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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 KDYH VLJQL¿FDQW GLI¿FXOW\ to engagement, service needs, and repeated psychiatric hospitalizations (Stein & Santos, 1998).

Assertive Community Treatment

$&7 KDV D ZHOO VSHFL¿HG FOLQLFDO RRGHO WKDW LQFOXGHV D mobile, self-contained, multidisciplinary team made up of a mix of disciplines, including psychiatry, nursing, addiction counseling, and vocational rehabilitation; a shared caseload among team members; direct servi provision by team members; a high frequency o consumer contact; 10/1 consumer-to-staff ratios; an 24/7 outreach in the community (Dixon et al., 2010) Fidelity scales have been developed to assess the ext to which new or established teams adhere to the model (Teague et al., 1998; Monroe-DeVita et al., 2011).

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 H I I H F W L Y H Q H V V W K H F R Q V L V W H Q W ¿ Q G L Q J V D F U R V V W K H E R D U 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 60. ACT is intended for those most-in-need people 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 K R V S L W D O X V H 3 X E O L V K H G V W X G L 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).

Over the years, ACT has become a platform for leveraging other evidence-based practices such as integrated dual disorders treatment and supported employment (Latimer, 2005). 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.

FACT Adaptations

FACT teams seek to leverage the ACT model by adding various practices designed (1) to interface with criminal justice processes at key sequential intercept S R L Q W V 0 X Q H W] * U L ¿ Q D Q G 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 S U R E D W L R Q D Q G O D Z H Q I R U F H P H Q 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 FOLQLFDO PRGHO WKDW LGHQWL¿HV ERWK WKH XQGHUOLQJ QHHG 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 VLJQL¿FDQW GLIIHUHQFHV EHWZHHQ JURXSV DQG WKH)$&7 had the higher re-arrest rate due largely to technical violations, rather than new charges (Solomon & Draine, 1995). However, a number of methodological GLI¿FXOWLHV LQFOXGLQJ UHFUXLWPHQW DQG DWWULWLRQ VKRUW DQG $&7 ¿GHOLW\ LVVXHV XQGHUPLQHG WKH YDOLGLW\ RI these results.

3RVLWLYH ¿QGLQJV DUH UHSRUWHG LQ WZR SXEOLVKHG VWXGLHV that employed pre-post designs (no control group). People/subjects who completed one year of Project Link in Rochester, NY, compared to the year prior to program DGPLVVLRQ KDG VLJQL¿FDQW UHGXFWLRQV LQ arrests, hospitalizations, and hospital days (Lamberti et al., 2001). A preliminary cost analysis also found that 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 WHDPV RU WR D KRVW RI RWKHU LQ

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 RXWFRPHV 7KH ¿UVW VWXG\ ZDV FR 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 &XVDFN HW DO 7KLV WHDP the ACT model on the Dartmouth Assertive Community Treatment Scale.

7KH ¿UVW VWXG\ &KDQGOHU 6SL arrests and jail days were lower for the IDDT group but WKH\ ZHUH QRW VLJQL¿FDQWO\ GL However, IDDT participants did experience a number RI VLJQL¿FDQW JDLQV ERWK ZLWK service outcomes (receiving an engagement-related service within 60 days after leaving jail, outpatient medications services, receiving medications, lower probability of psychiatric hospitalizations, shorter hospitals stays if admitted, and fewer participants with multiple crisis visits) and criminal justice outcomes (a lower likelihood of having multiple convictions, fewer LQFDUFHUDWLRQV +HUH DJDLQ ¿ tempered by several methodological limitations. The intervention departed in several important ways from the prevailing FACT model by not assigning all IDDT SDUWLFLSDQWV WR DQ $&7 WHDP D in this study was responsible for only half of the IDDT participants. 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). At 12 months following enrollment, FACT participants had VLJQL¿FDQWO\ IHZHU MDLO ERRNL contacts, and fewer hospital days than did usual care

participants. FACT participants had a higher probability of avoiding jail in the post period, although once jailed, 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.

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. $OWKRXJK WKHUH DUH VRPH PRGHUDWHO\ VWURQJ ¿QGLQJV supporting the effectiveness of FACT, more high quality, multi-site, randomized controlled studies are QHHGHG WR FRQVROLGDWH ¿QGLQJV DQG WR GHPRQVWUDWH 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 FDUHIXO\ VSHFL¿HV WKH KHWHURJHQHRXV QHHGV RI SHRSOH 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

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