

FORENSIC ASSERTIVE COMMUNITY TREATMENT: UPDATING THE EVIDENCE

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Forensic assertive community treatment (FACT) is an adaptation of the traditional assertive community treatment (ACT) model for people with serious mental illness who are involved with the criminal justice system (Lamberti et al., 2004). ACT is a psychosocial intervention that was developed for people with severe mental illness (a subset of serious mental illness marked by a higher degree of functional disability) who have severe mental illness, functional disabilities, and high rates of service use. Indeed, the main circumstance affecting the cost-effectiveness of ACT is whether the people served have a history of frequent psychiatric hospitalization that was developed for people with severe mental illness (most cost-effective when people served had at least 48-50 days of psychiatric hospitalization in the year prior to enrollment (Latimer, 1999; Dieterich et al., 2010; Morrissey et al., 2013)).

Assertive Community Treatment

FACT teams have been trying to follow the same pathway. Consistent findings across studies are that ACT is effective in reducing the use and number of days of psychiatric hospitalization and in promoting housing stability.

Over the years, ACT has become a platform for leveraging other evidence-based practices such as integrated dual disorders treatment and supported employment (Rosenheck, 2005). FACT teams have been trying to follow the same pathway.

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FACT Adaptations

ACT has been intensively studied over the past four decades to determine whether it is effective, and if so, for whom and under what circumstances. With regard to criminal justice processes at key sequential intercept points, that ACT is effective in reducing the use and number of days of psychiatric hospitalization and in promoting housing stability (Latimer, 1999; Dieterich et al., 2010; Morrissey et al., 2013) but not consistently effective in reducing psychiatric symptoms and arrests/jail time or improving social adjustment, substance abuse, and quality of life (Dieterich et al., 2010; Dixon et al., 2010; Bond et al., 2001; Calysn et al., 2005; Beach et al., 2013). Targeting is a big issue for ACT as it is a relatively expensive intervention costing as much as \$1 million per year for a team to serve a caseload of

FACT teams seek to leverage the ACT model by adding various practices designed (1) to interface with criminal justice processes at key sequential intercept points and avoid future criminal justice involvement. Examples of these FACT add-ons are creating teams that enroll only individuals with prior arrests and jail detentions, making re-arrest prevention an explicit goal for the team; accepting referrals from criminal justice agencies; recruiting criminal justice agency partners; using court sanctions to encourage participation; engaging staff of the treatment team; and adding substance abuse residential treatment units for consumers with dual

diagnoses (Lamberti et al., 2004; Morrissey et al., 2007). However, FACT continues to lack a well-validated sample of criminal justice-involved individuals and manualized interventions that can effectively address them. Most FACT teams focus on diversion from local jails, but a number also engage people with serious mental illness after their release from state prisons.

To date, only a handful of reports about the effectiveness of FACT or FACT-like programs have been published.

FACT Evidence Base

Like other recent mental health–criminal justice interventions, the evidence base for FACT has lagged far behind its rate of adoption nationally (Cuddeback et al., 2008). To date, only a handful of reports about the effectiveness of FACT or FACT-like programs have been published. One early, randomized study from 1992–94 in Philadelphia failed to show any statistically significant differences between the two groups. The FACT group had the higher re-arrest rate due largely to technical violations, rather than new charges (Solomon & Draine, 1995). However, a number of methodological limitations of these results.

The first study that employed pre-post designs (no control group) in Rochester, NY, compared to the year prior to program implementation. This study was responsible for much of the early evidence on FACT. It found that FACT participants had fewer arrests, hospitalizations, and hospital days (Lamberti et al., 2001). A preliminary cost analysis also found that the Project Link reduced the average yearly service cost per client (Weisman et al., 2004). Improvements were also noted in psychological functioning and engagement in substance abuse treatment. The second study focused on the Thresholds State-County Collaborative Jail Linkage Project in Chicago (McCoy et al., 2004). After one year of participation, participants had a decrease in jail days, days in the hospital, and reduced jail and hospital costs. However, the absence of control groups makes it unclear whether the gains reported in these two

studies can be fully attributed to participation in FACT. Two randomized clinical trials of FACT-like interventions have been recently reported. Both studies were carried out at sites that participated in California’s Mentally Ill Offender Crime Reduction (MIOCR) program and used administrative data to assess FACT with individuals released from a Bay-area county jail (Chandler & Spicer, 2006). It compared integrated dual disorders treatment (IDDT) with usual care. However, only one-third of the IDDT participants received ACT; the other two-thirds received case management services. The second study compared a FACT team to usual care in a different northern California county from 2003–05 & compared the ACT model on the Dartmouth Assertive Community Treatment Scale.

Arrests and jail days were lower for the IDDT group but however, IDDT participants did experience a number of service outcomes: receiving work engagement & related service within 60 days after leaving jail, outpatient & medications services, receiving medications, lower probability of psychiatric hospitalizations, shorter hospital stays, and lower participation in multiple prison visits and criminal justice outcomes (a lower likelihood of having multiple convictions, fewer hospitalizations, and fewer days in jail). The intervention departed in several important ways from the prevailing FACT model by not assigning all IDDT participants to ACT. Results were not reported separately for ACT and case management participants. Further, the study lacked comparability between IDDT and control groups at baseline on prior jail days and mental health costs as well as high attrition rates in the post period for both groups (Drake et al., 2006).

Much clearer and stronger evidence comes from the second study (Cusack et al., 2010). Following enrollment, FACT participants had fewer contacts, and fewer hospital days than did usual care

participants. FACT participants had a higher probability of illness. These programs are not a panacea and must be carefully targeted to those most in need. Further, the number of jail days did not differ between groups. Increased outpatient costs for FACT (resulting from greater outpatient service use) were offset by decreased inpatient costs. At 24 months following enrollment, the results followed a similar pattern.

Failure to recognize and tailor a response to ... diverse segments of the FACT population likely contributes to the inconsistent findings in the current literature.

Directions for Further Research

Current research on FACT consists of a handful of single-site studies with mixed results. The studies have relatively small sample sizes, variable team characteristics, and lack uniform outcome measures. supporting the effectiveness of FACT, more high quality, multi-site, randomized controlled studies are their reproducibility across diverse communities and geographical areas.

The major obstacle to advancing this research agenda continues to be the absence of a clinical model that who are served by FACT teams. Many of the people served have less psychosis and more criminogenic tendencies, whereas behaviors with psychogenic origins predominate for others (Hodgins et al., 2002). The implication is that traditional psychiatric interventions may not work well for all FACT participants. Other cognitive behavioral and contingency management interventions may be more successful with criminal behavior. Failure to recognize and tailor a response to these diverse segments of the FACT population likely literature.

Conclusions

can improve both criminal justice and behavioral health outcomes for jail detainees with severe mental

may become even more central to community efforts to help people with severe mental illness function in the community with minimal continued criminal justice involvement.

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