From "Reentry Planning for Offenders With Mental Disorders", Henry A. Dlugacz, Editor, Civic Research Institute, 2010.

Chapter 7

Forensic Assertive Community Treatment: Origins, Current Practice, and Future Directions

by J. Steven Lamberti, M.D., and Robert L. Weisman, D.O.

Introduction 7-2
Origins of Forensic Assertive Community Treatment 7-2
National Forensic Assertive Community Treatment Survey Study 7-3
Conceptual Framework for Forensic Assertive Community Treatment 7-11
- Access to Services 7-13
- Competent Care 7-13
- Legal Leverage 7-14

Challenges to Forensic Assertive Community Treatment Implementation and Operation 7-15
- Establishing Admission and Discharge Criteria 7-16
- Addressing Incomplete Staffing and the Need for Specialty Training 7-17
- Identifying and Managing Communication and Collaboration Barriers 7-18
- Managing Staff Issues Including Safety, Burnout, and Turnover 7-20
- Obtaining Residential Services 7-21
- Obtaining Primary Care Services 7-21
- Achieving Continuity of Care and Developing Step-Down Services 7-22
- Managing Dual Agency Role Confusion 7-22

Future Directions 7-23
Summary Points 7-24
References *7-25*

INTRODUCTION

Forensic assertive community treatment (FACT), an adaptation of the assertive community treatment (ACT) model, is designed to transition adults with severe mental illnesses from correctional facilities into the community. Since publication of the first study of FACT programs in 2004 (Lamberti, Weisman, & Faden, 2004), this treatment strategy has continued to proliferate across the United States (Deem, Lamberti, & Weisman, 2008). Despite the growth, a standardized FACT model has yet to emerge, and no controlled studies have been done to date. In this chapter, an overview of FACT, which includes its origins, current practice, operational challenges, and future directions, is provided.

ORIGINS OF FORENSIC ASSERTIVE COMMUNITY TREATMENT

The origins of FACT are rooted in the development of the ACT model. ACT's emergence was prompted by deinstitutionalization, when adults with severe mental illnesses were discharged en masse from state hospitals across the United States beginning in the mid-1950s. By the 1970s, it was abundantly clear that many deinstitutionalized persons required support to live successfully in the community. In response to this need, ACT originated when former state hospital employees in Madison, Wisconsin, began treating deinstitutionalized inpatients as outpatients in the community (A Community Treatment Program, 1974). The ACT model involved the use of mobile treatment teams that delivered services to clients wherever they lived, even if they resided in emergency shelters or slept on the streets. This treatment strategy was particularly well suited to clients whose illnesses prevented them from attending appointments at local mental health clinics. As ACT developed, it incorporated elements that enabled the model to provide comprehensive care, including mental health and addiction treatment services, vocational support, financial assistance, and transportation. Also, ACT teams employed a high staff-to-client ratio, and the teams were designed to be available around the clock to promote timely crisis intervention and continuity of care. Research subsequently demonstrated that ACT was effective at decreasing hospitalization rates and at increasing community tenure (Mueser, Bond, Drake, & Resnick, 1998). As a result, the ACT model became widely disseminated as an evidence-based practice for clients with severe mental illnesses who are at risk for homelessness and repeated hospitalization.

Despite this progress, by the 1990s and 2000s, a growing number of sources began reporting that persons with severe mental illnesses were overrepresented within the criminal justice system. On March 5, 1998, the *New York Times* featured a front-page headline proclaiming "Prisons Replace Hospitals for the Nation's Mentally Ill" (Butterfield, 1998). In 2003, a Human Rights Watch study reported that more individuals with severe mental illnesses reside in prisons than in hospitals (Abramsky & Fellner, 2003). In addition, studies by Teplin and colleagues (e.g., Teplin, 1984) and survey data from the U.S. Bureau of Justice Statistics (Ditton, 1999) suggested that the prevalence of severe mental illness in correctional facilities was two to four times higher than the general population rate. These reports highlighted the need for intervention strategies aimed at transitioning persons with severe mental illnesses out of correctional facilities as well as preventing their rearrest and incarceration.

Because of its comprehensive services, intensive staffing, and use of outreach, ACT appeared to be an ideal intervention strategy to address the problem. However, studies of standard ACT programs showed little or no effect on reducing rates of arrest and incarceration (Bond, Drake, Mueser, & Latimer, 2001; Mueser et al., 1998). Despite publication of these research findings in academic journals, frontline care providers across the country continued applying ACT to clients who were involved in the criminal justice system. These clients included inmates with severe mental illnesses referred for treatment after release from local jails and prisons. Although many clients from correctional facilities appeared no different than typical ACT clients, others presented with substantial criminal histories, including multiple arrests and incarcerations and histories of violent offenses. In light of these differences, clinicians began adapting the standard ACT model in various ways to manage formerly incarcerated clients in community settings.

A central difficulty in pinpointing exactly when and where FACT originated relates to the question of how FACT is defined. For the purposes of this discussion, FACT programs are operationally defined as ACT teams that (1) serve only clients with criminal histories; (2) receive most of their referrals from a jail, prison, or other criminal justice source; and (3) work in close partnership with a criminal justice agency to manage their mutual clients. This definition does not describe how the ACT model itself may have been modified. Indeed, such characterization may be premature given that FACT is a newly developing model. Rather, the goal of this definition is to enable the reliable identification of a distinct subgroup of ACT programs that are clearly forensic in nature in order to study them.

Using this definition, the first FACT program recognized by the American Psychiatric Association was Project Link in 1999, in Rochester, New York (Project Link, 1999), followed by Chicago's Thresholds Jail Linkage Project in 2001 (Thresholds State, 2001). An early reference to "forensic assertive community treatment" as an emerging model of care was published in the textbook *Serving Mentally Ill Offenders* in 2002 (Lamberti & Weisman, 2002). Although earlier descriptions of ACT teams serving criminal justice populations were published (Inciardi, Isenberg, Lockwood, Martin, & Scarpitti, 1992; Wilson, Tien, & Eaves, 1995), details about most prototype FACT programs did not find their way into the peer-reviewed literature until the national FACT survey study (Lamberti et al., 2004).

NATIONAL FORENSIC ASSERTIVE COMMUNITY TREATMENT SURVEY STUDY

Between July 2002 and January 2004, investigators at the University of Rochester Medical Center conducted a two-phase survey aimed at identifying and describing FACT programs in operation across the United States. The first phase consisted of a screening survey of all members of the National Association of County Behavioral Health Directors (NACBHD). NACBHD is a membership organization that represents all states where county authorities are required to supervise the arrangement and delivery of mental health, substance abuse, and developmental disability services. NACBHD was selected as the initial focus of the study because county health authorities typically have an excellent working knowledge of the services that exist within their respective locales. A total of 314 members representing twenty-eight states and

the District of Columbia were e-mailed a Web-based survey asking for contact information about programs that met two screening criteria: (1) their ACT teams served clients with criminal histories and (2) their ACT teams worked in close collaboration with the criminal justice system.

In the second phase, the contact person for each program identified by NACBHD was administered a forty-five-minute telephone survey to obtain details about the program's design and operation. One important issue to be decided about each program was whether it actually featured an ACT team. ACT fidelity was briefly assessed using selected criteria from the Dartmouth Assertive Community Treatment Scale (DACTS; Teague, Bond, & Drake, 1998). The criteria were time-unlimited services, twenty-four hour crisis availability, a psychiatrist-to-client ratio of at least 1:100, a staff-to-client ratio of at least 1:10, and in vivo service delivery. Only five items were used because a complete DACTS assessment was not feasible given the large scope of the study. These particular criteria were chosen because they appeared to be central to the ACT model and useful for identifying less clinically intensive programs. To qualify as an ACT program, programs needed to meet at least four of the five DACTS criteria. Programs that met the FACT operational definition noted earlier were selected for study inclusion. Specifically, criminal history needed to be identified as a program admission requirement, a criminal justice agency needed to be the primary source of client referrals, and programs needed to work in close partnership with a criminal justice agency.

The survey attained a 93 percent response rate with 291 NACBHD members responding. Applying the FACT definitional criteria, this group of respondents identified a total of sixteen programs in nine states, as listed in Table 7.1. The longest-running program identified in this survey study was the Community Treatment Alternatives program in Madison, Wisconsin, which began operations in 1991. It is fitting that the first FACT program identified in this study would come from Madison given that the first ACT team originated there. In reviewing the dates of service initiation for each program, however, it noteworthy was that the majority began operation only recently. Nearly two thirds of all identified programs got started in 1999 or later, providing evidence that FACT is a newly emerging intervention strategy. The diversity of funding sources is also notable, consistent with how these programs bridge mental health and criminal justice service domains and funding streams. All of the programs generated billable revenues, with Medicaid as a primary payor. Because these programs conducted some activities that were not covered by Medicaid, such as meeting with judges and probation officers, the programs also received funding from various local, state, and federal sources. Because of the presence of a single major funding source in California, the Mentally Ill Offender Crime Reduction Grant Program, half of all FACT programs in the study were found in California.

Table 7.2 shows program referral sources, admission requirements, and capacities. Local jails provided the primary referral source for thirteen programs (81 percent). The criminal justice history requirement for admission varied significantly between programs, ranging from programs that required misdemeanor histories to those requiring a current felony charge. Half of all programs accepted clients under involuntary or mandated outpatient treatment statutes, and most accepted clients who had recently been convicted of a violent crime. Program capacity data suggested that these are small, specialized programs. Program capacities ranged from 25 to 108 with an average size of 63 clients. An average of 53 clients was actually enrolled in each

Table 7.1
Programs That Met Forensic Assertive Community Treatment Study Criteria

Program name	Program location	Year of service initiation	Primary funding sources
Community Treatment Alternatives	Madison, Wisconsin	1991	Dane County Office of Mental Health
Project Link	Rochester, New York	1995	Robert Wood Johnson Foundation; New York State Office of Mental Health
Arkansas Partnership Project	Little Rock, Arkansas	1996	Arkansas Department of Mental Health
Substance Abuse and Mental Illness Court Program	Hamilton, Ohio	1997	Ohio Department of Alcohol and Drug Addiction Services; Ohio Department of Mental Health
Thresholds Jail Program	Chicago, Illinois	1998	Illinois Office of Mental Health; foundation grants
Forensic Assertive Community Team	Modesto, California	1999	California Board of Corrections Mentally Ill Offender Crime Reduction Grant (MIOCRG) Program
Forensic Assertive Community Treatment Project	Santa Rosa, California	1999	California Board of Corrections MIOCRG Program
Community Reintegration of Mentally Ill Offenders	Los Angeles, California	2000	California Board of Corrections MIOCRG Program
Multi-Agency Referral and Treatment	Ventura, California	2001	California Board of Corrections MIOCRG Program
CHANGES	Oakland, California	2001	California Board of Corrections MIOCRG Program
Monterey County Supervised Treatment After Release	Monterey, California	2001	California Board of Corrections MIOCRG Program
Mental health court	Ukiah, California	2001	California Board of Corrections MIOCRG Program
Support and Treatment After Release	Greenbrae, California	2002	California Board of Corrections MIOCRG Program
Suncoast Center Forensic FACT Team	St. Petersburg, Florida	2002	Florida Department of Children and Families
Project DOT (Divert Offenders to Treatment)	Portland, Maine	2003	Grant from the Substance Abuse and Mental Health Services Administration (SAMHSA)
Birmingham Jail Diversion Project	Birmingham, Alabama	2004	Grant from SAMHSA

Reprinted with permission from *Psychiatric Services, 55,* 1285-1293 (Copyright 2004). American Psychiatric Association.

Table 7.2
Program Referral Sources, Criminal Justice Admission Requirements, and Capacities

Program name	Primary referral source	Secondary referral source	Criminal justice history required for admission	Are clients who recently committed a violent crime eligible?	Maximum capacity
Community Treatment Alternatives	Dane County Jail	Mental health center crisis unit	Must be either incarcerated, not guilty by reason of insanity, on bail, or referred by courts	Yes	82
Project Link	Monroe County Jail	Rochester Psychiatric Center	Must have at least one previous arrest	Yes	50
Arkansas Partnership Project	Arkansas State Hospital forensic unit	Court system	Must be not guilty by reason of insanity	Yes	None
Substance Abuse and Mental Illness Court Program	Butler County Court	None	Must be a convicted felon	Yes	25
Thresholds Jail Program	Cook County Jail	None	Must be incarcerated in Cook County Jail	Yes	30
Forensic Assertive Community Team	Local jail	Restoration to trial competency program	Must be booked or in custody	Yes	48
Forensic Assertive Community Treatment Project	Local jail via mental health court	None	Must have more than three arrests and be incarcerated	Yes	100
Community Reintegration of Mentally Ill Offenders	Local jail via the court system	None	Must be incarcerated	No	108
Multi-Agency Referral and Treatment	Local jail	Mental health agencies	Must have an outstanding misdemeanor offense	No	40
CHANGES	Santa Rita Jail	Psychiatric emergency services	Must have history of repeated Santa Rita incarceration and psychiatric hospitalization	Yes	100
Monterey County Supervised Treatment After Release	Jail medical service	Court system	Must have at least two arrests, jail history, or probation violation	Yes	30

(*Continued*)

Table 7.2 (*Continued*)
Program Referral Sources, Criminal Justice Admission Requirements, and Capacities

Program name	Primary referral source	Secondary referral source	Criminal justice history required for admission	Are clients who recently committed a violent crime eligible?	Maximum capacity
Mental health court	Local jail via superior court	None	Must be incarcerated, referred by public defender	No	45
Support and Treatment After Release	Local jail	Court system	Must be incarcerated	Yes	70
Suncoast Center Forensic FACT Team	State forensic mental health facility	Court system	Must be charged with a felony, be not guilty by reason of insanity, or incompetent to stand trial on conditional release	Yes	100
Project DOT (Divert Offenders to Treatment)	Cumberland County Jail	Probation and parole	Must be in the correctional system	Yes	40
Birmingham Jail Diversion Project	Birmingham City Jail	None	Must be in Birmingham jails for misdemeanors	Yes	70

Reprinted with permission from *Psychiatric Services, 55,* 1285-1293 (Copyright 2004). American Psychiatric Association.

program at the time of the study. Of all enrolled clients, 69 percent were men, 56 percent had either schizophrenia or schizoaffective disorder, and 21 percent had bipolar disorder. Co-occurring substance use disorders were highly prevalent in this population, affecting 89 percent of all clients. An average of 64 percent of all clients in the identified programs had previous felony convictions, whereas 37 percent had committed violent crimes.

Table 7.3 shows where the identified programs interfaced and partnered with the criminal justice system. Of note, the major interfaces were correctional facilities, courts, and probation departments, while parole was the least common point of interface.

Table 7.4 summarizes additional characteristics of the programs that met study criteria. It is interesting that half of the programs incorporated a supervised residential component either as part of the program itself or through special service contracts with residential providers. Five of the eight programs with residential components offered residentially based addiction treatment services. In addition, eleven of the sixteen total programs identified included a credentialed addictions counselor on their teams. These data are consistent with the high prevalence of substance use disorders among adults with severe mental disorders and with the tendency of combined mental illness, addiction, and incarceration to contribute to homelessness. An average of 52 percent of

Table 7.3
Criminal Justice System Partnerships

Program name	Correctional facility	Probation	Parole	Courts	Law enforcement
Community Treatment Alternatives	X	X	X	X	X
Project Link	X	X	X	X	X
Arkansas Partnership Project				X	
Substance Abuse and Mental Illness Court Program	X	X		X	
Thresholds Jail Program	X	X			
Forensic Assertive Community Team	X	X	X	X	X
Forensic Assertive Community Treatment Project	X	X		X	X
Community Reintegration of Mentally Ill Offenders	X	X		X	X
Multi-Agency Referral and Treatment	X	X		X	X
CHANGES	X	X		X	
Monterey County Supervised Treatment After Release	X	X		X	X
Mental health court	X	X		X	X
Support and Treatment After Release	X	X	X		X
Suncoast Center Forensic FACT Team		X		X	
Project DOT (Divert Offenders to Treatment)	X	X	X	X	X
Birmingham Jail Diversion Project	X			X	

Reprinted with permission from *Psychiatric Services, 55,* 1285-1293 (Copyright 2004). American Psychiatric Association.

all clients in the identified programs was reported to be homeless at the time of their enrollment.

Another significant study finding is that eleven programs (69 percent) incorporated probation officers as team members. The probation officers provided community supervision to all program enrollees who were sentenced to probation, and they actively collaborated with the team clinicians in the management of those clients. Because probation is a common correctional disposition and probation officers work in the community, probation is an ideal point of interface for clinical teams that serve clients who are involved in the criminal justice system. The finding that 55 percent of all clients were on probation at the time of their enrollment further argues for the strategic importance of partnering with probation officers. The data on client race and ethnicity are consistent with the observed overrepresentation of African American and Hispanic individuals within the criminal justice system (Lamberti et al., 2001). An average of 49 percent of clients were African American, Hispanic, or from other racial and ethnic minority groups. Consistent with the importance of overcoming cultural and language barriers to engage and treat such clients, nearly a third of all program staff members were also from minority groups (32 percent).

To track the continued emergence of FACT programs in the United States, a follow-up national survey study is currently being conducted at the University of Rochester Medical Center (Deem et al., 2008). This study uses the same methodology as the original survey study, including an initial screening of NACBHD members and subsequent telephone interviews with each identified program. NACBHD has grown significantly since the original study was conducted in 2002-2003, now including 679 total members representing thirty states and the District of Columbia. As of the time of this writing, twenty-eight programs meeting FACT study criteria have been identified, a 75 percent increase in number compared with the sixteen programs identified in the original study. The extent that this increase is attributable to a more than 100 percent increase in the total number of NACBHD members available for survey is unclear. However, approximately twelve programs in the follow-up study were initiated after publication of the previous survey in 2004, strongly suggesting the continued emergence of new FACT programs.

Preliminary analysis of study data reveals some important areas of program similarity. For instance, twenty of twenty-eight programs (71 percent) include probation officers as team members. A very similar finding was reported in the original study, where eleven of sixteen programs (69 percent) incorporated probation officers as team members. Also, half of the programs identified reported having residential components, an identical finding to the 2004 study. Despite continued areas of program similarity, analysis suggests that existing FACT programs continue to show a significant degree of variability in terms of structure and function. For example, programs continue to show variable fidelity to the ACT model, different admission criteria, and differences in collaboration between the clinicians and the criminal justice system representatives.

These preliminary findings suggest that FACT continues to emerge as a new strategy for preventing criminal recidivism. However, the great variability between existing FACT programs underscores the need for further research to standardize and test this model of intervention. Given the pressing need for FACT programs (Cuddeback, Morrissey, & Cusack, 2008) and the lack of a standard approach, FACT model development is at an important turning point. In the absence of experimental data, what principles should guide FACT model development?

Table 7.4
Additional Characteristics of Programs Meeting Forensic Assertive Community Treatment Study Criteria

Program name	Supervised residential component	Probation officer on team	Credentialed addictions counselor on team	% staff from a racial or ethnic minority group	% patients from a racial or ethnic minority group
Community Treatment Alternatives	No	Yes	Yes	17	35
Project Link	Yes	No	No	80	85
Arkansas Partnership Project	Yes	No	Yes	50	40
Substance Abuse and Mental Illness Court Program	No	Yes	Yes	0	23
Thresholds Jail Program	Yes	Yes	Yes	60	70
Forensic Assertive Community Team	No	Yes	No	10	12
Forensic Assertive Community Treatment Project	Yes	Yes	No	20	16
Community Reintegration of Mentally Ill Offenders	No	Yes	Yes	52	70
Multi-Agency Referral and Treatment	Yes	Yes	Yes	25	35
CHANGES	No	Yes	No	70	64
Monterey County Supervised Treatment After Release	Yes	Yes	Yes	30	90
Mental health court	No	Yes	Yes	0	25
Support and Treatment After Release	Yes	Yes	Yes	32	55
Suncoast Center Forensic FACT Team	No	No	Yes	14	63
Project DOT (Divert Offenders to Treatment)	Yes	No	Yes	0	8
Birmingham Jail Diversion Project	No	No	Yes	50	100

Reprinted with permission from *Psychiatric Services, 55,* 1285-1293 (Copyright 2004). American Psychiatric Association.

CONCEPTUAL FRAMEWORK FOR FORENSIC ASSERTIVE COMMUNITY TREATMENT

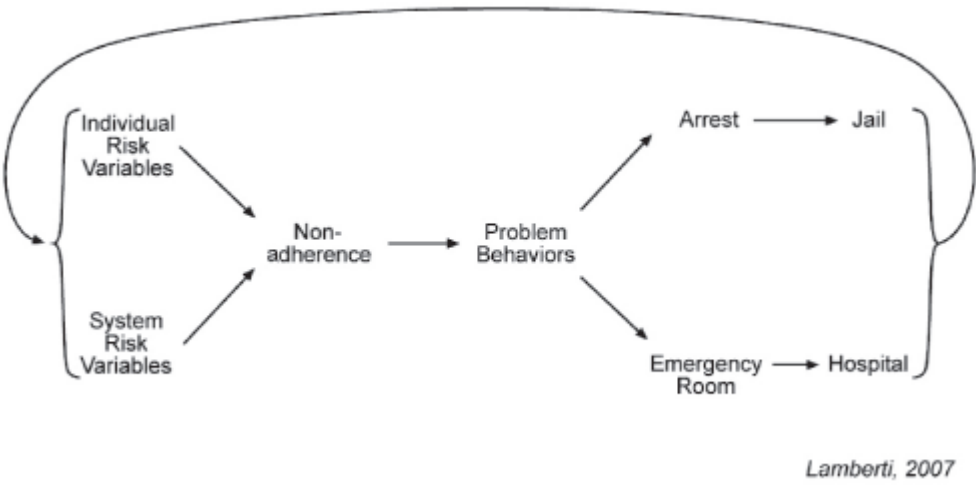
To develop FACT into a standardized and testable model of intervention, it is essential to understand why adults with schizophrenia and other psychotic disorders enter the criminal justice system. The mental health literature often cites deinstitutionalization and fragmentation of mental health services as likely culprits (Daly, 2006; Torrey, 1997). However, these factors fail to explain why some individuals with mental illnesses enter the criminal justice system while others do not. Because a primary goal of FACT is to prevent criminal recidivism, contemporary crime prevention theory can be applied to FACT model development. The principles of risk, needs, and responsivity, often referred to as *RNR theory* (Andrews & Bonta, 1998; Kennedy, 2003; Taxman & Marlowe, 2006) are part of the predominant approach to understanding and preventing crime. RNR theory emphasizes the importance of targeting modifiable risk factors for crime in order to prevent criminal recidivism. On the basis of a considerable body of research (Andrews & Bonta, 1998), eight primary risk factors have been identified that are predictive of criminal behavior. They are substance abuse, low levels of satisfaction or performance with work or school, lack of healthy recreational pursuits, family problems, history of antisocial behaviors, antisocial personality pattern, antisocial cognition, and antisocial attitudes.

Individuals with psychotic disorders have an increased prevalence of these established risk factors, particularly co-occurring substance use disorders (Regier et al., 1990), unemployment (Draine, Salzer, Culhane, & Hadley, 2002), and antisocial personality disorder (Moran & Hodgins, 2004). In addition, such individuals have high rates of homelessness, a factor that has been associated with arrest both among mentally ill and nonmentally ill persons (McQuistion, Finnerty, Hirschowitz, & Susser, 2003). Also, a growing body of literature suggests that psychosis itself is an additional risk factor for violence, particularly in the absence of prominent negative symptoms (Lamberti, 2007).

Because many of the risk factors noted above are modifiable with appropriate treatment, the relationship between these factors and criminal behaviors is mediated by treatment adherence. In light of the potential for treatment to prevent recidivism by addressing modifiable risk factors, treatment nonadherence becomes a critical target of intervention. The relationships between risks, nonadherence, and jail and hospital recidivism are shown in Figure 7.1. Individual risk variables include the eight primary risk factors for recidivism along with psychosis and homelessness, as well as denial of illness and cognitive impairment. System risk variables include lack of outreach, cultural and language barriers, financial barriers, and lack of effective services. In this framework, nonadherence is viewed as the result of a mismatch between individuals and systems of care rather than as a patient behavior per se. For example, nonadherence is more likely to occur among homeless clients if their local outpatient clinic provides no outreach services to promote engagement.

> ***Example—Part 1:*** Mr. Alvarez is a 32-year-old Hispanic man with diagnoses of chronic paranoid schizophrenia and alcohol dependence who has been incarcerated in the county jail for six months. His release plan includes discharge to a homeless shelter, probationary supervision, and follow-up at the local community mental health center. Mr. Alvarez *arrives late for* his first outpatient appointment and has difficulty

Figure 7.1
Cycle of Recidivism



Reprinted with permission from *Psychiatric Services, 58,* 773-781 (Copyright 2007). American Psychiatric Association.

understanding the therapist because of his auditory hallucinations and limited grasp of English. He stops taking his antipsychotic medications and later reports to his probation officer that his hallucinations are worsening. The probation officer calls the mental health center to schedule a crisis appointment for Mr. Alvarez, and he is given "the next available appointment" in two weeks. Meanwhile, Mr. Alvarez begins drinking heavily, is evicted from the homeless shelter, and misses his next two outpatient appointments. The mental health center subsequently closes his case due to noncompliance.

In the absence of adherence to effective treatment, high-risk adults with psychotic disorders are more likely to exhibit problematic behaviors including trespassing, public intoxication, theft, and verbal or physical assaultiveness. Whether individuals with mental illnesses with these behaviors are taken to a hospital or to jail often depends on who makes the initial intervention. For instance, a paranoid man who lives with his mother and destroys her television in response to delusions is likely to be taken to a hospital by ambulance. However, the same individual who destroys a television at a crowded shopping mall is likely to be arrested by the police and taken to jail. If jailed or hospitalized after such an event, the individual is likely to be released after a brief stay, thus continuing the cycle of recidivism.

Because recidivism can result from individual and systemic risk variables, effective intervention strategies must address both types of risk. In addition to targeting modifiable risk factors, interventions must be accessible to high-risk individuals, and they must incorporate the use of legal leverage. Legal leverage is a process whereby the legal authority of a judge, probation officer, or other criminal justice agent is used to compel high-risk individuals to adhere to treatment. Consistent with this conceptual framework, FACT prevents criminal recidivism by incorporating three core elements

of intervention. Although these elements are not unique to FACT, they are necessary to break the cycle of recidivism among high-risk adults with psychotic disorders.

Access to Services

Reviewing the latest evidence-based treatments for schizophrenia, the national schizophrenia Patient Outcomes Research Team (PORT) study identified lack of access as a major issue (Lehman, Steinwachs, & the Co-Investigators of the PORT Project, 1998). Likewise, the President's New Freedom Commission on Mental Health (2003) noted that few communities in the United States have accessible services for the mentally ill. For clients with multiple recidivism risk factors, ensuring access to a wide variety of services including mental health, addiction treatment, residential, and vocational services is essential (see Chapters 6 and 9 in this volume). By incorporating the ACT model, FACT delivers these services in a comprehensive and integrated manner through the use of outreach. Such delivery minimizes the fragmentation of care that many high-risk individuals experience in community settings. FACT also improves access for high-risk clients by utilizing eligibility criteria that specifically target individuals with criminal histories and by emphasizing the development of partnerships with criminal justice system representatives. An example of partnership development is the finding that over half of identified FACT teams have incorporated probation officers as team members (Deem et al., 2008; Lamberti et al., 2004). This finding demonstrates how FACT programs are adapting the ACT team model to bridge the gap between the mental health and criminal justice services. Coordination of such services is critical to provide access to care for clients who move between systems. In addition, FACT programs emphasize the importance of performing "inreach" into jails and prisons, providing opportunities to lay the groundwork for transitioning high-risk individuals back into their communities. For instance, these early contacts enable FACT team members to ensure that eligible inmates are enrolled in Medicaid (see Chapters 2 and 3 in this volume) prior to their release into the community (Morrissey et al., 2006).

Competent Care

Although clinical competencies for treating high-risk clients have yet to be established, clinicians who work with such individuals should be knowledgeable about evidence-based treatments for schizophrenia and other psychotic disorders. The ACT model is ideal for adaptation to treat clients with criminal recidivism because it is an evidence-based treatment that already targets several risk factors for criminal recidivism. ACT intervention components that target psychosis, co-occurring substance use, and unemployment have been incorporated as ACT model fidelity criteria (Teague et al., 1998). ACT also addresses the risks of homelessness and lack of social support by providing residential support, peer support, and outreach. In addition, although clinicians in traditional outpatient programs are sometimes uneasy in working with high-risk clients, ACT team members are required to have a certain level of comfort and interest in working with this challenging population. These interpersonal qualities can result in the establishment of a positive working alliance, a strong predictor of health outcomes (Horvath & Symonds, 1991; Martin, Garske, & Davis, 2000). In addition to incorporating the competence of ACT, FACT team members must also be

knowledgeable about the criminal justice system and able to work in partnership with criminal justice system representatives. Beyond improving access to care for clients involved in both systems, collaboration between mental health and criminal justice staff provides a foundation for the use of legal leverage.

Legal Leverage

Despite the presence of services that are highly accessible and clinically competent, some high-risk individuals will continue to refuse treatment. Although various types of leverage have been applied to promote adherence in community settings (Monahan et al., 2001, 2005), the involvement of clients in the criminal justice system presents the option of legal leverage. Legal leverage is regularly used in community settings to address nonadherence, especially with clients who have committed physical assaults (Swanson, Van Dorn, Monahan, & Swartz, 2006). FACT team members lay the groundwork for utilizing legal leverage by establishing collaborative partnerships with judges, probation or parole officers, or police officers, depending on a client's legal involvement and the resources available locally. In building such bridges, it is important for each partner to value treatment as a legitimate alternative to arrest and incarceration. Likewise, both partners should be committed to utilizing problem-solving approaches rather than punishment in addressing the behavioral problems that will inevitably arise. Without establishing such shared values and commitments through cross-training, use of legal leverage can result in increased risks for arrest and incarceration (Solomon, Draine, & Marcus, 2002). Depending on a client's individual needs, FACT teams can use legal leverage to promote medication adherence, adherence with addiction treatment, and/or adherence with residential services, as well as to prevent association with criminal companions. Use of legal leverage is consistent with the growing literature demonstrating that when combined with comprehensive services, legal leverage can promote treatment adherence among high-risk clients (Hiday, 2003; Swartz & Swanson, 2004).

> ***Example—Part 2:*** Mr. Alvarez (see Example—Part 1 in "Conceptual Framework for FACT") is arrested for disorderly conduct and taken into custody. He appears acutely psychotic while in custody and is transferred to the local psychiatric hospital for stabilization. Mr. Alvarez is discharged back to the homeless shelter after a brief hospital stay and, because of his history of multiple arrests, he is referred to a FACT team for follow-up. When Mr. Alvarez becomes disruptive at the homeless shelter one week after leaving the hospital, shelter workers call FACT team members who arrive an hour later to evaluate the patient. Evaluation reveals that Mr. Alvarez stopped his antipsychotic medication again and has resumed drinking. The FACT team assists in getting Mr. Alvarez an emergency room evaluation where he agrees to try a new antipsychotic medication. Mr. Alvarez appears much calmer after twenty-four hours in the emergency room, but he refuses to enter an alcoholism detoxification facility, stating "I don't need treatment for drinking." Following his discharge from the emergency room, FACT team members contact Mr. Alvarez's probation officer *with the information and treatment recommendations obtained* from the emergency room evaluation. The probation officer agrees to a joint meeting with the patient and the FACT team, where he offers the patient a choice between alcoholism treatment and a probation violation. Faced with the possibility of reincarceration and the presence of a supportive treatment team, Mr. Alvarez agrees to enter his first alcoholism treatment program. *In the meantime, the FACT team investigates more suitable housing for their new client.*

This conceptual framework provides a template to guide FACT development, including how the ACT model may need to be further adapted and modified for individuals with severe mental illnesses in the criminal justice system. As discussed later in the chapter (see "Future Directions"), these core elements of intervention require further definition, standardization, and testing to promote the development of FACT as an evidence-based practice. In the absence of such development, however, there remains a pressing need for intervention strategies to prevent criminal recidivism among high-risk adults with severe mental illnesses.

CHALLENGES TO FORENSIC ASSERTIVE COMMUNITY TREATMENT IMPLEMENTATION AND OPERATION

FACT programs continue to emerge across the United States despite the absence of a standardized model. This emergence has generated a need for technical assistance related to program design, implementation, and daily operations. In response to this need, the University of Rochester Medical Center Department of Psychiatry has provided technical assistance for the planning, implementation, and operation of FACT programs since 2001. On the basis of the authors' experience in providing FACT technical assistance, several common needs and challenges for FACT programs have been identified. This section presents an overview of lessons learned from technical assistance activities, including recommendations for avoiding common pitfalls faced by new and established FACT programs.

To determine these challenges, data were gathered from a series of two-day technical assistance visits conducted at ten different programs in nine locations across the United States and Canada between January 2002 and December 2007. Visits were conducted at programs located in Arkansas, British Columbia, Hawaii, Louisiana, Maine, New Mexico, New York (two programs), Utah, and Virginia. Four of the technical assistance visits were delivered to start-up FACT programs that were in various stages of planning and implementation, whereas six visits involved established FACT programs. Start-up programs were defined as FACT teams that had been operating less than four months. These programs typically had not hired all of their clinical staff members and/or had not achieved a full enrollment of clients.

Information gathered during each technical assistance visit was obtained from multiple sources. These included FACT clinical team members, criminal justice partners, program heads, grant administrators, and public policy officials. In addition, clients, family members, and peer specialists often provided their perceptions and experiences regarding their respective programs. To tailor technical assistance visits to meet the consultation and training needs of each FACT program, information was gathered in advance of the visits through teleconferences with program representatives. Information typically included details about the stage of program development, program design, and perceived program strengths and weaknesses. At the beginning of each visit, FACT team clinicians were subsequently asked to list their perceived challenges and to rate them on a scale from 1 to 4, with 4 representing the areas of greatest concern.

On the basis of responses from FACT team clinicians collected during technical assistance visits, eight common challenges were identified. For each challenge, a summary of responses according to the level of FACT team experience is provided in Table 7.5. Level of concern about each item is represented with + symbols, with ++++

Table 7.5
Challenges Identified by Start-Up and Established Forensic Assertive Community Treatment Team Members

Identified challenge	Start-up FACT teams	Established FACT teams
Establishing admission and discharge criteria	+++	+
Addressing incomplete staffing and the need for specialty training	++++	++
Identifying and managing communication and collaboration barriers	+++	++
Managing staff issues including safety, burnout, and turnover	+++	+++
Obtaining residential services	++++	++++
Obtaining primary care services	+++	++
Achieving continuity of care and developing step-down services	+	+++
Managing dual agency role confusion	+++	+

Reprinted with permission from *Psychiatric Services, 58,* 773-781 (Copyright 2007). American Psychiatric Association.

representing the highest level of concern and + representing the lowest. The following sections provide a brief discussion of each challenge, including general recommendations to address them that were made as part of the technical assistance process.

Establishing Admission and Discharge Criteria

All teams reported a lack of either clear admission criteria, clear discharge criteria, or both. Most teams were uncertain about how to define appropriate client lengths of stay for their respective programs. In particular, new FACT teams described external pressures to admit clients with a wide range of diagnostic and social issues to satisfy their grant providers or to meet financial expectations of parent health care agencies. Team members consistently expressed the desire to be able to refuse cases that they deemed inappropriate. However, the teams' concerns were typically overridden in the face of pressure to quickly enroll to full capacity or to accept all community and correctional referrals. These challenges were particularly burdensome for new teams that lacked full complements of staff or significant FACT experience. Despite these needs, new FACT teams were generally expected to proceed with initiating outreach and other clinical services. The situation was described by one team leader as "trying to do too much with much too little." By contrast, established FACT teams reported less concern about admission criteria and enrollment rates and more concern about discharge criteria and lengths of stay. Most experienced FACT teams reported that they had clarified their admission criteria over time. However, similar to traditional mental health clin-

ics, the established teams found themselves holding on to stable clients. Although this practice had the benefits of promoting client stability and buffering the teams' high acuity caseloads, it also proved problematic in light of the presence of long waiting lists for FACT services.

During the technical assistance process, FACT programs are instructed to define their admission and discharge criteria early in conjunction with key stakeholders, including their referral sources. Primary FACT referral sources were usually local jails, courts, and forensic mental health facilities. Because the ACT model itself was designed primarily for clients with severe mental illnesses, including schizophrenia and bipolar disorder, FACT teams are encouraged to adopt admission criteria that target similar diagnoses. Given the high prevalence of co-occurring substance use disorders, antisocial personality features, and other risk factors within the severely mentally ill adult population, this focus encompasses substantial diagnostic breadth while maximizing the likelihood of treatment responsiveness. Many teams reported an abundance of referrals of individuals with primary character pathology and co-occurring substance use disorders in the absence of the Axis I psychopathology for which ACT was originally developed. In contrast to the criminalization of the mentally ill (Abramson, 1972), attempting to rehabilitate general offender populations in FACT programs can be viewed as the mentalization of the criminally ill. FACT team members consistently expressed significant frustration and demoralization about this practice. With respect to enrollment rates, teams were advised during technical assistance visits to enroll clients at a rate of no greater than approximately two clients per week, if possible. This rate parallels the enrollment standards of ACT (Teague et al., 1998), allowing FACT teams to manage the most challenging cases in an intensive manner. Once the FACT programs were filled to capacity, however, experienced FACT teams reported very limited success in discharging clients to existing community mental health centers given the clients' needs for more intensive services. This need for development of step-down or intermediate intensity programs is discussed separately below (see "Achieving Continuity of Care and Developing Step-Down Services").

Addressing Incomplete Staffing and the Need for Specialty Training

All FACT teams reported at least some difficulty in hiring appropriately trained and experienced staff. Several teams reported hiring staff members who lacked co-occurring substance use disorder experience or who had no experience with the criminal justice system. In addition to the need for training in these areas, FACT teams reported the need for training in vocational rehabilitation and trauma-related interventions. Many programs also reported that they were understaffed and that their team leaders shouldered the brunt of incomplete staffing and inadequate training. These team leaders, typically highly resourceful and experienced professionals, subsequently found themselves sidetracked by responsibilities falling outside of their job descriptions. These included taking on extra clients along with providing crisis intervention and addiction treatment services to all clients. Team leaders reported that these extra duties interfered with their usual "boundary spanner" responsibilities (Steadman, 1992) in interfacing with criminal justice partners, as well as their role in providing oversight and supervision for their team members. Primarily in new programs, these shortcomings

were compounded by expectations of rapid enrollment of new clients along with expectations of positive early program outcomes.

Both new and established FACT teams also reported difficulty in acquiring a team-based psychiatrist or, if none was available, an advance practice nurse to conduct pharmacotherapy. Having a dedicated psychiatrist or nurse practitioner is necessary for effective communication around clinical issues as well to ensure availability of prompt in vivo clinical assessment and treatment of clients. FACT team members reported serving clients who had failed traditional outpatient community mental health services because they were either unwilling or unable to engage in office-based treatment. Access to care for such individuals is best achieved using a mobile treatment approach that includes highly trained mental health professionals. The daily hands-on involvement of highly trained clinicians was also reported to inspire the confidence of other treatment team members in facing the challenges inherent in managing high-risk clients. As such, FACT teams that borrow part-time clinicians from community mental health centers or that use off-site professionals may be at a disadvantage compared with programs that have dedicated psychiatrists and nurses. FACT teams without dedicated psychiatrists or advance practice nurses reported feeling constrained by their clinicians' limited availability and by their resistance to performing necessary clinical outreach. In turn, nondedicated FACT clinicians cited overwhelming clinical caseloads, the time ineffectiveness of outreach, and fear of unpredictable circumstances in the field as barriers to their further involvement.

FACT requires adequate staffing to manage high-risk individuals in community settings. To best serve their caseloads, the teams need to hire criminal-justice-savvy staff and competent, street-smart clinicians. Consistent with the ACT model and the high prevalence of co-occurring substance use disorders, FACT teams are encouraged to hire at least one certified addictions counselor. In the absence of such individuals, FACT programs must seek out existing opportunities for training in the management of co-occurring disorders. Identifying such opportunities is a focus of technical assistance visits. Teams are also encouraged to consider having at least one bilingual staff member, depending on the population demography served, to help overcome cultural and language barriers. Whenever possible, programs are encouraged to recruit dedicated on-site psychiatrists or advance practice nurses for their FACT teams. Sometimes such individuals are simply not available. However, at other times, their recruitment is hindered by beliefs that off-site staff are just as effective, that high-level clinicians are not necessary, and that dedicated staff are too expensive. Given that most teams reported using part-time off-site psychiatrists to balance operating costs, another focus of technical assistance is to promote an understanding that dedicated clinicians are worthwhile investments.

Identifying and Managing Communication and Collaboration Barriers

New FACT programs reported challenges in communication and collaboration between clinical teams and their criminal justice partners. Beyond the basic question of how to get busy people from different agencies to work together, programs often reported philosophical differences as a barrier to collaboration. Specifically, clinical team members reported having a therapeutic orientation toward clients, in contrast to

their criminal justice partners, who appeared to have a more punitive and public-safety-minded orientation. During interactions with criminal justice agencies, some new teams reported hearing skepticism from judges, lawyers, and law enforcement officers regarding the likelihood of success of their FACT program. Two FACT team leaders reported receiving criticism from senior criminal justice representatives, including a description of one team's program as a "waste of taxpayer's money" and another as "soft on crime."

If housed within mental health centers or clinics, new FACT teams also reported the phenomenon of "FACT envy." Newly funded FACT programs typically received significant attention in their communities as well as within the mental health centers or clinics where they are located. To support the management of high-risk clients across mental health and criminal justice systems, FACT clinical teams often received special grant or contract support in addition to billable revenues. These extra funds provided new FACT teams with offices, secretaries, state-of-the-art computers, cellular telephones, and even agency vehicles for use with clients. For new teams within academic centers, having program evaluators and data collectors hovering about them added to the perception of a special status among their non-FACT clinic peers. Many new FACT programs found themselves within the local media spotlight, further adding to the perception of their exclusivity. As a result of these factors, new FACT clinical teams described being the target of jealousy in ways that contributed to operational problems. These included the dumping of undesirable clients from clinic programs, omission of critical information at the time of referral, and reluctance of clinics to accept referrals of stabilized clients from FACT teams.

One established FACT program described challenges regarding a team member who was housed within its local correctional facility to coordinate and expedite referrals to the FACT clinical team. Interagency conflict developed over who would decide the staff member's job description and who would provide daily supervision and oversight. Breakdowns in communication and cooperation subsequently occurred between the FACT program's clinical team and the team's correctional service partner. Another established FACT program reported on the challenge of operating across regional boundaries. Because of county demarcations, certain individuals were not eligible to receive FACT services, although all clients originated from the same correctional facility. This issue became an impediment to FACT operations, requiring the program to deal with time-consuming complaints and inquiries.

To prevent communication and collaboration barriers, individuals and agencies who want to initiate a FACT program must appreciate at the outset that FACT involves partnerships between treatment teams and criminal justice agencies. It must also be anticipated that the majority of referrals to FACT teams will come from local criminal justice agencies. Key clinical and criminal justice stakeholders must be included in the FACT program planning process, and an identified project head should set meeting agendas that include discussion of interface topics. Agenda topics should include philosophy differences, with an emphasis on areas of commonality. For example, all clinicians and criminal justice representatives are likely to agree that the goals of FACT include preventing incarceration and improve community tenure. To that end, it is important for clinicians and criminal justice staff to embrace treatment as a legitimate and effective alternative to incarceration. Also, organizational meetings should include discussions of administrative structures, including who will be responsible for human resource activities such as job descriptions and staff supervision. In

addition, FACT programs should create opportunities for their clinical and criminal justice staff members to provide cross-training. For example, FACT clinicians can present concise reviews on diagnosis and treatment of mental illness, whereas criminal justice staff members can provide information about legal, judicial, and correctional issues. Cross-training will build mutual awareness of the respective roles, strengths, and limitations of clinical and criminal justice representatives, setting the stage for the development of shared philosophies and practices. During the technical assistance process, FACT clinical teams are encouraged to take the initiative to organize meetings with current and prospective criminal justice partners as early as possible. Informal meetings over coffee and doughnuts can help key individuals place faces with names, laying the groundwork for the resolution of the problems that will inevitably emerge within cross-system collaborations. The use of team-building exercises, simulated case discussions, and conflict-resolution techniques can further build and maintain effective cross-system collaborations. FACT teams are also encouraged to maintain regular stakeholder meetings beyond the program start-up phase. These ongoing meetings can include clinical and criminal justice representatives, heads of parent agencies, funding partners, and key community stakeholders such as residential service providers, social service agency representatives, and consumer advocates.

Managing Staff Issues Including Safety, Burnout, and Turnover

Clients referred to FACT programs usually have multiple risk factors for arrest and incarceration, including homelessness, substance use, antisocial attitudes, and treatment nonadherence. Although most arrests are the result of minor crimes, such as trespassing and panhandling, these risk factors can also result in agitation, threatening behaviors, and physical violence. The expectation that FACT teams will manage high-risk clients while maintaining around-the-clock availability presents special challenges in terms of staff safety and care delivery, especially for inexperienced and understaffed teams. New FACT team members sometimes reported being overwhelmed by their job responsibilities, resulting in demoralization, feelings of failure, and burnout. Consistent with such problems, most FACT programs reported experiencing an initial period of rapid staff turnover that compounded their hiring challenges. These teams described the perception that they were "always playing catch-up." Of note, some FACT teams reported that morale problems were lessened by the daily presence of a supportive psychiatrist or advanced practice nurse on the team.

Because FACT team members frequently interact with high-risk individuals in the streets and other uncontrolled community settings, safety training is offered as part of the technical assistance visits. Risk assessment approaches are taught and strategies for addressing environmental barriers to safe and effective service delivery are demonstrated and practiced using a prevention-based safety and violence education curriculum (Weisman & Lamberti, 2002). Team leaders are also instructed to be vigilant for poor clinical decision making, boundary violations with clients, and other indications that further staff training and supervision are needed. Additional strategies to protect FACT teams from staff burnout and turnover include supporting continuing education, flexible use of vacation days, and granting time-off requests for special events. Staff retreats, team-building exercises, and staff recognition activities can also go a long

way toward enhancing staff morale and promoting staff retention despite the rigors of intensive work.

Obtaining Residential Services

The greatest need, described by both start-up and experienced FACT programs, was for access to supervised housing. All FACT programs reported a lack of safe, supportive housing for their clients, particularly clients with multiple risk factors. Residential service providers, if available, shunned referrals of FACT clients who were actively using substances, had histories of felony convictions or violence, or had burned their bridges with other housing providers. As a result, both new and established FACT programs tended to utilize low-rent rooming houses and transient hotels for their high-risk clients. Unfortunately, these housing establishments were typically located within crime-ridden, drug-infested areas of each city. Such environments placed high-risk FACT clients at even greater risk for a relapse of their psychosis and addiction, as well as for violation of their probation or parole if applicable.

FACT team members are strongly encouraged to meet with local residential service providers to develop working partnerships. In forming these partnerships, it is important to recognize that most residential programs suffer from insufficient staffing and a lack of access to mental health professionals. In return for access to residential services, FACT teams can offer daily visits to the residential facility along with twenty-four-hour access to crisis services in the event of emergencies. Another strategy for FACT programs in the early planning stages is to consider funding an extra staff position for a local residential service provider. By offering staffing enhancements in addition to prompt access to clinical care, FACT programs can gain access to supportive residential services for their high-risk clients.

Obtaining Primary Care Services

Clients enrolled in FACT programs frequently present with a combination of serious psychiatric and physical health issues. Because of exposure to unsanitary living situations, unhealthy lifestyles and habits, effects of psychiatric illness, and treatment side effects, these clients are at significantly greater risk for metabolic, hepatic, cardiovascular, and infectious diseases. Despite the high prevalence of medical illnesses among persons with schizophrenia and other psychotic disorders (Meyer & Nasrallah, 2003), a large proportion will fail to access primary care medical services. New FACT teams reported difficulty accessing primary care for their clients, and they described a lack of flexibility, patience, and tolerance on the part of available primary care providers in their regions. The teams also reported that their early priorities were focused more on maintaining psychiatric stability and reducing substance use than on obtaining medical care for their clients. Established programs reported somewhat greater access to primary care services than did newer programs, and they attributed their success to the eventual identification of local primary care providers who were sensitive to their clients' special needs.

FACT teams are encouraged to develop inroads with local primary care clinics, offering to provide transportation, collaboration, and other services as needed to support the medical care of their clients. Teams are also instructed to attend initial primary care

visits along with their clients (see Chapter 6). Not only does this practice ensure clients' timely attendance of medical appointments, but it enables FACT teams to provide health care information to primary care providers and to lay the foundation for ongoing collaboration on each client's behalf.

Achieving Continuity of Care and Developing Step-Down Services

In contrast to new teams, established FACT programs commonly reported the need for transitional or "step-down" treatment programs. Whereas start-up FACT programs struggled to keep up with new referrals and to build collaborations, experienced programs reported reaching their full enrollments and then facing long waiting lists for their services. The strong demand for FACT services creates a dilemma for programs about where to refer clients who respond well to FACT intervention. Transferring clients from FACT programs that are highly structured and intensive into traditional clinic services is fraught with difficulty. FACT team members reported that many of their clients referred to local mental health centers failed to engage and became lost to follow-up. If the clients were later located, they were typically readmitted to their original FACT programs. Unfortunately, some clients who failed to engage in outpatient clinic services relapsed into drug use, psychosis, or problematic behaviors including survival behaviors and criminal activities. These clients were often arrested and reincarcerated, further highlighting the need for intermediate intensity programs and services to aid FACT clients' transitions into the community and standard care.

During technical assistance visits, FACT programs are advised to anticipate the scarcity of transitional services and to consider alternatives for their clients. Because "time-unlimited services" is recognized as an important element of ACT (Teague et al., 1998), one alternative is to advocate for ongoing FACT services for the most tenuous clients. A second alternative is to advocate with funding sources for expansion of existing FACT services. Depending upon population size, most urban centers will need more than one FACT team (Cuddeback et al., 2008). A third alternative is to discharge stable clients to the most high-intensity clinic services available. Although not as intensive as FACT services, the combination of clinic services, case management, and supervised housing may provide an adequate system of care for stable clients. All FACT clients who are discharged to the community should be discharged with the understanding that the transition may or may not be successful. Rather than viewing a failed discharge as a client's personal failure or as a program failure, the experience should be viewed as a necessary step along the client's road to recovery.

Managing Dual Agency Role Confusion

The challenge of managing dual agency issues was reported most commonly by new FACT programs. Dual agency role confusion refers to a tendency among some FACT clinical team members to act as both clinician and legal official, essentially wearing two hats. Instances of role confusion typically emerged around the monitoring of client adherence to FACT services and legal reporting obligations. One new program described hiring a part-time case manager from the local criminal justice system. The case manager eventually served as a monitor for court-ordered

supervision of a particular client while also being responsible for providing direct clinical services to that same individual in the community. This case manager's dual agency raised concerns within the program about whether the therapeutic alliance between the client and case manager would be jeopardized. In addition, the program reported being concerned that this dual agency would result in the client receiving more frequent sanctions than clients who had separate clinical team and criminal justice staff members. Inexperienced FACT team members also found themselves in a quandary about whether to report clients' illicit drug or alcohol use or failure to comply with treatment recommendations to their partner criminal justice agencies.

The importance of partnerships between mental health and criminal justice staff, as well as the pitfalls, are discussed during technical assistance consultations. It is a valid concern that reporting clients' violations might result in more frequent punitive sanctions. However, such consequences are less likely to occur with open communication and collaborative problem solving between mental health and criminal justice partners. Experienced FACT team members typically reported that they felt included by their criminal justice partners in all decisions about whether to invoke sanctions. Most clinical team members also expressed confidence in their partners' judgment, with two programs reporting that their criminal justice partners were actually less likely to favor sanctions than they were. Because FACT programs frequently use legal leverage to promote adherence to treatment, it is critical that clinical team members establish active partnerships with criminal justice staff as opposed to simple reporting relationships. The distinction between collaborative relationships and reporting relationships is discussed during technical assistance visits, and strategies for establishing and maintaining collaborative relationships are encouraged.

FUTURE DIRECTIONS

FACT is an emerging approach to managing high-risk adults with severe mental illnesses that can be applied to transitioning them from correctional facilities into the community. In the absence of a clearly defined model, national health care trends and clinical care demands continue to spur FACT evolution and development. Several important issues remain to be addressed to develop FACT into an evidence-based practice. First, the core elements of FACT intervention must be defined, standardized, and tested. One core element of FACT that requires careful attention is legal leverage, an element that perhaps best distinguishes FACT from ACT. Although "assertive engagement mechanisms" is listed as an ACT fidelity criterion (Teague et al., 1998), FACT's incorporation of legal leverage represents a significant departure from how ACT teams operate. In a study of therapeutic limit setting within ACT, case managers reported patients' behaviors to criminal justice representatives in only 4 percent of cases (Neale & Rosenheck, 2000). This finding suggests that ACT teams operate in a manner largely independent of the criminal justice system. Legal leverage is commonly applied in criminal justice venues, including mental health courts and probation and parole offices, but evidence supporting the use of legal leverage is mixed (Hiday, 2003; Skeem & Louden, 2006; Swanson et al., 2000; TAPA Center for Jail Diversion, 2004), and its use remains controversial (M. Allen & Smith, 2001; Petrila, Ridgely, &

Borum, 2003). Research is needed to develop procedures for how FACT clinicians and their criminal justice partners should work together in using legal leverage most appropriately and effectively to promote treatment adherence.

Competent care is another element of FACT that requires further study, and it relates to staff competencies, including the types of services that they deliver. Because FACT is based on the ACT model, FACT teams provide mental health services, treatment for co-occurring substance use disorders, and vocational rehabilitation services. However, according to FACT's conceptual framework, such services will not prevent recidivism if criminal behavior is primarily driven by antisocial cognitions and attitudes. Antisocial personality features are common among adults with severe mental illnesses, particularly those with histories of criminal recidivism. Although some evidence suggests that intensive outpatient mental health services can lower recidivism rates among adults with schizophrenia and antisocial personality, optimal prevention may require interventions that specifically target problematic personality traits (Skeem, Monahan, & Mulvey, 2002). Cognitive behavioral interventions are beginning to show promise in addressing antisocial personality disorder within general offender populations (L. Allen, Mackenzie, & Hickman, 2001; Landenberger & Lipsey, 2005; Lipsey, Chapman, & Landenberger, 2001), and FACT programs may eventually benefit from their incorporation. In the 2004 national FACT survey study, however, only one FACT program was identified that incorporated cognitive behavioral treatment for antisocial personality features (Lamberti et al., 2004). Another aspect of FACT that requires attention is the incorporation of residential services. Research suggests that half of existing FACT programs incorporate residential care, especially residentially based addiction treatment services (Deem et al., 2008; Lamberti et al., 2004). Further research is needed to develop this component of care, including how FACT teams and residential service providers can best collaborate to promote their clients' independence.

In addition to developing the core elements of FACT, several operational facets of FACT will need to be addressed. These include clarification of admission and discharge criteria; determination of staffing requirements; incorporation of financial, social, and medical services; and development of sustainable funding sources. Sustainability is a significant challenge for FACT programs, the majority of which are dependent upon special grants and contracts in the absence of established funding streams. Moreover, approaches to overcoming barriers to interagency communication and collaboration, along with risk management and staff retention strategies, will likely benefit FACT teams and their clients in the future.

SUMMARY POINTS

In conclusion, the following list summarizes the need for and advantages of FACT programs.

1. Adults with severe mental illnesses are overrepresented within jails and prisons.
2. Individuals with schizophrenia and other psychotic disorders share similar recidivism risk factors as the general population, along with having psychotic symptoms that further increase their risk of arrest and incarceration.

3. Persons with psychotic disorders who have multiple recidivism risk factors often do not engage in treatment and "fall through the cracks" between the mental health and criminal justice systems.
4. Transitioning high-risk individuals from correctional facilities requires engaging them in treatments that target recidivism risk factors and promotes continuity of care between mental health and criminal justice services.
5. FACT is an emerging adaptation of the ACT model that is used to transition adults with psychotic disorders from correctional facilities.
6. FACT involves the development of collaborative partnerships between mental health and criminal justice professionals to ensure continuity of care and to promote treatment adherence through use of legal leverage.
7. FACT programs are growing in number across the United States, but there is significant variability between programs and an absence of controlled studies to demonstrate their effectiveness.
8. Further research is needed to standardize the FACT model and to examine its effectiveness at preventing criminal recidivism and promoting successful transitions from correctional facilities into the community.

References

Abramsky, S., & Fellner, J. (2003). *Ill-equipped: U.S. prisons and offenders with mental illness*. New York: Human Rights Watch. Retrieved June 17, 2009, from http://www.hrw.org/reports/2003/usa1003/

Abramson, M. F. (1972). The criminalization of mentally disordered behavior: Possible side effect of a new mental health law. *Hospital and Community Psychiatry*, *23*, 101-105.

Allen, L., Mackenzie, D., & Hickman, L. (2001). The effectiveness of cognitive behavioral treatment for adult offenders: A methodological quality-based review. *International Journal of Offender Therapy and Comparative Criminology*, *45*, 498-514.

Allen, M., & Smith, V. (2001). Opening Pandora's box: The practical and legal dangers of involuntary outpatient commitment. *Psychiatric Services*, *52*, 342-346.

Andrews, D., & Bonta, J. (1998). *The psychology of criminal conduct*. Cincinnati, OH: Anderson.

Bond, G. E., Drake, R. G., Mueser, K. T., & Latimer, E. (2001). Assertive community treatment for people with severe mental illness: Critical ingredients and impact on patients. *Disease Management and Health Outcomes*, *9*, 141-159.

Butterfield, F. (1998, March 5). Prisons replace hospitals for the nation's mentally ill. *New York Times*, p. 1.

A Community Treatment Program. (1974). *Hospital and Community Psychiatry*, *25*, 669-672.

Cuddeback, G., Morrissey, J., & Cusack, K. J. (2008). How many forensic assertive community treatment (FACT) teams do we need? *Psychiatric Services*, *59*, 205-208.

Daly, R. (2006). Prison mental health crisis continues to grow. *Psychiatric News*, *41*(20), 1.

Deem, A., Lamberti, J. S., & Weisman, R. L. (2008, October). *Forensic assertive community treatment: Partnering with probation*. Paper presented at the 39th Annual Meeting of the American Association for Psychiatry and the Law, Seattle, WA.

Ditton, P. M. (1999). *Mental health and treatment of inmates and probationers* (Bureau of Justice Statistics Special Report No. NCJ 174463). Washington, DC: U.S. Department of Justice, Office of Justice Programs. Retrieved June 17, 2009, from http://www.ojp.usdoj.gov/bjs/abstract/mhtip.htm

Draine, J., Salzer, M., Culhane, D., & Hadley, T. (2002). Role of social disadvantage in crime, joblessness, and homelessness among persons with serious mental illness. *Psychiatric Services*, *53*, 565-573.

Hiday, V. (2003). Outpatient commitment: The state of empirical research on its outcomes. *Psychology, Public Policy, and Law*, *9*, 8-32.

Horvath, A., & Symonds, B. (1991). Relation between working alliance and outcome in psychotherapy: A meta-analysis. *Journal of Counseling Psychology*, *38*, 139-149.

Inciardi, J. A., Isenberg, H., Lockwood, D., Martin, S. S., & Scarpitti, F. R. (1992). Assertive community treatment with a parolee population: An extension of case management. *National Institute on Drug Abuse Research Monograph: Progress and Issues in Case Management*, *127*, 350-367.

Kennedy, S. (2003, Winter). A practitioner's guide to responsivity: Maximizing treatment effectiveness. *Journal of Community Corrections*, 7-30.

Lamberti, J. S. (2007). Understanding and preventing criminal recidivism among adults with psychotic disorders. *Psychiatric Services*, *58*, 773-781.

Lamberti, J. S., & Weisman, R. L. (2002). Preventing incarceration of adults with severe mental illness: Project Link. In G. Landsberg, M. Rock, & L. Berg (Eds.), *Serving mentally ill offenders: Challenges and opportunities for mental health professionals* (pp. 133-143). New York: Springer.

Lamberti, J. S., Weisman, R. L., & Faden, D. (2004), Forensic assertive community treatment: Preventing incarceration of adults with severe mental illness. *Psychiatric Services*, *55*, 1285-1293.

Lamberti, J. S., Weisman, R. L., Schwarzkopf, S. B., Price, N., Ashton, R. M., & Trompeter, J. (2001). The mentally ill in jails and prisons: Towards an integrated model of prevention. *Psychiatric Quarterly*, *72*, 63-77.

Landenberger, N., & Lipsey, M. (2005). The positive effects of cognitive-behavioral programs for offenders: A meta-analysis of factors associated with effective treatment. *Journal of Experimental Criminology*, *1*, 451-476.

Lehman, A., Steinwachs, D., & the Co-Investigators of the PORT Project. (1998). Patterns of usual care for schizophrenia: Initial results from the Schizophrenia Patient Outcomes Research Team (PORT) client survey. *Schizophrenia Bulletin*, *24*, 11-20.

Lipsey, M., Chapman, G., & Landenberger, N. (2001). Cognitive-behavioral programs for offenders. *Annals of the American Academy of Political and Social Science*, *578*, 144-157.

Martin, D., Garske, J., & Davis, M. (2000). Relation of the therapeutic alliance with outcome and other variables: A meta-analytic review. *Journal of Consulting and Clinical Psychology*, *68*, 438-450.

McQuistion, H. L., Finnerty, M., Hirschowitz, J., & Susser, E. S. (2003). Challenges for psychiatry in serving homeless people with psychiatric disorders. *Psychiatric Services*, *54*, 669-676.

Meyer, J. M., & Nasrallah, H. A. (Eds.). (2003). *Medical illness and schizophrenia*. Washington, DC: American Psychiatric Association.

Monahan, J., Bonnie, R. J., Appelbaum, P. S., Hyde, P. S., Steadman, H. J., & Swartz, M. S. (2001). Mandated community treatment: Beyond outpatient commitment. *Psychiatric Services*, *52*, 1198-1205.

Monahan, J., Redich, A. D., Swanson, J., Robbins, P. C., Appelbaum, P. S., Petrila, J., et al. (2005). Use of leverage to improve adherence to psychiatric treatment in the community. *Psychiatric Services*, *56*, 37-44.

Moran, P., & Hodgins, S. (2004). The correlates of comorbid antisocial personality disorder in schizophrenia. *Schizophrenia Bulletin*, *30*, 791-802.

Morrissey, J. P., Steadman, H. J., Dalton, K. M., Cuellar, A., Stiles, P., & Cuddeback, G. S. (2006). Medicaid enrollment and mental health service use following release of jail detainees with severe mental illness. *Psychiatric Services*, *57*, 809-815.

Mueser, K. T., Bond, G. R., Drake, R. E., & Resnick, S. G. (1998). Models of community care for severe mental illness: A review of research on case management. *Schizophrenia Bulletin*, *24*, 37-74.

Neale, M., & Rosenheck, R. (2000). Therapeutic limit setting in an assertive community treatment program. *Psychiatric Services*, *51*, 499-505.

Petrila, J., Ridgely, M., & Borum, R. (2003). Debating outpatient commitment: Controversy, trends, and empirical data. *Crime and Delinquency*, *49*, 157-172.

President's New Freedom Commission on Mental Health. (2003). *Achieving the promise: Transforming mental health care in America* (DHHS Pub. No. SMA-03-3831). Rockville, MD: Author.

Project Link. (1999). Gold Award: Prevention of jail and hospital recidivism among persons with severe mental illness. *Psychiatric Services*, *50*, 1477-1480.

Regier, D. A., Farmer, M. E., Rae, D. S., Locke, B. Z., Keith, S. J., Judd, L. L., et al. (1990). Comorbidity of mental disorders with alcohol and other drug abuse: Results from the Epidemiologic Catchment Area (ECA) Study. *JAMA*, *264*, 2511-2518.

Skeem, J. L., & Louden, J. E. (2006). Toward evidence-based practice for probationers and parolees mandated to mental health treatment. *Psychiatric Services*, *57*, 333-342.

Skeem, J. L., Monahan, J., & Mulvey, E. P. (2002). Psychopathy, treatment involvement, and subsequent violence among civil psychiatric patients. *Law and Human Behavior*, *26*, 577-603.

Solomon, P., Draine, J., & Marcus, S. C. (2002). Predicting incarceration of clients of a psychiatric probation and parole service. *Psychiatric Services*, *53*, 50-56.

Steadman, H. (1992). Boundary spanners: A key component for the effective interactions of the justice and mental health systems. *Law and Human Behavior*, *16*, 75-87.

Swanson, J., Swartz, M., Borum, R., Hiday, V., Wagner, R., & Burns, B. (2000). Involuntary out-patient commitment and reduction of violent behavior in persons with severe mental illness. *British Journal of Psychiatry*, *176*, 324-331.

Swanson, J. W., Van Dorn, R. A., Monahan, J., & Swartz, M. S. (2006). Violence and leveraged community treatment for persons with mental disorders. *American Journal of Psychiatry*, *163*, 1404-1411.

Swartz, M., & Swanson, J. (2004). Involuntary outpatient commitment, community treatment orders, and assisted outpatient treatment: What's in the data? *Canadian Journal of Psychiatry*, *49*, 585-591.

TAPA Center for Jail Diversion. (2004). *What can we say about the effectiveness of jail diversion programs for persons with co-occurring disorders?* (Accession No. 020010). Washington, DC: National GAINS Center. Retrieved June 17, 2009, from http://gainscenter.samhsa.gov/pdfs/jail_diversion/WhatCanWeSay.pdf

Taxman, F., & Marlowe, D. (2006). Risk, needs, responsivity: In action or inaction? *Crime and Delinquency*, *52*, 3-6.

Teague, G., Bond, G., & Drake, R. (1998). Program fidelity in assertive community treatment development and use of a measure. *American Journal of Orthopsychiatry*, *86*, 216-232.

Teplin, L. A. (1984). Criminalizing mental disorder: The comparative arrest rate of the mentally ill. *American Psychologist*, *39*, 794-803.

Thresholds State. (2001). Gold Award: Helping mentally ill people break the cycle of jail and homelessness. (2001). *Psychiatric Services*, *52*, 1380-1382.

Torrey, E. (1997). *Out of the shadows: Confronting America's mental illness crisis*. New York: Wiley.

Weisman, R. L., & Lamberti, J. S. (2002). Violence prevention and safety training for case management services. *Community Mental Health Journal*, *38*, 339-348.

Wilson, D., Tien, G., & Eaves, D. (1995). Increasing the community tenure of mentally disordered offenders: An assertive case management program. *International Journal of Law and Psychiatry*, *18*, 61-69.