

Assertive Community Treatment (ACT) is a service delivery model in which treatment is provided by a team of professionals with services determined by consumer needs for as long as needed (Phillips et al., 2001). ACT combines treatment, rehabilitation, and support services in a self-contained clinical team made up of a mix of disciplines, including psychiatry, nursing, addiction counseling, and vocational rehabilitation (Stein & Santos, 1998; Dixon, 2000). The ACT team operates on a 24/7 basis, providing services in the community to offer more effective outreach and to help the consumer generalize the skills to real life settings (Phillips et al., 2001). ACT is intended for consumers who have severe (a subset of serious with a higher degree of disability) mental illness, are functionally impaired, and at high risk of inpatient hospitalization.

Evidence-Base for ACT

The effectiveness of ACT has been well established with over 55 controlled studies in the US and abroad. In one recent review (Bond et al., 2001), ACT was found to be most effective in reducing the use and number of days in the hospital, but *not* consistently effective in reducing symptoms and arrests/jail time or improving social adjustment, substance abuse, and quality of life (See also Burns & Santos, 1995; Dixon, 2000; Marshall & Lockwood, 2004; Ziguras & Stuart, 2000). When tested against other forms of case management, ACT teams have proven to be more effective *only* in reducing psychiatric hospitalizations and improving housing stability (Bond et al., 2001; Ziguras & Stuart, 2000; LewinGroup, 2000).

The lack of effectiveness in preventing arrests/jail detentions and reducing substance abuse in these studies is disappointing. However, very low base rates of arrest and the consequent lack of statistical power hamper drawing clear conclusions about these outcome indicators. A relevant question becomes: Can we keep persons with severe mental illness out of jail by assigning them to special ACT teams that focus on forensic populations and incorporate new specialists within the team with criminal justice system know-how?

FACT Adaptations

A number of ACT-like programs have grown up in communities around the country that focus on keeping people with severe mental illness out of jails and prisons. The name “forensic ACT” or FACT is the emerging designation for these hybrid teams. Little standardization of program practices and staffing exists for FACTs. Among the core elements that distinguish FACT from ACT are: (1) the goal of preventing arrest and incarceration; (2) requiring that all consumers admitted to

the team have criminal justice histories; (3) accepting the majority of referrals from criminal justice agencies; and (4) the development and incorporation of a supervised residential treatment component for high-risk consumers, particularly those with co-occurring substance use disorders (Lamberti et al., 2004).

Can ICM Substitute for ACT?

Intensive Case Management (ICM) is a model that has some distinct differences from ACT and requires less funding than a full-fidelity ACT team. ICM often mirrors ACT with regard to assertive, in-vivo, and time-unlimited services, but it uses case managers with individual caseloads, has no self-contained team, lacks 24/7 capacity, and brokers access to psychiatric treatment rather than providing it directly. Brokered case management is much less intensive due to larger caseloads, often office-based services, and less frequent client contact. Evidence indicates that brokered case management is ineffective (Marshall et al., 1998) whereas strengths case management appears to be effective in a small number of trials (Rapp, 2004). We have located 26 programs in 12 states that have described their ACT or ICM program as one that serves a forensic population.

FACT Evidence-Base

Published evidence on FACT teams is limited to two recent studies (McCoy et al., 2004). In a pre-post study (no control group), consumers who completed one year of Project Link in Rochester, NY (Lamberti et al., 2001), compared to the year prior to program admission, had significant reductions in jail days, arrests, hospital days, and hospitalizations. A preliminary pre-post cost analysis also found that Project Link reduced the average yearly service cost per client (Weisman et al., 2004). Improvements were also noted in psychological functioning and engagement in substance abuse treatment. In two pre-post studies (no control group) after one year at the Thresholds State County Collaborative Jail Linkage Project (CJLP) in Chicago, consumers had a decrease in days in jail and days in the hospital and reduced jail and hospital costs (McCoy et al. 2004).

FICM Evidence-Base

The evidence base for FICM effectiveness comes from published studies (Cosden et al., 2003; Godley et al., 2000; Solomon & Draine, 1995; Wilson et al., 1995) and from the nine-site SAMHSA Jail Diversion Demonstration, where sites used FICM in a service linkage model (Broner et al., 2004; Steadman & Naples, 2005).

The first study (Broner et al., 2004; Steadman & Naples, 2005) involved a non-random comparison group design that used

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FICM to divert detainees to community treatment services at diverse sites around the country. Diverted individuals reported more days in the community, more service use, and fewer jail days than did the non-diverted comparison groups, but there were no consistent differences on symptoms or quality of life.

The research to date remains unclear on the effectiveness of FACT as an evidence-based treatment.

people with severe mental illness and co-occurring substance abuse disorders to usual care.

Two random clinical trials have been reported here as well (Cosden et al., 2003; Solomon & Draine, 1995). The Solomon and Draine study compared FICM with FACT and with usual care services, finding no significant differences in social or clinical outcomes after one year of services but a higher re-arrest rate for FACT (attributed to having probation officers on the team). The Cosden et al. study compared a combined mental health court and FICM model (that also had probation officers as team members) with usual care; at 12 months, both groups exhibited improvements in life satisfaction, psychological distress, independent functioning, and drug problems. No differences were found for time in jail or number of arrests, but consumers in the intervention arm were more likely to be booked and not convicted, and to have been arrested for probation violations. The usual care group were more likely to be convicted of a new crime.

Conclusions

FACT teams are relatively new adaptations of the ACT model and come in many forms. When adhering to the core ACT model, they show promise for reducing inpatient hospitalizations. With their “criminal justice savvy” (Morrissey & Cuddeback, 2005), they can be expected to reduce recidivism and maintain certain clients in the community. Nonetheless, they are a high intensity, high cost intervention that fits the most disabled segment, perhaps 20 percent, of the persons being diverted or reentering from the criminal justice system. The community management models of choice for the other 80 percent or so of less disabled individuals are multiple, less costly forms of criminal justice-informed case management that rely on brokering services from mainstream providers rather than providing all services via a FACT team. While brokered case management models are still a challenge for many communities with limited resources, they are sustainable in areas where services are more ample. ■

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