SAMHSA'S GAINS Center for Behavioral Health and Justice Transformation

Forensic Assertive Community Treatment: Updating the Evidence

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Joseph P. Morrissey, PhD, UNC-Chapel Hill
Ann-Marie Louison, CASES, NYC

Forensic Assertive Community Treatment (FACT): Updating the Evidence

Presenters:
Joseph P. Morrissey, PhD, UNC-Chapel Hill
Ann-Marie Louison, CASES, NYC

SAMHSA's GAINS Center for Behavioral Health and Justice Transformation
Webinar Series: Part 1
on Evidence-Based Practices for Justice-Involved Persons

Topics for Today's Webinar

1. FACT evidence update (Joe Morrissey)

2. Best Practices: Opinions from the Field (Ann-Marie Louison)

3. Questions & Answers (All)

1. Evidence Update

Reference Document: “Forensic Assertive Community Treatment: Updating the Evidence,” SAMHSA’S GAINS Center Evidence-Based Practice Fact Sheet, December 2013. Available at: http://gainscenter.samhsa.gov/cms-assets/documents/141801-618932.fact-fact-sheet---joe-morrissey.pdf

FACT rests upon ACT

- FACT is an adaptation of assertive community treatment (ACT) for persons involved with the criminal justice system
- ACT is a psychosocial intervention developed for people with severe mental illness* who have significant difficulty living independently, high service needs, and repeated psychiatric hospitalizations

* SMI= a subset of serious mental illness, marked by a higher degree of functional disability

ACT: key principles

- Multidisciplinary staff
- Integrated services
- Team approach
- Low consumer-staff ratios
- Locus of contact in community
- Medication management
- Focus on everyday problems in living
- Rapid access (24-7)
- Assertive outreach
- Individualized services
- Time unlimited services

- Origins in 1970s; slow adoption but now widespread use throughout US, Canada, Europe & Australia
- Program model has been standardized and DACT fidelity scale developed

ACT: evidence

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➢1st generation studies also showed no consistent improvement in social adjustment, substance abuse, arrests/jail time

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➢ ACT has become a platform for leveraging other Evidence-Based Practices such as integrated dual disorder treatment and supported employment

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- Most consistent finding: decreased use & days of psychiatric hospitalization
- Inconsistent results regarding symptoms & quality of life
- 1st generation studies also showed no consistent improvement in social adjustment, substance abuse, arrests/jail time
- ACT has become a platform for leveraging other Evidence-Based Practices such as integrated dual disorder treatment and supported employment

➢FACT teams have been trying to follow the same pathway

FACT: adaptations

New goals

- ✓ Keep folks out of jail & prison
- ✓ Avoid/reduce arrests
- ✓ Interface with CJ system

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ACT Team add-ons

- Enroll only folks with SMI and prior arrests and detentions
- Partner with CJ agencies / add CJ personnel to treatment team
- Use of court sanctions to encourage participation
- Residential treatment units for folks with dual diagnoses
- Cognitive-behavioral approaches

FACT: evidence[1]

- FACT practices have disseminated rapidly around the U.S., far out-stripping the evidence base supporting their effectiveness

FACT: evidence[1]

- FACT has been adopted much more rapidly than has the evidence base to support its effectiveness
- To date, only a handful of reports about the effectiveness of FACT or FACT-like programs have been published with mixed results
  - Two pre-post (no control group) studies
    - Project Link in Rochester NY (2001, 2004)
    - Thresholds Jail Linkage Project in Chicago, Il (2004)
  - Three randomized control trials (RCTs)
    - Philadelphia (1995)
    - California Bay Area (2006)
    - California Central Valley (2010)

FACT: evidence[2]

- Pre-post studies
  1. Rochester: jail diversion, 12 mo. follow-up, N= 41-60
     - + Significant reductions in jail days, arrests, hospitalizations, hospital days
     - + Improved psychological functioning and substance treatment engagement
     - + Significant reductions in annual costs per participant

FACT: evidence[2]

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     - Reduced jail and hospital costs

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- Weakness: Small pilot studies; lack of control group makes it unclear that gains can be uniquely attributed to FACT

FACT: evidence[3]

- Controlled studies
  1. Philadelphia: jail diversion, randomized, 12 mo. follow-up, N= 94
     - No statistically significant differences between groups; FACT had higher re-arrest rate
     - Number of methodological difficulties re recruitment, retention, ACT fidelity, violations

FACT: evidence[3]

- Controlled studies
  1. Philadelphia: jail diversion, randomized, 12 mo. follow-up, N= 94
     - + No statistically significant differences between groups; FACT had higher re-arrest rate
     - + Number of methodological difficulties re recruitment, retention, ACT fidelity, violations
  2. California Bay Area: jail diversion, randomized, 19 mo. follow-up, N= 182
     - + Dual disorder intervention (IDDT) in FACT-like setting
     - + No statistically significant differences between groups on arrests and jail days but intervention group (IG) fewer incarcerations and lower likelihood of multiple convictions
     - + Intervention group also had improved service receipt and engagement on a number of indicators
     - + Finding tempered by methodological limitations: unequal FACT exposure among intervention participants, baseline differences, high attrition rates in post-period

FACT: evidence[3]

- Controlled studies
  3. California Central Valley: jail diversion, randomized, 24 mo. follow-up, N= 134
     - High DACT fidelity at baseline
     - At 12 and 24 mos. FACT participants had significantly fewer jail bookings
     - FACT participants were more likely to avoid jail; however, if jailed, there were no differences in jail days between groups
     - FACT participants' higher outpatient mental health service use and costs were offset by lower inpatient use and costs
     - **These are the strongest findings to date demonstrating that FACT interventions can improve both criminal justice and behavioral health outcomes for jail detainees with SMI**

FACT: some unanswered questions

Unlike ACT . . . FACT still lacks a well-validated clinical or program model that specifies:

- Who is most appropriate for this approach?
- What are their needs (crimnogenic v. psychogenic)?
- How can we meet these needs?
- How can we manualize the interventions?
- What are the best outcomes?
- What are the best outcome measures?

FACT: growing the evidence base

1. The clinical / program model for FACT needs to be carefully specified

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2. Then, more high quality, multi-site, large N, controlled studies are needed
   - To consolidate current findings
   - To demonstrate reproducibility of findings across diverse communities and geographical areas

FACT: growing the evidence base

1. The clinical / program model for FACT needs to be carefully specified
2. Then, more high quality, multi-site, large N, controlled studies are needed
   - To consolidate current findings
   - To demonstrate reproducibility of findings across diverse communities and geographical areas
3. With a stronger evidence base, FACT programs can be relied upon to help individuals with SMI avoid criminal justice contacts and improve community functioning

2. Best Practices

Best Practices: Opinions from the Field

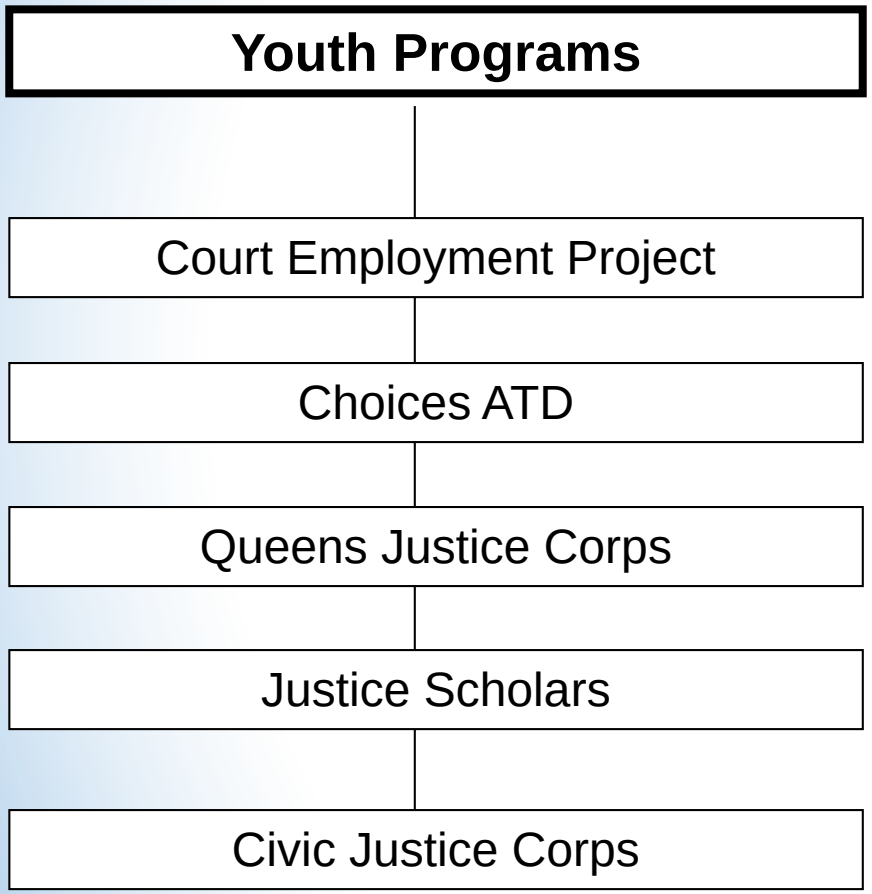
Ann-Marie Louison

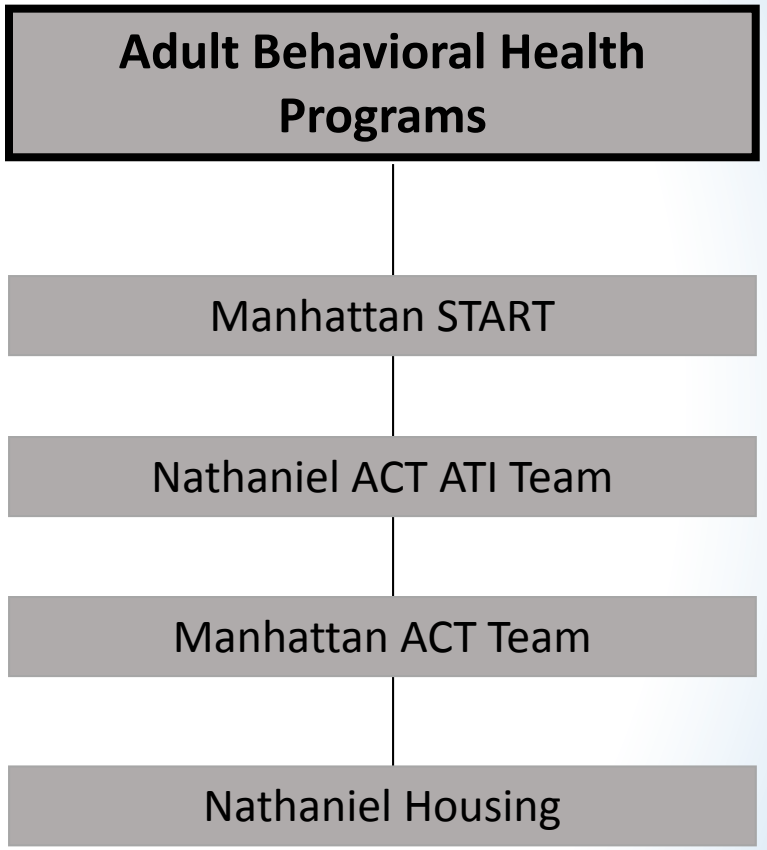
Director Adult Behavioral Health Programs,

CASES, NYC

alouison@cases.org

CASES – New York City





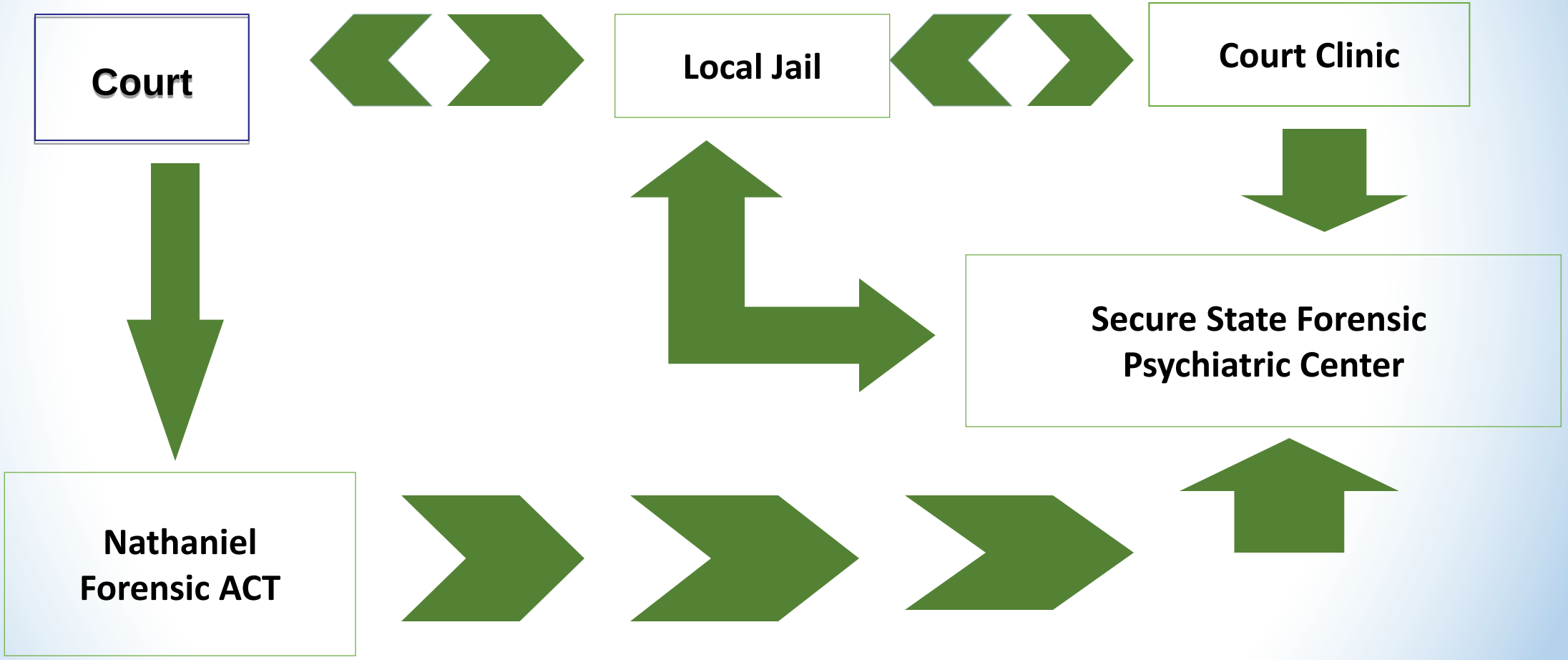
Why was Nathaniel ACT Alternative to Incarceration Created?

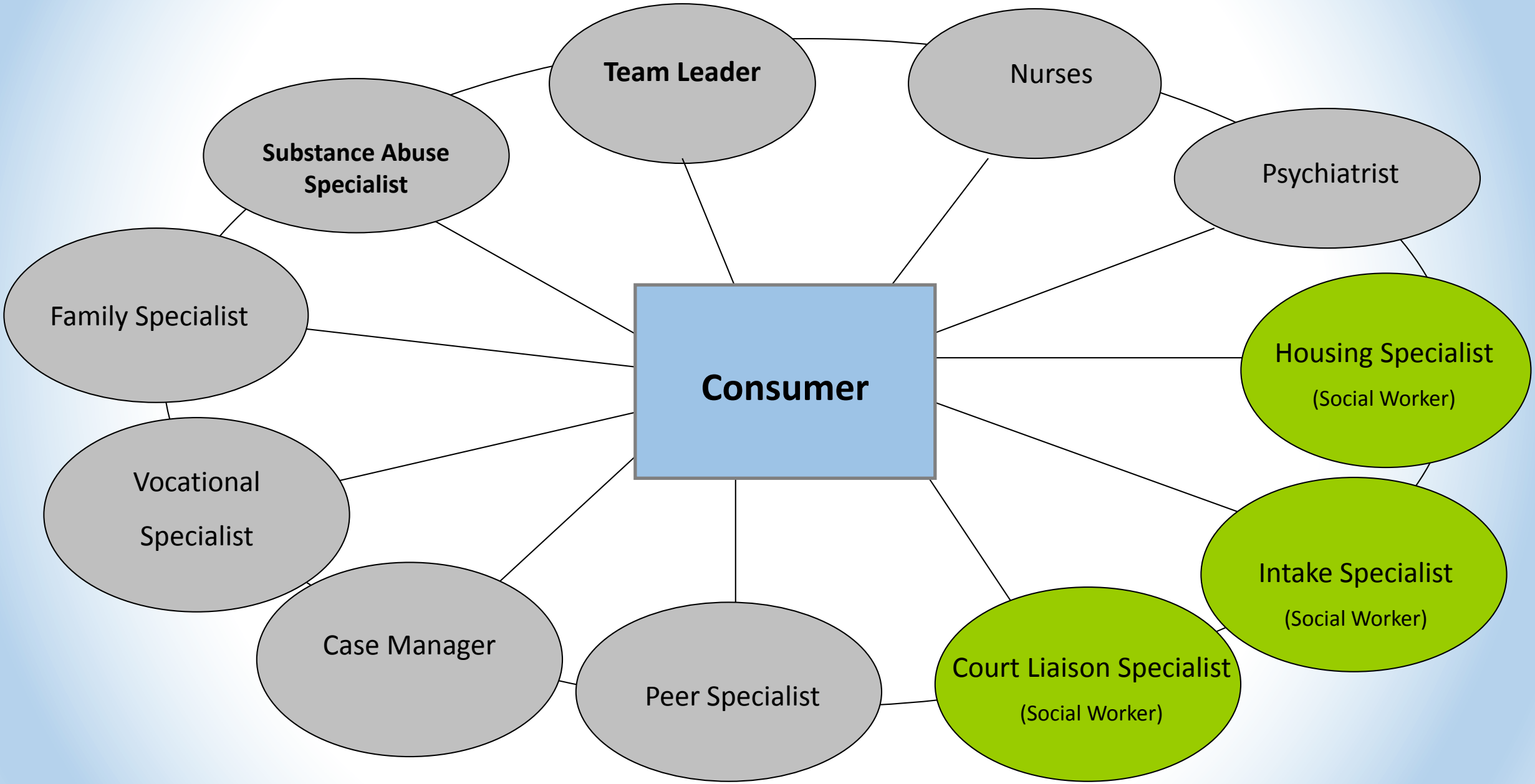
"Criminal "
Not ACT consumer
"Dangerous"
"Drug use"

- **Bias**
- **Distrust**
- **Prejudice**
- **Fear**
- **Avoidance**

Reduced Access

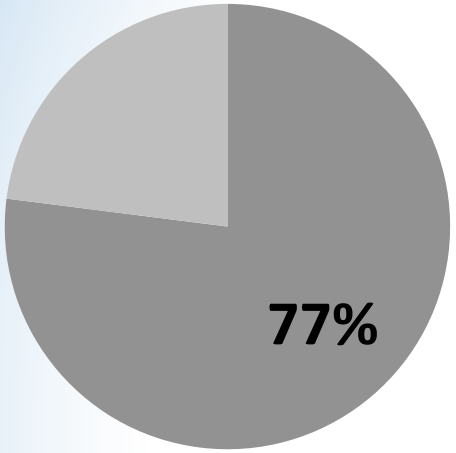
ACT Eligible in Criminal Justice Settings



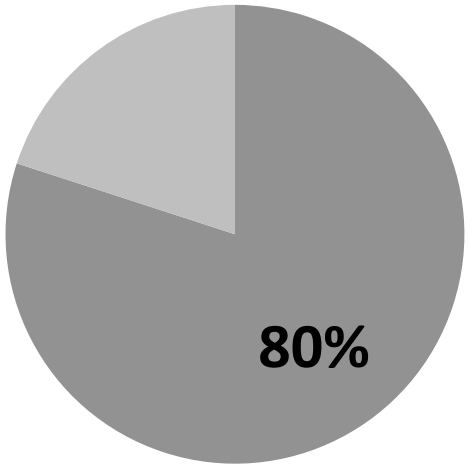

Team Leader
Nurses
Substance Abuse Specialist
Psychiatrist
Family Specialist
Consumer
Housing Specialist
(Social Worker)
Vocational Specialist
Intake Specialist
(Social Worker)
Case Manager
Peer Specialist
Court Liaison Specialist
(Social Worker)

FACT Recipients

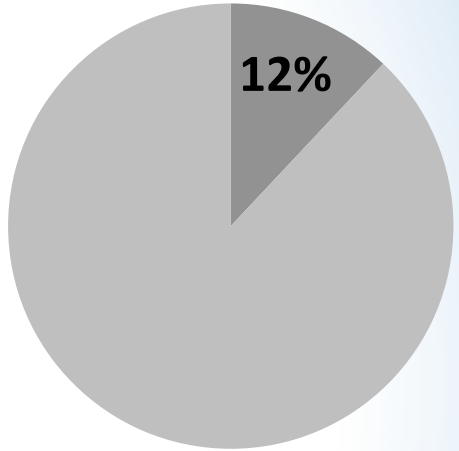
Co-Occurring Substance Use



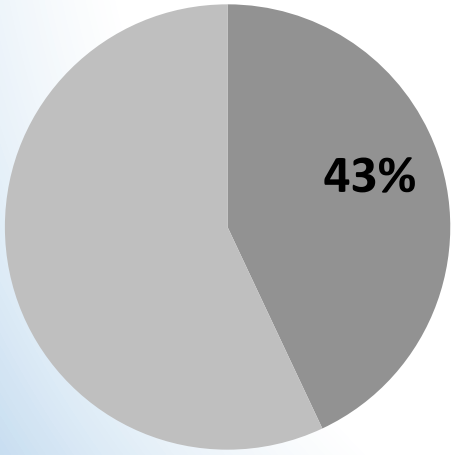
Schizophrenia



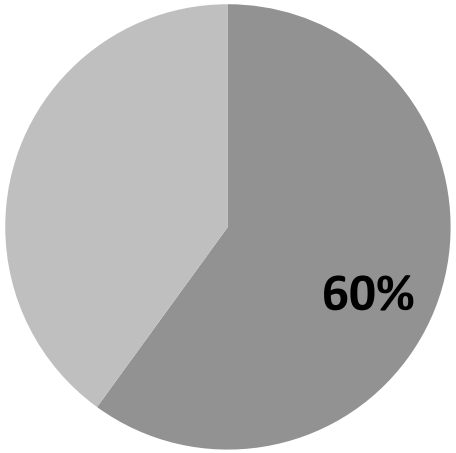
Outpatient Commitment



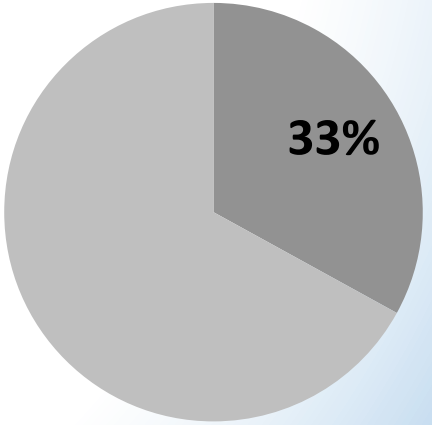
Homeless



High Use Psychiatric Hospitals



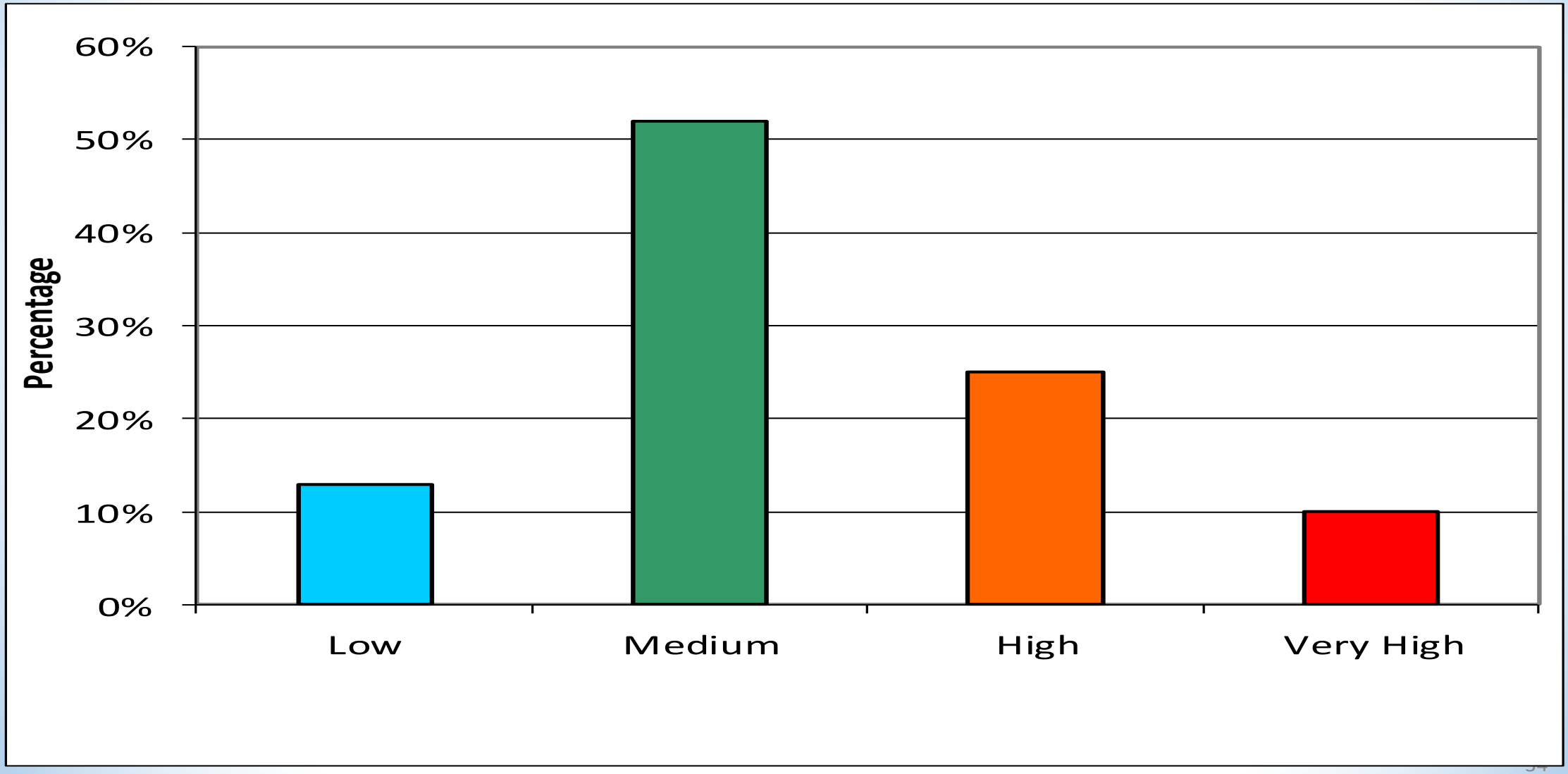
High Use ER visits



Felony Convictions
Assault
Criminal Sale Controlled Substance
Robbery
Burglary
Grand Larceny
Criminal Contempt

33

Recidivism Risk



Criminogenic Need Clinical Profiles

Variable	Low	Medium	High	Very High
Risk Total Score	7.67	14.67	23.82	31.28
Criminal History	**.67**	**1.84**	**3.58**	**4.06**
Antisocial Associates	**.17**	**1.07**	**1.84**	**3.11**
Antisocial Cognition	**.22**	**.49**	**1.68**	**3.06**
Antisocial Personality	**.44**	**.87**	**2.16**	**2.89**

Criminogenic Needs Influence Outcomes

RISK GROUP	LOW	MEDIUM	HIGH/ VERY HIGH	TOTAL
Nathaniel Consumers	15%	35%	50%	100%
Re-Arrested in 2-Years	0%	30%	52%	36%

ACT *Plus* = FACT

Consumer Characteristics

- Psychiatric Diagnosis
- Co-Occurring Substance Abuse
- **Criminal Justice Status and CJ History**
- **Criminogenic Needs**
- Health Problems
- Homeless at Intake
- General Demographics
  - Gender
  - Race
  - Age
- Baseline Utilization History
  - Hospital & ER

Criminal Justice Responsibilities

Alternatives to Incarceration

Treatment & Supervision

Behavioral Health & Public Safety Outcomes

Comprehensive Screening & Intake Advocacy

Integration of Supervision into MH Treatment

Court Liaison Social Worker Escorting Participants to Court, Probation, and regular progress reports and notification of change in status

Treatment for Mental Health, Substance Use, & Psych-social Needs

Assessment for Risk and Rehabilitation to address risk for re-arrest

Assertive treatment based on needs and current circumstances

Clinical Integrity of ACT Model

Ever Evolving Model

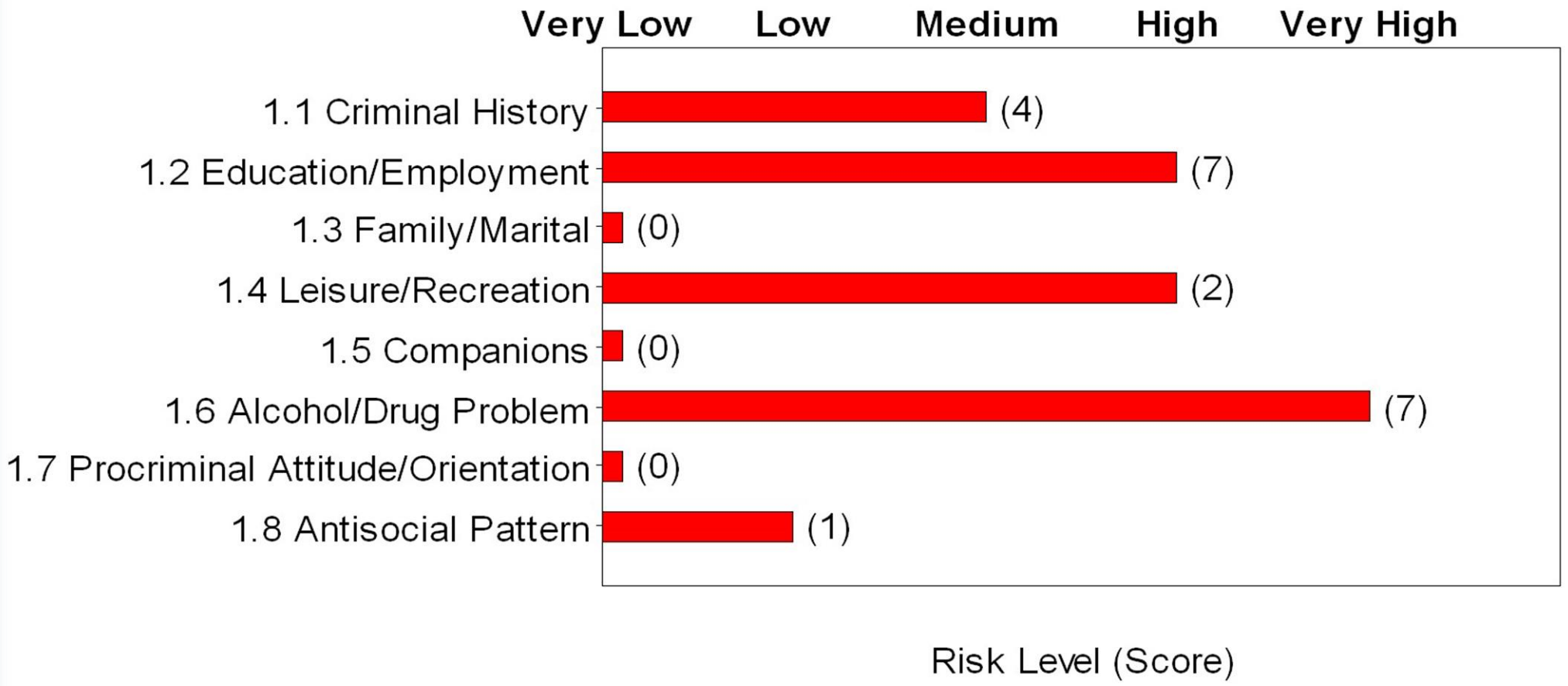
Forensic ACT

- Adheres to national ACT fidelity standards
- All core elements of ACT
- Adheres to local ACT standards for eligibility
- Integrates assessment, service-planning and services related to community integration after incarceration, for successful community supervision, and on-going risks of reoffending and recidivism

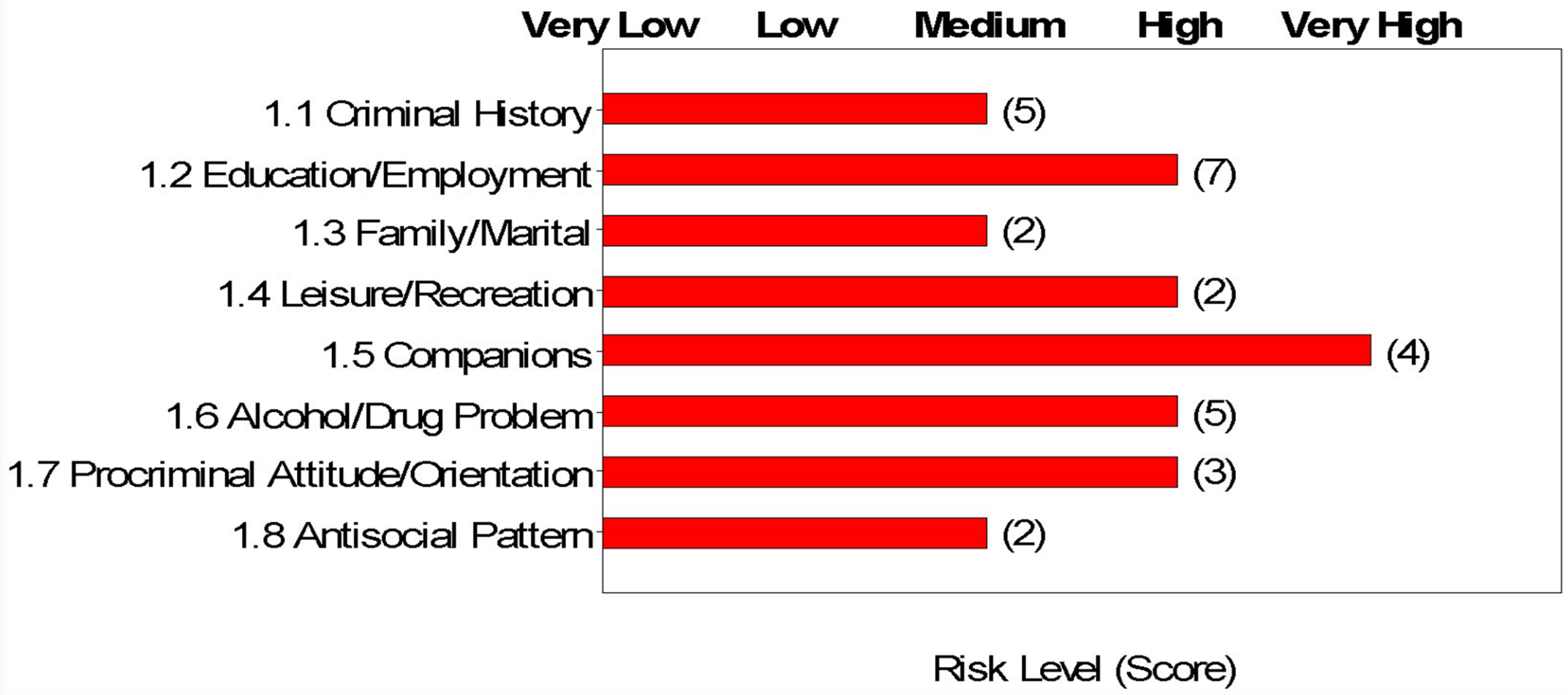
Clinical Model

Criminal History
Anti-social attitudes
Anti-social friends and peers
Anti-social personality pattern
Substance abuse
Family and/or marital factors
Lack of education/Poor employment history
Lack of pro-social leisure activities
Nature of Relationship with Criminal Justice
Criminal Justice Partner Member of Team
Criminal Justice Outcomes

Case Study 1


Very Low
Low
Medium
High
Very High
1.1 Criminal History
(4)
1.2 Education/Employment
(7)
1.3 Family/Marital
(0)
1.4 Leisure/Recreation
(2)
1.5 Companions
(0)
1.6 Alcohol/Drug Problem
(7)
1.7 Procriminal Attitude/Orientation
(0)
1.8 Antisocial Pattern
(1)
Risk Level (Score)

Case Study 2


Very Low
Low
Medium
High
Very High
1.1 Criminal History
(5)
1.2 Education/Employment
(7)
1.3 Family/Marital
(2)
1.4 Leisure/Recreation
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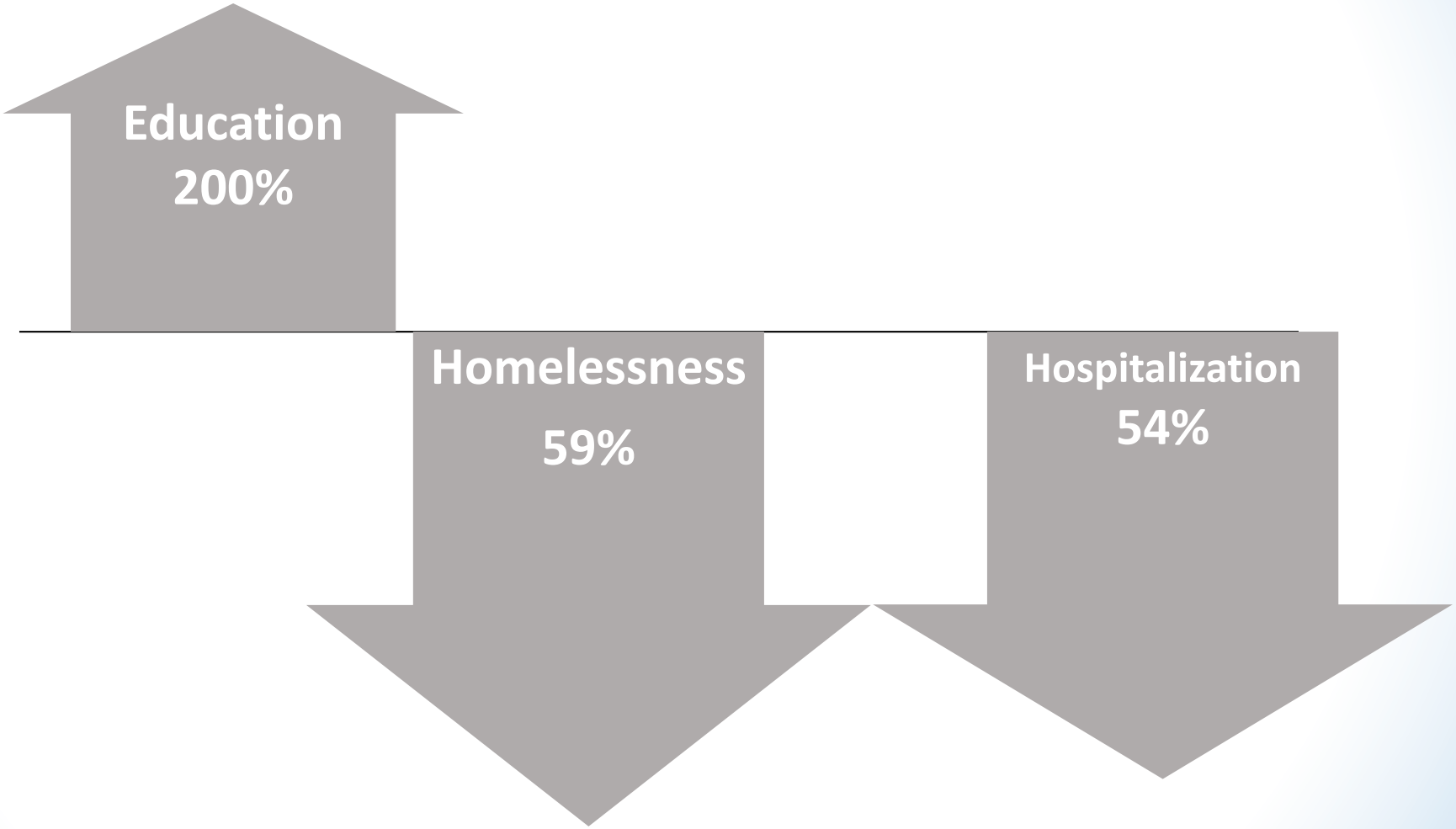
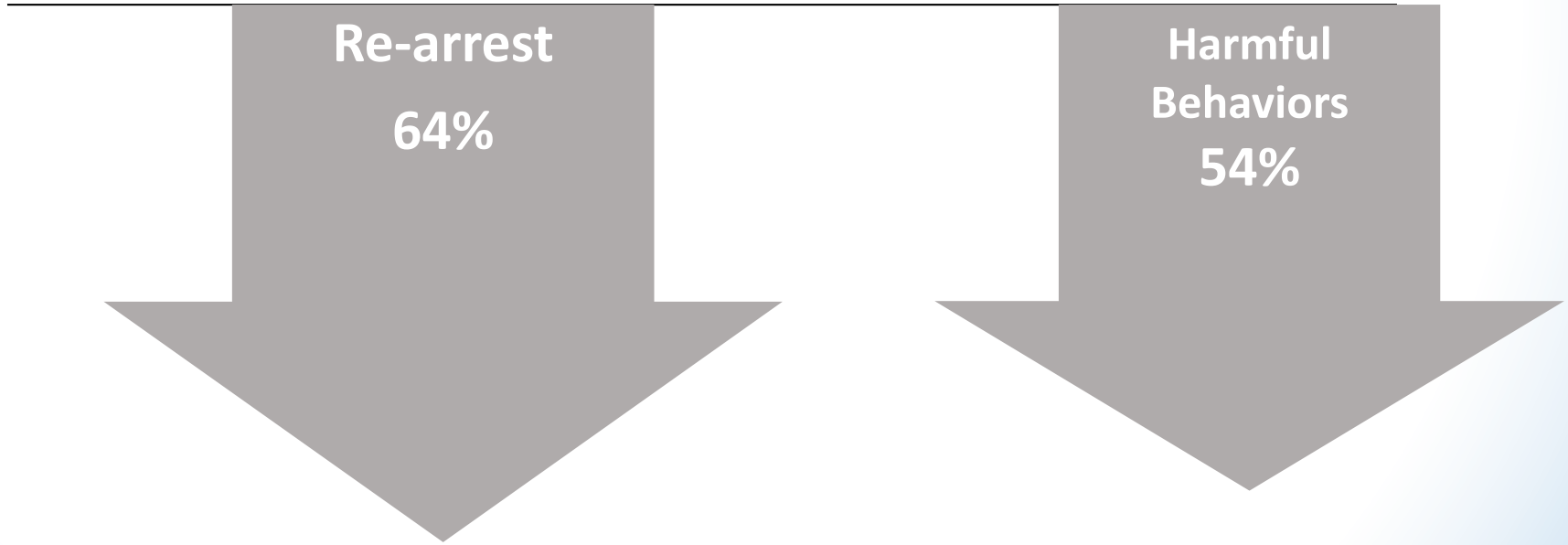
1.6 Alcohol/Drug Problem
(5)
1.7 Procriminal Attitude/Orientation
(3)
1.8 Antisocial Pattern
(2)
Risk Level (Score)

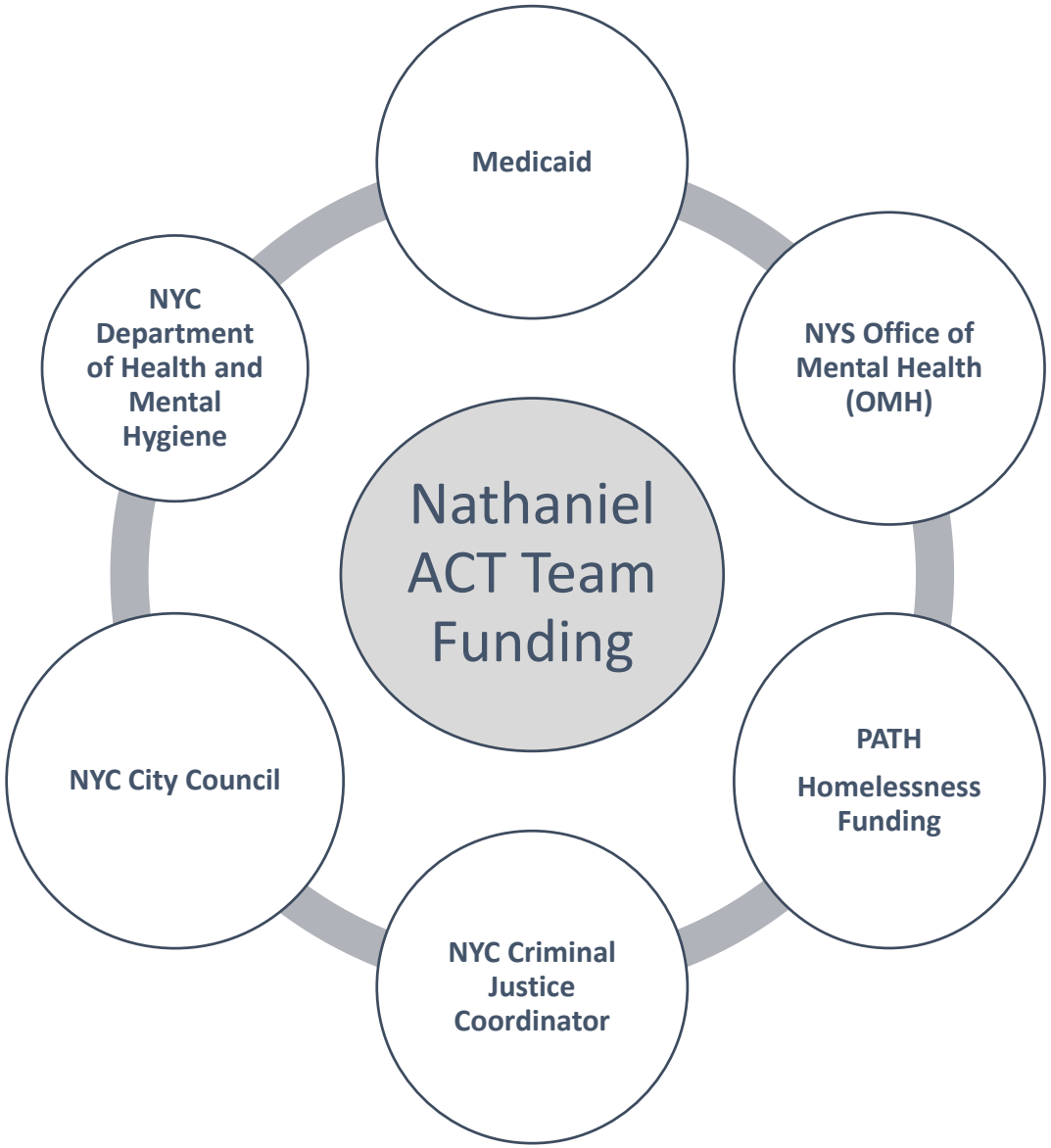
Clinical Model Impacts Outcomes



Clinical Model Impacts Outcomes



Who Pays?


Medicaid
NYS Office of Mental Health (OMH)
PATH
Homelessness Funding
NYC Criminal Justice Coordinator
NYC City Council
NYC Department of Health and Mental Hygiene
Nathaniel ACT Team Funding

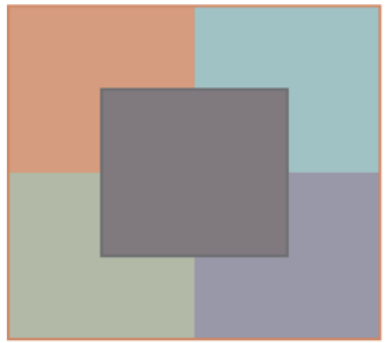
3. Questions?

FACT Discussion Group

"Ask the Experts" discussion session

- Joseph P. Morrissey, PhD, UNC-Chapel Hill
- Ann-Marie Louison, CASES, NYC
  - Monday, February 3, 2041 from 3:00 – 4:00 pm EST
  - To register:
    http://prainc.adobeconnect.com/factreg/event/registration.html

    **Details will also be sent out via the GAINS Center listserv



SAMHSA's GAINS Center *for*

Behavioral Health and Justice Transformation

345 Delaware Avenue
Delmar, NY 12054
PH: (518) 439-7415
FAX: (518) 439-7612

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