Persons with severe mental disorders are overrepresented in jails and prisons in the United States. Studies by Teplin and colleagues (1,2), survey data from the Bureau of Justice Statistics (3), and a review by Lamb and Weinberger (4) suggest that the prevalence of severe mental disorders in correctional facilities ranges between 6 percent and 16 percent. These rates are significantly higher than the rate of 2.8 percent in the general population (5). The recent Criminal Justice/Mental Health Consensus Project (6), the Substance Abuse and Mental Health Services Administration (SAMHSA) (7,8), and national advocacy organizations (9,10) have expressed concern about the problem and have called for effective strategies to address it.

Jail diversion is currently a predominant approach to preventing unnecessary arrest and incarceration of persons with severe mental illness. This approach encompasses a wide range of strategies that are positioned primarily within the criminal justice system (11), including specialized police teams, mental health courts, and pretrial service agencies (12,13). Because these strategies are designed to prevent incarceration by diverting high-risk individuals to treatment, their effectiveness is likely to depend on the availability of appropriate services in the community (8). Despite the importance of access to treatment and support services, many diversion programs lack effective linkages to community-based care. In a national sur-
vey of jail diversion programs, few programs had specific procedures for following up diverted detainees or for ensuring that initial linkages to treatment were maintained (13). In addition, in a national survey of probation and parole agency directors, 82 percent of the directors indicated a need for improved access to mental health services and professionals (14).

Assertive community treatment was developed to help persons with severe mental illness who are at risk of homelessness and hospitalization become integrated into their communities (15–17). This treatment modality engages high-risk individuals in care by using mobile services that are available around the clock and by performing active outreach. Engagement is further promoted through delivery of comprehensive services, including mental health and addiction treatment, transportation, financial services, and vocational support. Although assertive community treatment has been shown to be effective at reducing hospital use and promoting community tenure, most studies have shown little effect on rates of arrest and incarceration (18). In a recent review of controlled studies examining assertive community treatment’s impact on jail and arrest rates, Bond and colleagues (19) found that 70 percent of studies showed no effect, and 10 percent showed worsening.

If jail diversion requires access to treatment and assertive community treatment engages high-risk individuals in care, then combining these models should produce synergistic effects. An example of such a combined approach is Project Link, an assertive community treatment–based program established in 1995 to prevent arrest and incarceration of adults with severe mental illness in Rochester, New York (20,21). Described as a “comprehensive diversion approach” by the Bazelon Center for Mental Health Law (22), Project Link differs from typical assertive community treatment programs in a number of ways. These differences include its requirement of a history of arrest for admission, its use of jail as the primary referral source, its close partnership with multiple criminal justice agencies to divert clients from further involvement with the criminal justice system, and its incorporation of residentially based addiction treatment. Research has suggested that this program may be effective at reducing rates of arrest, incarceration, and hospitalization as well as improving community adjustment (23,24).

Studies have recently been published of other assertive community treatment programs that have been modified to treat mentally ill offenders (25–30). Despite the development of Project Link and other programs over the past decade, there has been a paucity of controlled research. Published reports have consistently shown these programs to be effective at reducing arrest and incarceration rates, but most of the studies have been naturalistic and were conducted without comparison groups or randomization. In addition, studies have not indicated the extent to which mean differences in service use may have been due to outliers in the study samples. Lack of information about outliers limits the ability to assess the effectiveness of particular programs or to compare outcomes. Also, basic descriptive studies that delineate the structural and function-
Forensic assertive community treatment (FACT) programs that met the FACT study criteria

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

In vivo service delivery, a staff-to-client ratio of at least 1:10, a psychiatrist-to-client ratio of at least 1:100, 24-hour availability for crises, and time-unlimited services. Programs were required to meet at least four of the five DACTS criteria to qualify as assertive community treatment programs. Telephone interviews required approximately 45 minutes to complete and were conducted Monday through Friday between 9 a.m. and 5 p.m., eastern time. The telephone survey instrument is available from the authors on request.

Assertive community treatment programs were selected that met three criteria. First, client history of involvement with the criminal justice system was an admission requirement. Second, a criminal justice agency was the primary source of referrals. Third, the program worked in close partnership with a criminal justice agency to perform jail diversion. Identified representatives from each selected program were subsequently asked to review written summaries of information gathered about their respective programs to ensure accuracy. Verified survey data were numerically coded and entered into a Microsoft Excel database for analysis.

**Results**

A total of 291 NACBHDD members (93 percent) responded to the survey. Of these, 98 (34 percent) identified programs that met phase 1 screening criteria. Of the 98 programs identified, 16 programs in nine states subsequently met the DACTS criteria and the study inclusion criteria and are listed in Table 1. Approximately two-thirds of all programs had begun operations since 1999. Although all the programs received funding through Medicaid or other sources of billable revenues, all received additional funding through grants, contract sources, or both. Major funding sources were the California Board of Corrections Mentally Ill Offender Crime Reduction Grant (MIOCRG) program (eight of the 16 programs) and other state health authorities (five programs). Private foundations and SAMHSA's Center for Mental Health Services (CMHS) each funded two programs. The primary client referral sources for 13 programs (81 percent) were local jails. The most common secondary sources of referrals involved various parts of the court system (five programs, or 31 percent). Eight programs (50 percent) accepted clients under involuntary outpatient treatment statutes.

Referral sources, admission requirements, and program capacities are summarized in Table 3 and Table 4, respectively. Eight programs (50 percent) had supervised residential components that were incorporated either as part of their programs or through special service contracts with residential providers. Five of these programs provided residentially based addiction treatment. Eleven programs (69 percent) incorporated probation officers as members of their assertive community treatment teams. These officers provided probation services to all enrollees served by the assertive community treatment teams who...
were on probation, and they actively collaborated with team members around management of those individuals. Among the 16 programs, a mean±SD of 32±25.7 percent of all team members providing direct care were African American, Hispanic, or from other racial or ethnic minority groups. The most common deviation among the measures of assertive community treatment fidelity was inadequate availability of a psychiatrist, noted for five programs (31 percent). Twelve programs (75 percent) reported having an advisory or oversight board with mental health and criminal justice representatives.

The mean level of enrollment in

<table>
<thead>
<tr>
<th>Program name</th>
<th>Primary referral source</th>
<th>Secondary referral source</th>
<th>Criminal justice history required for admission</th>
<th>Are clients who have recently committed a violent crime eligible?</th>
<th>Maximum capacity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community Treatment Alternatives</td>
<td>Dane County Jail</td>
<td>Mental health center crisis unit</td>
<td>Must be either incarcerated, guilty by reason of insanity, on bail, or referred by courts</td>
<td>Yes</td>
<td>82</td>
</tr>
<tr>
<td>Project Link</td>
<td>Monroe County Jail</td>
<td>Rochester Psychiatric Center</td>
<td>Must have at least one previous arrest</td>
<td>Yes</td>
<td>50</td>
</tr>
<tr>
<td>Arkansas Partnership Project</td>
<td>Arkansas State Hospital forensic unit</td>
<td>Court system</td>
<td>Must be not guilty by reason of insanity</td>
<td>Yes</td>
<td>None</td>
</tr>
<tr>
<td>Substance Abuse and Mental Illness Court Program</td>
<td>Butler County Court</td>
<td>None</td>
<td>Must be a convicted felon</td>
<td>Yes</td>
<td>25</td>
</tr>
<tr>
<td>Thresholds Jail Program</td>
<td>Cook County Jail</td>
<td>None</td>
<td>Must be incarcerated in Cook County Jail</td>
<td>Yes</td>
<td>30</td>
</tr>
<tr>
<td>Forensic Assertive Community Team</td>
<td>Local jail</td>
<td>Restoration to trial competency program</td>
<td>Must be booked or in custody</td>
<td>Yes</td>
<td>48</td>
</tr>
<tr>
<td>FACT Project</td>
<td>Local jail via mental health court</td>
<td>None</td>
<td>Must have more than three arrests and be incarcerated</td>
<td>Yes</td>
<td>100</td>
</tr>
<tr>
<td>Community Reintegration of Mentally Ill Offenders</td>
<td>Local jail via the court system</td>
<td>None</td>
<td>Must be incarcerated</td>
<td>No</td>
<td>108</td>
</tr>
<tr>
<td>Multi Agency Referral and Treatment</td>
<td>Local jail</td>
<td>Mental health agencies</td>
<td>Must have an outstanding misdemeanor offense</td>
<td>No</td>
<td>40</td>
</tr>
<tr>
<td>CHANGES</td>
<td>Santa Rita Jail</td>
<td>Psychiatric emergency services</td>
<td>Must have a history of repeated Santa Rita incarceration and psychiatric hospitalization</td>
<td>Yes</td>
<td>100</td>
</tr>
<tr>
<td>Monterey County Supervised Treatment After Release</td>
<td>Jail medical service</td>
<td>Court system</td>
<td>Must have at least two arrests, jail history, or probation violation</td>
<td>Yes</td>
<td>30</td>
</tr>
<tr>
<td>Mental Health Court</td>
<td>Local jail via Superior Court</td>
<td>None</td>
<td>Must be incarcerated, referred by public defender</td>
<td>No</td>
<td>45</td>
</tr>
<tr>
<td>Support and Treatment After Release</td>
<td>Local jail</td>
<td>Court system</td>
<td>Must be incarcerated</td>
<td>Yes</td>
<td>70</td>
</tr>
<tr>
<td>Suncoast Center Forensic FACT Team</td>
<td>State forensic mental health facility</td>
<td>Court system</td>
<td>Must be charged with a felony, not guilty by reason of insanity, or incompetent to stand trial on conditional release</td>
<td>Yes</td>
<td>100</td>
</tr>
<tr>
<td>Project DOT (Divert Offenders to Treatment)</td>
<td>Cumberland County Jail</td>
<td>Probation and parole</td>
<td>Must be in the correctional system</td>
<td>Yes</td>
<td>40</td>
</tr>
<tr>
<td>Birmingham Jail Diversion Project</td>
<td>Birmingham City Jail</td>
<td>None</td>
<td>Must be in Birmingham jails for misdemeanors</td>
<td>Yes</td>
<td>70</td>
</tr>
</tbody>
</table>
the programs at the time of interview was 53±30 clients; maximum capacity averaged 63±29 clients. Of clients in all programs, a mean of 69±11 percent were men; 56±22 percent had a diagnosis of schizophrenia or schizoaffective disorder, and 21±10 percent had a diagnosis of bipolar disorder. A mean of 89±12 percent of clients had co-occurring substance use disorders, and 52±35 percent of all clients were homeless at the time of enrollment. A mean of 49±29 percent of clients were African American, Hispanic, or from other racial or ethnic minority groups. A mean of 64±32 percent had previous felony convictions, and 37±26 percent had histories of committing violent crimes. A mean of 55±39 percent of clients were on probation at the time of enrollment in the program. Five of the 16 programs accepted patients who were on parole at the time of enrollment.

Three programs reported that they had published outcome data in academic journals. Cimino and Jennings (25) reported on the first 18 patients treated in the Arkansas Partnership Program. Seventeen patients had remained arrest free and without substance abuse while living in the community an average of 508 days. In a study comparing outcomes among 41 patients during the year before and after enrollment in Project Link, the mean number of jail days per patient dropped from 107.7±133.5 to 46.4±83.7 (p<.01, two-tailed Wilcoxon test) (23). Significant reductions were also noted in the number of arrests and hospitalizations, along with improved community functioning as measured with the Multnomah Community Ability Scale (MCAS) (32,33). The mean MCAS scores improved from 51.5±7.6 to 61.5±8.6 (p<.001, two-tailed Wilcoxon test) during the first year in the program. In a study of the first 30 patients enrolled in the Thresholds Jail Project, the total number of jail days dropped from 2,741 in the previous year to 469 during the first year of enrollment (26). The total number of hospital days dropped from 2,153 to 321 for the group. Total savings in jail costs during the one-year study period was $157,000, and total savings in hospital costs was $917,000.

**Table 3**

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

**Discussion and conclusions**

This study identified a group of 16 promising programs with similar target populations, system coordination, and service elements that have been implemented since 1991. Although a well-defined and replicable model has yet to be developed, the observed convergence in approach can be understood as representing an early stage of the development process. The proposal that a new approach to care called forensic assertive community treatment (FACT) is emerging raises several basic questions that are only partially addressed by data from this study. Does FACT differ from assertive community treatment in substantive and meaningful ways? What are the core elements of the FACT approach? Who should FACT programs treat?

On the basis of study findings and experience with Project Link, we suggest that the primary distinction between FACT and standard assertive community treatment programs lies in the extent to which the goals of preventing arrest and incarceration determine program structure and function. Although assertive community treatment teams often treat patients who have criminal histories and interface with criminal justice agencies, these activities are undertaken more by necessity than by design. FACT prioritizes the treatment of mentally ill offenders, as evidenced by its requirement that clients have a criminal history and the predominance of criminal justice agencies as primary referral sources. Beyond interfacing with criminal justice agencies on an as-needed basis, the 16 programs identified in this study are developing integrated mental health and criminal justice service systems. An example is the incorporation of probation officers as team members by 69 percent of identified programs. In addition to promoting effective communication, such integration may be strategically important in preventing unnecessary incarceration, because it can facilitate the use of legal leverage to promote treatment adherence when necessary.

Assertive community treatment’s
The core elements of the FACT approach relate to the type of housing provided. Half the programs identified in this study had a supervised residential component, with most providing addiction treatment services. Although assertive community treatment programs routinely link patients to existing housing (17), the development and incorporation of a residential treatment component is not part of the assertive community treatment model. Such development may be critical for persons with mental illness in correctional facilities, especially those with felony convictions, histories of violence, and active psychosis.

These factors have been found to predict failed community placements shortly after release despite the involvement of a transition team that links clients to community housing (37). In addition, the reluctance of housing providers to serve high-risk individuals can be a significant barrier to obtaining existing community housing (20). The incorporation of a supervised residential treatment component in FACT programs suggests that structured housing may be necessary to promote safety and residential stability among certain mentally ill offenders. Further research is needed to clarify the purpose, target subpopulation, level of care, and types of residential programming that are most effective as FACT programs continue to develop.

The core elements of theFACT approach have yet to be fully determined. We chose three critical elements as the criteria for this study because they were integral to determining the structure and function of Project Link and because they could be reliably measured. Although these criteria enabled identification of a group of similar programs, it is important to note that the programs differed on several dimensions. A key dimension is how diversion is accomplished. Some programs are “pre-booking” in nature (engaging clients at the point of arrest), whereas others are “post-booking” (engaging clients on release from the courts or jail). Most programs have developed partnerships with multiple criminal justice agencies, but others use a small number of partnerships as their basis for diversion, as can be seen in Table 3. The characteristics and needs of clients who are typically served in these different diversion strategies as well as the relative effectiveness of these approaches require further study.

The programs also varied in terms of the services provided. As can be seen in Table 4, programs vary in the scope of residential and addiction treatment services as well as in the racial or ethnic composition of the service providers. The degree to which the demographic characteristics of service providers approximates

<table>
<thead>
<tr>
<th>Program name</th>
<th>Supervised residential component</th>
<th>Probation officer on the team</th>
<th>Credentialled addictions counselor on the team</th>
<th>% staff from a racial or ethnic minority group</th>
<th>% patients from a racial or ethnic minority group</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community Treatment Alternatives</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>17</td>
<td>35</td>
</tr>
<tr>
<td>Project Link</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
<td>80</td>
<td>85</td>
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<tr>
<td>Arkansas Partnership Project</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
<td>50</td>
<td>40</td>
</tr>
<tr>
<td>Substance Abuse and Mental Illness Court Program</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>0</td>
<td>23</td>
</tr>
<tr>
<td>Thresholds Jail Program</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>60</td>
<td>70</td>
</tr>
<tr>
<td>Forensic Assertive Community Team</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>10</td>
<td>12</td>
</tr>
<tr>
<td>Forensic Assertive Community Treatment Project</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
<td>20</td>
<td>16</td>
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<tr>
<td>Community Reintegration of Mentally Ill Offenders</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>52</td>
<td>70</td>
</tr>
<tr>
<td>Multi Agency Referral and Treatment CHANGES</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>25</td>
<td>35</td>
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<tr>
<td>Monterey County Supervised Treatment After Release</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>70</td>
<td>64</td>
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<tr>
<td>Mental Health Court</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>0</td>
<td>25</td>
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<tr>
<td>Support and Treatment After Release</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>32</td>
<td>55</td>
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<td>Suncoast Center Forensic FACT Team</td>
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<td>14</td>
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<td>Project DOT (Divert Offenders to Treatment)</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
<td>0</td>
<td>8</td>
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<tr>
<td>Birmingham Jail Diversion Project</td>
<td>No</td>
<td>No</td>
<td>Yes</td>
<td>50</td>
<td>100</td>
</tr>
</tbody>
</table>
that of service recipients may be im-
portant given that minority groups are
everpresent in correctional
facilities (38,39) and because cultural
and language differences represent
major barriers to treatment (39). It
became apparent during the inter-
views that the programs also varied in
their level of fidelity to the assertive
community treatment model on di-
mensions beyond those formally as-
sessed, such as whether they included
vocational specialists. Structural and
organizational DACTS items were
chosen to screen programs to ensure
some measurable degree of consis-
tency between programs. A small
number of items were used to limit
the duration of the telephone inter-
view, although a full DACTS assess-
ment would have enabled more de-
tailed program descriptions. Whether
particular fidelity deviations are more
common among FACT teams than
among assertive community treat-
ment teams is not known.

The question of who FACT pro-
grams should treat is difficult to an-
swer in the absence of a clearly de-
fined model of intervention. It is note-
worthy that admission criteria vary
substantially among current pro-
grams. Although most programs tar-
get persons with schizophrenia and
bipolar disorder, others admit clients
who have a wide range of diagnoses,
including primary personality disor-
ders. Because assertive community
treatment may not be effective for
persons with personality disorders
(40), the inclusion of these individuals
in FACT programs is potentially prob-
lematic, especially when drug use and
criminal behaviors are present.

The programs also varied substan-
tially in their criminal justice admis-
sion criteria. Understanding the level
of risk of criminal recidivism among
clients who are admitted to FACT
programs is critical to determining
the model’s effectiveness at prevent-
ing recidivism. In a meta-analysis of
studies of criminal and violent recidi-
vism among mentally ill offenders,
Bonta and colleagues (41) found that
criminal history variables were the
best predictors of recidivism. These
variables include adult criminal histo-
ry, history of juvenile delinquency, as-
association with criminal companions,
criminal use of weapons, and pres-
ence of an antisocial personality. In a
recent study of 802 adults with severe
mental illness, Swanson and associ-
ates (42) found that past violent vic-
timization, violence in the surround-
ing environment, and substance
abuse had a cumulative association
with risk of violent behavior.

Despite the likely importance of
criminal history and social-environ-
mental variables in determining the
risk of criminal recidivism, none of
the 16 programs we surveyed as-
sessed these variables by using a stan-
dardized measure. One method for

Although
most assertive
community treatment
programs target persons
with schizophrenia and
bipolar disorder; others admit
clients with a wide range
of diagnoses, including
personality
disorders.

assessing the risk of recidivism attri-
utable to such variables is to incorpo-
rate the use of standardized assess-
ment tools such as the Level of Ser-
vice Inventory–Revised in screening
potential clients (43,44). This instru-
ment has achieved the highest predic-
tive validity with recidivism in the
general population among available
instruments (45). Additional instru-
ments that have good predictive pow-
er include the Psychopathy Check-
list–Revised (46) and the Lifestyle
Criminality Screening Form (47). Al-
though not validated and normed for
use among adults with severe mental
illness, such tools may help us under-
stand which clients are most appro-
priate for FACT and to evaluate the
effectiveness of this approach.

Implicit in FACT’s design to pro-

tigate engagement of clients in psy-
chopharmacology, addiction treat-
ment, and community support servic-
es is the notion that such interven-
tions will reduce criminal recidivism.
Although intensive services may re-
duce recidivism among persons who
are arrested as a result of untreated
psychosis, drug addiction, or home-
lessness, such services are probably
not sufficient for everybody. Individ-
uals with co-occurring psychopathy
may also benefit from additional in-
terventions that directly target antiso-
cial attitudes, skills, and cognitions
(48,49). Research in populations of
persons who do not have a mental ill-
ness has suggested that the most ef-
fective approaches to individuals who
are at a high risk of criminal recidi-

mism incorporate highly structured
cognitive-behavioral interventions
(45,50,51). The FACT approach may
benefit from inclusion of such strate-
gies in managing persons who have
both severe mental illness and psy-
chopathic traits. One example of a
program that is currently using these
strategies is the Monterey County Su-

nervised Treatment After Release

MCSTAR) program. In addition to
standard treatments, the program in-
corporates cognitive-behavioral inter-
ventions, including specialized
groups and courses designed to target
and restructure criminal thinking.

Is “forensic assertive community
treatment” an appropriate name for
this approach to care? The acronym
FACT is currently used for other
health care models, including family-
assisted assertive community treat-

ment (52). In addition, the term
“forensic” has a connotation that re-
lates to persons who have been found
not guilty by reason of insanity, guilty
but mentally ill, or incompetent to
stand trial. Such individuals are often
treated in specialized forensic hospi-
tals by forensic psychiatrists and oth-
er forensic specialists. By contrast,
forensic assertive community treat-
ment is designed to engage adults
with severe mental illness in commu-

nity-based care.
Forensic specialists can play a key role as FACT clinicians because of their special knowledge of the criminal justice system and relevant case law. However, although clinicians in the surveyed programs were knowledgeable about criminal justice and mental health systems, few were forensic specialists. Formal forensic training is helpful in bridging these systems, but it may not be necessary as long as clinicians are comfortable and familiar with both systems. Forensic assertive community treatment was chosen as a name for this approach to care because of the criminal justice system involvement of the target population and the criminal justice identity of its referral sources and partnerships. In addition, some programs surveyed had already begun using the FACT designation to identify themselves.

Several limitations of this study must be recognized. Because the survey covered only the 28 states represented by NACBHD, the actual number of such programs operating across the country is probably higher than indicated here. However, the goal of this study was to describe the early emergence of a promising model of care rather than to create a directory of existing programs. Although county behavioral health directors are generally knowledgeable about programs in their jurisdictions, the NACBHD members we surveyed had a high degree of discretion in determining which programs to identify in phase 1 of the survey. Also, the use of DACTS items to screen programs in phase 2 raises significant methodologic limitations. The selected items fail to capture important aspects of assertive community treatment programs, such as their team approach and vocational interventions.

In addition, the construct validity of the DACTS rests on direct review of records and interviews of staff members that were not conducted. The reliability of survey data collected in phase 2 was also limited, because only one senior representative from each program was interviewed, and the roles and responsibilities of these respondents varied between programs. Respondents sometimes provided rough estimates in response to interview questions, and data were not validated beyond being reviewed by the respondents. Also, many of these data points will change as programs continue developing. Given the likelihood of change over time, this study is best understood as providing a snapshot of an evolving approach to care.

FACT is an emerging approach to the prevention of recidivism that incorporates both assertive community treatment and criminal justice components. Although the extent and nature of incorporation varies among programs, the blend has created a foundation for new interventions that offer enhanced community treatment as an alternative to involvement with the criminal justice system. The combination of intensive service delivery and legal leverage represents a critical balance for persons who would otherwise be left at the mercy of untreated illness, streets, and jails. Sadly, 69 percent of the program representatives surveyed were uncertain whether their programs would continue after their current grants and contracts expired. Further work is necessary to develop funding streams to support the continued development of this promising model of care.

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Submissions for Datapoints Invited

Submissions to the journal’s Datapoints column are invited. Areas of interest include diagnosis and practice patterns, treatment modalities, treatment sites, patient characteristics, and payment sources. National data are preferred. The text ranges from 350 to 500 words, depending on the size and number of figures used. The text should include a short description of the research question, the database and methods, and any limitations of the study.

Inquiries or submissions should be directed to Harold Alan Pincus, M.D., or Terri L. Tanielian, M.S., editors of the column. Contact Ms. Tanielian at RAND, 1200 South Hayes Street, Arlington, Virginia 22202 (terri_tanielian @rand.org).