

ACT

Assertive Community Treatment Supports Recovery for Parolees with Histories of Injecting Drugs

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Prison inmates with histories of injecting drugs pose a range of potential problems upon release from the institution. In addition to the anticipated difficulties with community reintegration and recidivism, there is the specter of relapse to drug abuse. For those whose drug dependence involves the intravenous use of heroin, cocaine, amphetamines, or other drugs, there is the issue of HIV infection and AIDS.

During the early 1980s, it was determined that addicts who injected drugs were not only the second highest risk group for AIDS, but also played a primary role in the secondary spread of HIV disease. A task force of the United States Public Health Service began a series of initiatives in 1985 to address the problem (Inciardi, 1990).

The National Institute on Drug Abuse (NIDA) took the lead in this effort. In 1989 it allocated funds for a series of five-year innovative treatment projects, research demonstration projects designed to reduce the spread of AIDS by improving treatment for drug abuse (NIDA, 1989).

Of more than 100 grant applications submitted, ten were ultimately funded. The University of Delaware's Assertive Community Treatment (ACT) program is one of these projects. This paper describes the ACT program, which is being implemented for parolees with histories of injecting drugs, and the experimental design being used to evaluate the effectiveness of the program.

ACT

CLINICAL FOUNDATIONS OF ASSERTIVE COMMUNITY TREATMENT

The Assertive Community Treatment (ACT) program is based on the continuity of care model for the community treatment of the chronically mentally ill that originated in Madison, Wisconsin during the early 1970s (Test et al., 1985).

Often referred to as assertive case management, the focus is on helping the client reenter the community by providing material, interpersonal and moral support in the areas of education, vocational training, use of leisure time and self-care in dealing with the stresses and pressures of interpersonal living.

The basic components of the approach include: a) counselors actively keeping track of their clients with numerous face-to-face contacts, rather than waiting for problems to arise; b) staff being available to clients at all times; c) staff working to treat clients normatively; and d) counselors having access to instrumental support for clients in the form of job training, rent and food money, tools for work, transportation and child care, as well as the more traditional forms of treatment, rehabilitation and support group services (Anthony and Margules, 1974; Cutler et al., 1984).

Although evaluations of the assertive community treatment approach with the mentally ill are limited, the results are generally positive. Studies demonstrate that, when compared with matched control patients who are discharged from inpatient psychiatric and other mental health settings without some form of case management program, those in the assertive treatment models tend to have better occupational functioning and live in residential situations requiring some level of independence. They also tend to be less socially isolated, be rehospitalized less often, and remain in the community longer before rehospitalization (Stein et al., 1975; Stein and Test, 1980; Test, 1981; Rapp and Chamberlain, 1985; Bond et al., 1988; Goering et al., 1988).

Similarities between chronically mentally ill patients and drug users suggest that the multidimensional model characterizing assertive community treatment is appropriate in the drug abuse field. Both populations require treatment and a comprehensive network of continuing support in order to interrupt the relapse cycle and remain stabilized in the community.

The prevention of relapse has challenged the addiction treatment field despite several decades of research.

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With the additional problems of criminal involvement and a history of injecting drugs, the cycle of potential recidivism and relapse becomes even more complex.

The vast majority of drug users leaving correctional institutions require a variety of rehabilitative services to deal with the multiple areas of their lives affected by drugs. Research has suggested that treatment outcome is more likely to be successful when one considers drug use as having a multitude of symptom patterns which involve various dimensions of the individual's life (McLellan et al., 1981; Lipton, 1989).

This perspective lends itself to the biopsychosocial model of rehabilitation used with the chronically mentally ill, an approach that stresses multimodal and holistic methods of assessment and treatment.

While relapse prevention can also be

presented as a psychoeducational task with needs for skill development (Daley, 1986), other dimensions of the problem can be treated effectively when properly integrated in a comprehensive rehabilitation program that provides reinforcement and support in the community (Anthony and Margules, 1974).

Continuity of care is a related concern which, when appropriately addressed, can benefit drug treatment clients. A review of the literature indicates impressive gains in the mental health field with community support systems (CSS) for comprehensive service delivery (Lamb, 1979).

Assertive community treatment programs appear to be the backbone of the CSS approach (Bachrach, 1981; Rapp and Chamberlain, 1985). As such, it is likely that a similar approach to the treatment of drug abuse and its concomitant, multidimensional problems will reduce the potential for relapse.

In contrast to its use in the mental health field, the major difference in the application of the assertive community treatment model to parolees is the expectation that their substance abuse and related problems can improve, and that eventually they may cease to need this wide spectrum of assistance. Consequently, although it is not a short program, the ACT program for parolees has time limits and success goals, rather than the continuous availability of help envisioned for the mentally ill.

SPECIFICS FOR THE ACT INTERVENTION

After classification to parole status, each ACT client receives an in-depth, comprehensive biopsychosocial evaluation. This assessment includes:

1. A biopsychosocial history, which provides a holistic or multimodal assessment of a client's history;
2. The Progress Evaluation Scale (PES), which examines seven dimensions of functioning: family interaction, occupation, getting along with others, feelings and mood, use of free time, problems and attitude toward self. The PES is used to indicate both current status of functioning and goals (Ihlevich and Gieser, 1988); and,

3. Any necessary specialized instruments for further assessment of problems identified for each individual client.

When the evaluation is completed, a primary case manager is assigned and each client receives a written, comprehensive, individualized Master Treat-

The implementation of the relatively lengthy case management phase is crucial to the effectiveness of assertive community treatment.

ment/Service Plan. The plan is developed with the client and his or her family, if appropriate. It addresses client involvement in all aspects of treatment, as well as necessary adjunctive services available in the community. The treatment/service plan contains specific, measurable goals and objectives which include time frames expected for achievements.

A comprehensive outpatient drug treatment program is provided which includes individual, group and family therapy, drug education, training in relapse prevention skills, AIDS education and on-site AA/NA meetings.

The relapse prevention training and support are based on a synthesis of available psychoeducational models. Skill development emphasizes the efficacy of life-style changes that produce increased self-esteem. These include but are not limited to: developing healthy, supportive friendships, coping with cravings and situations which are a risk to relapse, managing stress and using leisure time effectively.

There are four phases to the drug treatment:

1. Intensive Drug Treatment Phase (six weeks). During the first two weeks, clients are involved in group counseling (seven and one-half hours/week),

drug and AIDS education and discussion groups (four hours/week), and individual counseling (minimum of one 50-minute session/week). Family assessment therapy is scheduled based on the needs of each family.

The next four weeks of intensive treatment have three group sessions each week, five days of drug and AIDS education/discussion, and special issue groups. Individual counseling is provided a minimum of one session per week. Family therapy is scheduled reflecting the needs of the family.

2. Moderately-Intensive Treatment Phase (six weeks). For the first three weeks of this phase, clients are provided group counseling at two sessions per week. Education/discussion sessions come more to the forefront.

They begin to focus on relapse prevention and continue with AIDS-related issues three times each week. Individual sessions continue as previously scheduled and vary according to individual needs. Family sessions oc-

cur as needed, at the discretion of the therapist.

For the next three weeks, treatment takes on a more supportive posture. Group counseling is scheduled once a week; relapse prevention (psycho-educational model) is provided twice a week. Individual counseling and family therapy are on an as-needed basis.

3. Relapse Prevention Phase (six weeks). During this period, group sessions meet once per week for support of relapse prevention. In addition, relapse prevention education is provided twice a week and individual counseling and family therapy are scheduled as needed.

4. Case Management Phase (twelve weeks). After clients have successfully completed their active involvement in the Assertive Community Treatment program, they transfer into a phase called case management, designed to support their transition into less intensive involvement with treatment. The transition may include a vocational training program or direct job placement.

You're bright enough to master
Cobol and Fortran.

And you're still smoking?

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Case management contacts are initiated to determine if clients have remained free of alcohol and other drugs and if they have complied with vocational training/job placement plans. Contacts also determine if clients are in stable family and employment situations and if they are in need of further service or referral.

5. Follow-Up Phase (1-year). Follow-up contacts/assessments are initiated by case managers for each client at one month after discharge and at three-, six-, nine- and 12-month intervals. These contacts are face-to-face if possible, or by letter or telephone, for the purpose of determining:

1. If the client has remained free of alcohol and other drugs;
2. Compliance with the aftercare plan;
3. Education/training and employment status;
4. Status of family/social relationships;
5. Legal status;
6. Psychological/psychiatric status;
7. Medical status; and,
8. Appropriateness of any further services or referrals.

CASE MANAGEMENT AND ADVOCACY

The implementation of the relatively lengthy case management phase is crucial to the effectiveness of assertive community treatment. This phase is handled by a multidisciplinary staff which works as a team in the overall case management of the clients. In addition, ACT staff serve as advocates for the clients in dealings with other programs, treatment and service providers in Delaware's human services network, and the criminal justice system.

These ancillary service agencies provide additional resources to clients, and include mental health treatment, medical and dental services, financial support, social services, child care and transportation.

Case managers provide direct counseling services and work with clients to develop the skills necessary to function successfully in the community. Case managers also function as group facilitators to provide direct skill training and support in the area of their specialty, such as AIDS education, relapse pre-

vention, remedial education and employability skill training. Scheduled activities rotate in order for staff to have available time to work closely with the clients on their caseloads.

Team meetings are regularly scheduled. These allow staff to adjust client and program goals and objectives in a realistic manner. This process keeps the program responsive to the immediate needs of the clients and case managers benefit from the input and support of other staff members involved with their clients. The assigned case manager reviews the team staffing outcome with each client (and his or her family, if appropriate).

Staff teach adaptive behavior through instruction, modeling, encouragement and realistic limit-setting.

Client services are monitored at all stages in order to ensure the stability and quality of the client/provider relationship. The progress of clients in the planned services is evaluated on an ongoing basis to adjust services in response to the client's ability to benefit from them.

In addition, staff teach adaptive behavior through instruction, modeling, encouragement and realistic limit-setting. There are family consultations and crisis intervention services whenever necessary, geared toward maintaining the client in the community and preventing relapse.

Finally, the ACT intervention includes, when necessary, a program of education and/or reeducation and skills training for job readiness and job seeking, designed to increase the client's marketable employment skills. Remedial education is offered in the areas of reading, math and language arts. When appropriate, there is GED preparation utilizing video instruction materials and accompanying workbooks. Teacher

assistance is available to facilitate the learning process.

The employability skills training component uses the PACE Learning Systems Employability Skills Training program (McKee, 1987). This program focuses on employability, job-retention skills and valuable life or "survival" skills; for example, how to live within a budget, buy a reliable used car, etc.

Support and assistance in job seeking/job placement are provided with consideration given to immediate, short-term employment and also long-term vocational needs.

EVALUATION OF ACT

It must be emphasized that the Assertive Community Treatment project with Delaware parolees is a research-driven initiative. It is structured to demonstrate the clinical efficacy and relative effectiveness of ACT in addressing the problems of clients with drug use and HIV-risk behaviors, as compared to the normal parole process.

Consequently, over the life of the project, 400 Delaware parolees with histories of injecting drugs will be randomly assigned upon release to either the ACT project or conventional parole. Immediately prior to release, all 400 subjects will receive HIV and urine testing, assessments of drug use, histories of HIV-risk behaviors and AIDS prevention education.

At six months and 18 months after release, all 400 subjects will have HIV testing and urine testing. There will also be reassessments, by questionnaire, of drug use and HIV-risk behaviors.

Data from questionnaires and from HIV and urine tests will be used to test statistically the relative effectiveness of the ACT program versus conventional parole for inmates with a history of injecting drugs. Criteria to be used include both discrete outcomes (e.g., relapse, recidivism) and time-relative measures (e.g., length of time drug-free).

Other information from the questionnaires will be used to identify additional factors beyond the ACT program that may predict likelihood of success in avoiding drug use, other HIV-risk behaviors and recidivism.

The ACT program for parolees has time limits and success goals.

Since this is a research project, the random assignment procedure raises some potential questions about treatment and ethics. Some inmates wishing to be in the ACT program are assigned to the control group; some inmates assigned to ACT may not be those that clinical personnel would normally classify as ready for treatment.

All subjects have the right to choose not to participate in the study and to discontinue participation if they choose. Federal law requires that the use of prisoners as human subjects involve no coercion nor withholding of benefits to those who do not want to participate. The only inducement provided to all participants is to pay them for the testing. (\$50 at each of three intervals.)

Although all who may wish to be in the ACT program cannot be accommodated, the overall effect of the program is to increase treatment available to inmates in Delaware. The procedure allows for assessment of program effectiveness up to 18 months after parole with some statistical precision.

Success of the ACT program in terms of reduced drug use and recidivism will lead to more general use of the program, both in Delaware and nationally. If the program fails to produce discernable improvements in reducing relapse and recidivism, it will suggest looking elsewhere for promising treatment alternatives.

Approximately seventy-five parolees are currently in treatment or control groups. Preliminary data should be available in about a year. ■

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