelity scores overall may not be a reliable indicator of outcomes because individual components that have low scores may be the components that future research will show to be most essential.

The preliminary findings described below suggest that re-entry into the mental health system, too, ought to be viewed as a staged process, starting with diversion and linkage mechanisms supported by *formal* coordination between the criminal and mental health systems, followed by an equally staged process of engagement and preparation for integration into the mental health system relying first on intensive ACT services.

PROGRAM DESCRIPTION AND TREATMENT COMPONENTS: THRESHOLDS' ACT LINKAGE AND AFTERCARE

Originally a pilot project designed to show the efficacy of ACT in maintaining persons with lengthy histories of arrests and jail days in the community, "Thresholds' Jail Demonstration Linkage Project" eventually became–because of continued need and because of the program's early success–an agency-funded ACT program dedicated to this population (Lurigio, 2000; Psychiatric Services, 2001). Thresholds' Jail Linkage and Aftercare Teams, in effect, form two parts of an Assertive Community Treatment team. The team is different from a traditional ACT team in that it has staff dedicated to criminal justice related matters, only takes referrals from Cook County Jail, relies on smaller staff to consumer ratios, and plans for time sensitive transition points in the

move from the criminal justice system into the mental health system. More specifically, the staff to consumer ratio was increased from 1:10 to 1:6, intensive monitoring through increased service hours and payeeship was routine instead of being done on a case-by-case basis, all basic provisions–housing, food, clothes, renewed benefits–did not depend on agreeing to receive mental health services and were always in place before individuals were released from jail. Finally, support and advocacy were provided throughout all phases of the individual's involvement with the law–pretrial, post-adjudication, and post-release, and probation–which served to keep individuals engaged in Thresholds' services.

The four person linkage team provides the first set of services in the continuum of care so important for persons entering the mental health system. While the linkage team works most intensively with people while in jail, before linking them to Thresholds aftercare team, or if full, to another Thresholds' ACT team, they continue to see them after they are linked.[1] The linkage team is responsible for creating and maintaining the criminal justice relationships upon which the aftercare team relies so heavily. In the early stages of the project, the linkage staff advocated for the program as well as for particular individuals; they were the ones responsible for ensuring that the benefits of aftercare were understood. Now they are responsible for ensuring that the program remains a viable option within the criminal justice system.

The 10 person *multidisciplinary*, self-contained aftercare team, comprising the linkage case management staff, a weekend case manager, two case managers, a program supervisor, a consulting psychiatrist, a part-time nurse, and an administrative support person, provide all mental health services. Per the model, a set of team members are on call 24 hours a day, seven days a week, make frequent visits to clients' apartments to help them with everyday tasks, ranging from doing laundry to working on social skills to nurturing ties with clients' landlords, family, and other community contacts. Additionally, staff accompany consumers on all criminal justice related appointments and provide invaluable advocacy work in multiple contexts. Communication with the courts, police, and probation officers was crucial to coordinating services and to making sure there were no gaps in care. Most important, however, is that the team, unlike other forensic ACT teams, is non-punitive and coordinates care with and meets the requirements of the criminal justice system in this spirit.

Indeed developing and maintaining trusting relationships–both with individuals being served and with important persons in their lives–is

crucial and occurs through routine ACT case management services, such as the provision of housing and through support in Having housing benefits and services *immediately* available helps to prevent the individual from returning to familiar patterns of arrests and hospitalizations or to an increase in symptoms due to lack of psychiatric care. Meeting these immediate needs serves as engagement strategies, which in turn, makes keeping housing in place through acute crises precipitated by medication nonadherence, disputes with landlords, or having no money, a routine problem. The engagement strategy most important, though, is ongoing outreach for individuals inconsistently engaged with services.

In sum, the ACT team has a proven service structure and can easily integrate evidence based treatment into this structure and philosophy of care, an ability that will allow forensic involved persons to receive best practices. ACT works from a basic-needs-first and assertive outreach philosophy. Paramount to ACT is ongoing outreach in the community to multiple stakeholders, making outreach to the criminal justice system business-as-usual. All services are provided by the team, thus making coordination of care relatively easy. This is a crucial feature given the difficulties many individuals have in navigating multiple health care services and the problems that arise with coordinating care among various agencies.

METHODS

Design

Using administrative data and a repeated measures design, ACT aftercare was evaluated comparing arrests, jail episodes, hospital admissions, and hospitalization episodes three years prior to being intaked to three years after intake.

Sample Description

Participants were recruited from Cook County Jail in Chicago. Study participants were eligible if they had been referred to Cook County Jail's mental health services, Cermak Health Services, had been diagnosed there with an Axis I disorder, and from records obtained from Chicago Police Department (CPD) and the Illinois Criminal Justice Authority (ICJIA), had appeared in court at least 20 times in their lifetime

as documented in Cook County Clerk records, and had at least five hospitalizations in a lifetime. Preference was given to people convicted of nonviolent offenses and who are considered to be at low risk of violence in the community. Illness severity was not an exclusionary criterion for the project.

Participants were approached while in Cermak Hospital initially by a social worker responsible for discharge planning at Cermak, who mentioned the Thresholds' program. Upon receiving agreement, the discharge planner contacted a Thresholds' staff who, after checking court and hospitalization records, met with the prospective participant either pretrial or post-adjudication. Of the first group of individuals eligible to participate in the first year, 24 were linked to the jail aftercare team. While exact numbers of refusals were not recorded, only a handful are estimated to have refused indicating they preferred to stay in jail. Any individual who expressed a desire to stay out of jail agreed to participate in the program. The pilot project ran from 1997-2000 and was integrated into Thresholds' routine services in 1999 during which time routine service use and outcome data were collected.

Between 1999 and 2003, the team served a total of 96 individuals. 72% (n = 69) were male and 28% (n = 27) were female. Fifty-nine percent (n = 57) of the sample were African American, 37 % (n = 35) were EuroAmerican, 1% (n = 1) were American Indian, and 1% (n = 1) Asian. Most consumers (44%; n = 42) had a diagnosis of schizophrenia, while many had a diagnosis of a schizoaffective disorder (18%; n = 17) or a bi-polar disorder (17%; n = 14). The average age at intake was 42.19 (SD = 11.13). The majority of individuals had never been married (73%; n = 70), while 15% (n = 14) had been divorced. Only 1% of the sample was currently married and living with spouse, with 4% (n = 4) separated. The mean years of education was 12.10 (SD = 2.755).

Of these 96, 35 stayed less than a year. Two individuals were linked to other Thresholds teams and 33 were linked to other programs outside of Thresholds, typically because the level of services provided by the aftercare services were unnecessary. Eighteen percent (N = 17) were linked to outside agencies after one year of aftercare services. Thirty eight percent (n = 36) stayed with the team for 3 years requiring extra support. Demographic and baseline characteristics do not significantly differ among these two groups. The criterion for linkage was being on the team for at least a year; occasionally someone would be linked before a year because the team had reached capacity.

MEASURES

Forensic Outcomes and Functional Status

Arrests, jail episodes, and jail time prior to being served by the ACT team were retrieved from databases maintained by the Illinois Office of Mental Health, Chicago Police Department, and the Cook County Department of Corrections. For this project, routinely collected administrative data were recorded from electronic medical records between the years 1997 and 2002, put into an Excel database, and deidentified for use by the Primary Investigator. Data include jail and hospital episode outcomes. With the exception of the number of jail and hospital episodes and days collected prior to being served by the ACT team, all data was collected and entered by clinical staff.

DATA ANALYSIS: PRE ACT SERVICES–POST ACT AFTERCARE

Analyses consisted of descriptive statistics and analysis of covariance (ANCOVA) on the four post ACT aftercare outcome variables; hospital days, hospital admits, jail days, and arrests. It was hypothesized that participants would have fewer arrests and jail days one or more years after being on the team. Length on team was recalculated into a categorical variable of one year of services or less, one to two years, and two to three years of services. ANCOVAs were performed for each outcome variable comparing three years before receiving aftercare services and three years after receiving services.

RESULTS

Criminal Justice Involvement and Hospitalization Outcomes

A series of between-subjects ANCOVAs were performed on ACT aftercare service. Four separate models were run to assess significant relationships between exposure to ACT and jail and hospital use. The dependant variables included post ACT aftercare hospital days, hospital admits, jail days, and number of arrests. Covariates included three year pre ACT service data on hospital days, hospital admits, jail days, and arrests.

Analyses were performed by SPSS 15.0 for Windows, using the General Linear Model function at a 95% confidence level. We hypothesized first that exposure to services (length on team) would be a significant predictor of change in each variable. Findings showed that exposure was significantly associated with a change in hospital and jail use post-services, controlling for baseline hospital and jail use; hospital days $F = 4.905$ ($p = .029$), hospital admits $F = 40.206$ ($p = .00$), admits $F = 64.576$ ($p = .00$), and post-jail days $F = 4.033$ ($p = .021$) confirming our hypothesis.

After basic ANCOVAs were run to assess the four pre and post variables, models were run including all four variables as covariates to reveal more complex relationships. Although several interactions were found to be significant throughout the four models, perhaps the most interesting results lie in the models of the dependant variables post jail days and post arrests. A significant relationship was shown between length of services and post jail days. These findings also confirm our hypothesis that length of service and jail days are related, showing positive outcomes of the ACT service with respect to length of time spent in jail while receiving services. Persons receiving services for one year or less, on average, can expect 76.275 more post services jail days, $B = 76.275$ (21.736, 130.813), $p = .007$. Although length of stay was found to have a significant relationship with post jail days, no relationship was observed with post arrests. Only a slight difference in mean arrests was observed; one year of services or less, 2.55 ($SD = 3.247$), one to two years, 3.10 ($SD = 3.635$), and two to three years of service, 3.81 ($SD = 8.4246$).

DISCUSSION

In conclusion, ACT with a forensic liaison staff, in this case a linkage team, provides a good base for providing services because of their ability to target the multiple needs of forensic-involved individuals with a serious mental illness. Aftercare was found to be particularly effective at reducing hospitalizations and days incarcerated but not as effective in reducing arrests, a finding also found in studies of intensive, office based case management services (Draine & Solomon, 1994). The reasons that community based services also showed little difference in arrest rates may be because the team had yet to systematically implement IDDT, an anecdotal explanation from several staff for many arrests. This suggests that ACT care may cut short incarceration time rather than avoiding

it altogether. That is, assertive outreach and systems integration works most well post-arrest. This finding also suggests that supported employment services for individuals with longer tenure on the team is warranted, as working has shown to reduce hospitalizations and arrests (Sneed et al., 2006).

ACT is currently the best set of services to intervene in a seemingly unstoppable cycle by providing housing, benefits, and psychiatric medication and then working in creative ways to help people maintain them. As has been reported of this particular sample previously, many suffered from a set of what–given current public policy and social service funding–can only be called intractable problems, problems which include poverty, victimization, homelessness, and social isolation (McCoy, 2004). ACT works by engaging individuals into treatment, which despite being complicated by court ordered treatment and mandatory reporting can be done by framing services as supportive and truly providing non-punitive, ongoing support.

There are a number of limitations to this study. The study does not report follow-up data for those individuals who were referred outside of Thresholds, nor does it report referral source for those individuals. As a result, a more fine grained analysis of what "dosage" of ACT is necessary and for whom could not be conducted. Additionally, like so many other studies of ACT care for this population, quality of life and functioning outcomes are not fully reported. Nonetheless, the study adds to the literature by providing preliminary 3-year data on ACT care for persons with a severe mental illness and repeated forensic involvement.

NOTE

1. The outcomes reported here are for those individuals referred to the Jail ACT aftercare team.

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