

Behavioral Health is Essential To Health



Prevention Works



Treatment is Effective



People Recover



Rochester Forensic Assertive Community Treatment (R-FACT)

Toward an Evidence-Based Practice

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Thanks

- **Collaborators**

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- *Catherine Cerulli, JD, PhD*
- *Geof Williams, MD, PhD*
- *Ann Russ, PhD*
- *David Jacobowitz, MA*

- **Sponsors**

- *National Institute of Mental Health*
- *Robert Wood Johnson Foundation*
- *Monroe County Office of Mental Health*

Declaration of Interest

- **Drs. Lamberti and Weisman are co-founders of Community Forensic Interventions, LLC**

Purpose

- ***To describe R-FACT development efforts***
- ***To discuss R-FACT daily operations***
- ***To present a case vignette***

Scope of the Problem



- **6,899,000 in corrections in United States**
 - *Approximately 16% have serious mental illness*

"All the News
That's Fit to Print"

The New York Times

Late Edition

New York: Today, a mix of sun and clouds. High 45. Tonight, becoming mainly clear. Lows in the lower 30's. Tomorrow, sunny, high 45. Yesterday, high 51, low 40. Details on page D08.

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\$1 beyond the greater New York metropolitan area

60 CENTS

Prisons Replace Hospitals for the Nation's Mentally Ill

By FOX BUTTERFIELD

LOS ANGELES — Michael H. had not had a shave or haircut in months when he was found one recent morning sleeping on the floor of St. Paul's Episcopal Church in suburban Lancaster, next to empty cans of tuna and soup from the church pantry.

There was little to suggest that he had once been a prosperous college graduate with a wife and two children — until he developed schizophrenia, lost his job and, without insurance, could no longer afford the drugs needed to control his mental illness.

Charged with illegal entry and burglary, Michael H. was taken to the Los Angeles County Jail. The jail, by default, is the nation's largest mental institution. On an average day, it holds 1,500 to 1,700 inmates who are severely mentally ill, most of them detained on minor charges, essentially for being public nuisances.

The situation in the jail, scathingly criticized as unconstitutional by the United States Justice Department last fall, is the most visible evidence that jails and prisons have become the nation's new men-



Monica Almeida/The New York Times

The new Twin Towers jail in Los Angeles has an area for mentally ill inmates, but offers little treatment.

Scope of the Problem



- **6,899,000 in corrections in United States**
 - *16% have serious mental illness*
- ***4,751,400 in community supervision***

Ditton 1999, Glaze and Kaeble 2013

Why Is This Happening?

The Conventional Wisdom

- **The problem is “criminalization” due to deinstitutionalization and lack of access to mental health services.**
- **The solution is to “divert” justice-involved individuals into existing mental health services.**

Current Approaches for Justice-Involved Clients

“Jail Diversion” Programs

Police-Based Diversion:

- *Crisis Intervention Teams
- *Mental Health Response Teams
- *Joint Police/Mental Health Teams

Assisted Outpatient Treatment:

- *Civil Law (ex: Kendra’s Law, Laura’s Law)
- *Criminal Law (ex: NGRI)

Court- Based Diversion:

- *Mental Health Courts
- *Drug Courts, Veterans Courts
- *Conditional Release

Jail-Based Diversion:

- *Pre-Trial Services

Community Corrections:

- *Probation
- *Parole

Effectiveness of Current Approaches

- **Two large randomized controlled trials of outpatient commitment failed to find a significant effect on reducing criminal involvement**
- **A 2009 review of 21 jail diversion studies “revealed little evidence of the effectiveness of jail diversion in reducing recidivism among persons with serious mental illness”**
- **A 2011 Cochrane Review concluded “We found little evidence that compulsory treatment was effective”**

Sirotych 2009; Swartz et al. 2001; Steadman et al. 2001; Kisely, Campbell and Preston 21011

Understanding and Preventing Criminal Recidivism Among Adults With Psychotic Disorders

J. Steven Lambert, M.D.

The high prevalence of adults with psychotic disorders in the criminal justice system has received much attention recently, but our understanding of this problem is marked by diverging opinions. Mental health professionals point to deinstitutionalization and our fragmented mental health system as primary causes. Criminologists minimize the role of mental illness and contend that persons with and without mental illness are arrested for the same reasons. Meanwhile, practice guidelines offer little guidance to clinicians about how to address the problem. Drawing upon contemporary crime prevention principles as well as current knowledge of psychotic disorders and their treatment, this article presents a conceptual framework for understanding and preventing criminal recidivism. The framework highlights the importance of individual and service-system risk variables and emphasizes the central role of treatment nonadherence as a mediator between modifiable risk variables and recidivism. On the basis of the conceptual framework described in this article, three necessary elements of intervention are presented for preventing recidivism among adults with psychotic disorders: competent care, access to services, and legal leverage. Research is needed to further define and test these intervention elements as foundations for future service delivery efforts. (*Psychiatric Services* 58: 773-781, 2007)

On March 5, 1998, the *New York Times* published a front-page headline stating "Prisons Replace Hospitals for the Nation's Mentally Ill" (1). Five years later a Human Rights Watch report noted that more people with severe mental illness reside in our prisons than in our hospitals (2). Despite concerns raised by these and similar reports (3,4), a consensus regarding the causes of this phenomenon is lacking. Are inmates with mental illness criminals or have they been criminalized?

This article reviews the literature on criminal recidivism among adults with schizophrenia or other psychotic

disorders as well as the current literature in the field of criminology. On the basis of this review and synthesis, a conceptual framework for understanding and preventing criminal recidivism is proposed and necessary elements of intervention are identified and discussed.

Scope of the problem

Psychotic symptoms are reported by 15% and 24% of all prison and jail inmates, respectively, according to the latest U.S. Department of Justice survey (5). Although these findings are based on self-report, findings about the prevalence of schizophrenia and

other psychotic disorders from more rigorous studies are also concerning. Using data from the Epidemiologic Catchment Area program, Robins and Regier (6) found that 6.7% of prisoners had experienced symptoms of schizophrenia at some point in their lives. A Correctional Service of Canada study using the Diagnostic Interview Schedule and the American Psychiatric Association's (APA's) *DSM-III-R* criteria found a 7.7% prevalence of psychotic disorders in a sample of 9,801 inmates (7). Also, a large study comparing the weighted prevalence of psychotic disorders between the national household survey and prisons in Great Britain found a tenfold higher prevalence of psychotic disorders among prisoners (8). These findings are consistent with reports that individuals with psychotic disorders are arrested more frequently and have higher rates of criminal conviction for both nonviolent and violent offenses, compared with the public (9,10).

Most persons with schizophrenia are arrested for minor crimes, such as disturbing the peace and public intoxication (11), but some commit violent acts, including assault and murder (12-14). Although these events are rare, their serious and tragic nature highlights the need for effective treatment strategies (15). Persons with schizophrenia and other psychotic disorders are unlikely to receive adequate treatment within correctional facilities. According to the U.S. Department of Justice only about half of all inmates with mental illness receive treatment, with most receiving no treatment other than medications while in custody (16).

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Why *Do* Mentally Ill Adults End Up in Jail More Often Than Others?

Risk-Needs-Responsivity Model:


1. They have higher rates of *criminogenic risk factors*

“Big Eight” Risk Factors

- 1. History of Antisocial Behaviors**
- 2. Antisocial Personality**
- 3. Antisocial Cognitions**
- 4. Social Support for Crime**
- 5. Substance Abuse**
- 6. Work and School Problems**
- 7. Family and Marriage Problems**
- 8. Lack of Healthy Leisure and Recreation**

Recidivism Risk Factors

Severely Mentally Ill Adults Have More



	Schizophrenia	General Public
Substance Use	40%	10%
Antisocial Personality	23%	3%
Unemployment	73%	7%
Less than HS degree	50%	25%

Why *Do* Mentally Ill Adults End Up in Jail More Often Than Others?

- 1. They have higher rates of established risk factors**
- 2. *They also have psychotic and manic symptoms which can lead to arrest***

Swanson et al. 2006, Lamberti 2007, Christopher 2012,

The Key to Preventing Criminal Recidivism in Justice-Involved Clients

- ***To engage them in interventions that target the risk factors driving their recidivism***


Causes of Non-Adherence

SYSTEMIC CAUSES

- Lack of outreach
- Limited hours of availability
- Clinician inexperience
- Treatment ineffectiveness
- Treatment side effects
- Cultural and language barriers
- Geographical barriers
- Financial barriers

INDIVIDUAL CAUSES

- Unawareness of illness
- Attitudes toward medications
- Psychotic or mood symptoms
- Cognitive impairment
- Substance abuse
- Homelessness
- Negative family influences
- Fear of stigmatization



**Sometimes optimizing care is
not enough**

VIDEO

R-FACT Development

Monroe-Livingston Demonstration Project 1987-1992

- **First capitated payment program for SPMI adults**
- **Funded new community mental health services as *Rochester Psychiatric Center* downsized**



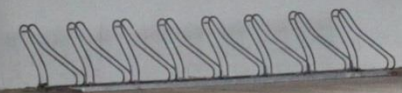
STRONG  HEALTH

STRONG TIES

UNIVERSITY OF ROCHESTER MEDICAL CENTER

2613

NO
SMOKING



Monroe County Jail

1993 Jail Survey



Monroe County OMH

1995 Request for Proposals

- For a “culturally competent case management team” awarded to URMH
- 1997: RWJF grant:
 - *Convert ICM team to **ACT** team*
 - *Develop a **Housing Component***
 - *Develop **Criminal Justice Collaborations***

Why ACT?

- **ACT targets *some* recidivism risk factors:**
 - *Psychosis* —————→ *Psychiatrist, medications*
 - *Substance Use* —————→ *Dual Dx Counselor/Model*
 - *Unemployment* —————→ *Employment Specialist*
- **ACT is *ineffective* at preventing criminal recidivism (Mueser et al. 1998, Bond et al. 2001)**

PROJECT LINK



A MODEL
FOR URBAN
COMMUNITIES



Prevention of Jail and Hospital Recidivism Among Persons With Severe Mental Illness

**Project Link, Department of Psychiatry, University of Rochester,
Rochester, New York**

Project Link is a university-led consortium of five community service agencies in Monroe County, New York, dedicated to preventing repeated incarceration and hospitalization of persons with severe mental illness and promoting their reintegration into the community. The consortium spans the health care, social service, and criminal justice systems and features a mobile treatment team with a forensic psychiatrist, a dual diagnosis treatment residence, and multicultural staff.

The department of psychiatry of

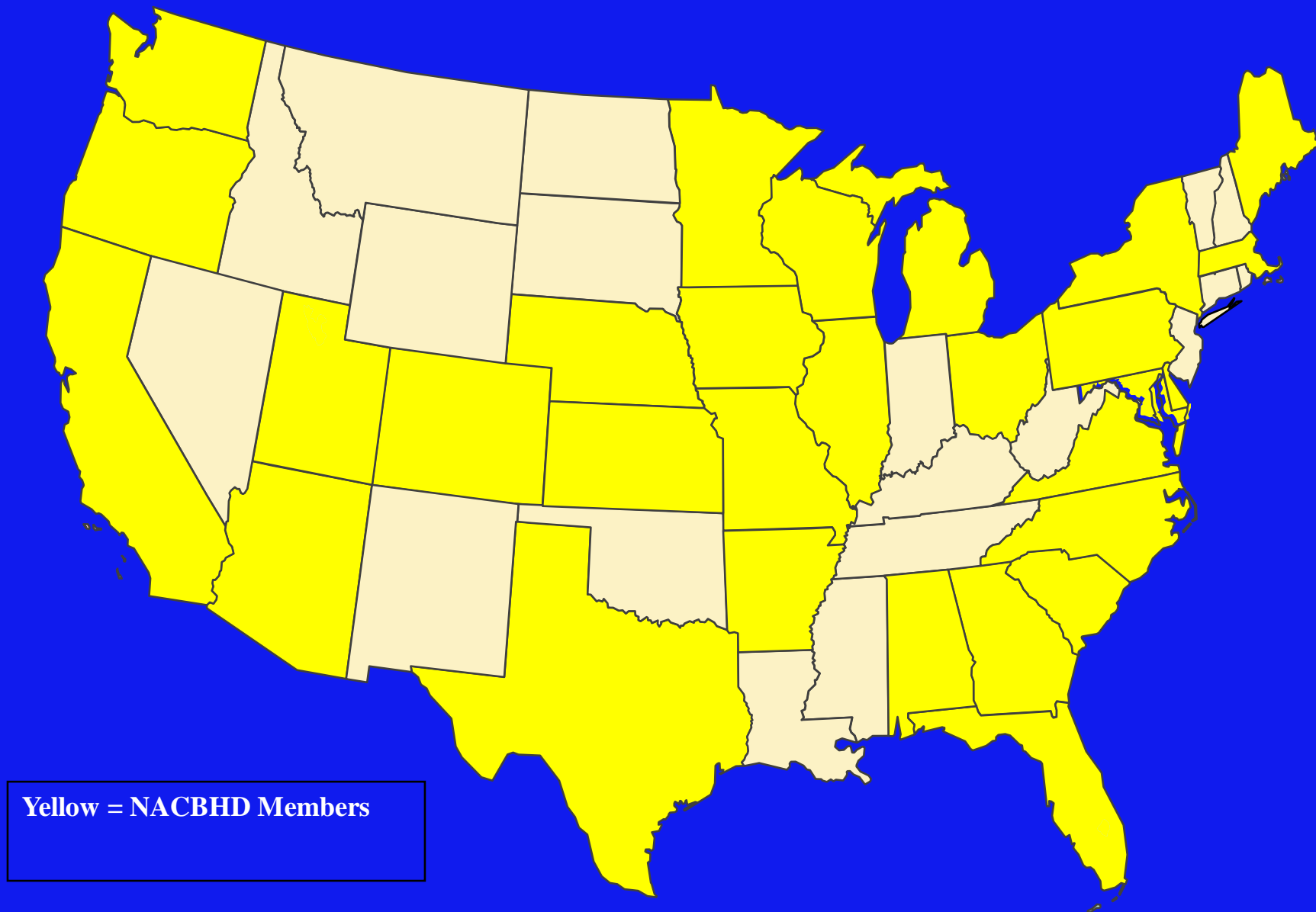
The demonstration project created a broad base of community services and forged early ties among providers committed to improving community-based care. However, despite the presence of these services, during recent years it became clear that many prospective patients were missed. They lived on the streets and were noncompliant with medication and often were dependent on alcohol and illegal drugs. They cycled between jails, hospital emergency rooms, and brief episodes of inpatient care, after which they were back

presented annually by the American Psychiatric Association to recognize outstanding programs for mentally ill and developmentally disabled persons. It includes a \$5,000 prize made possible by a grant from Pfizer, Inc., U.S. Pharmaceuticals.

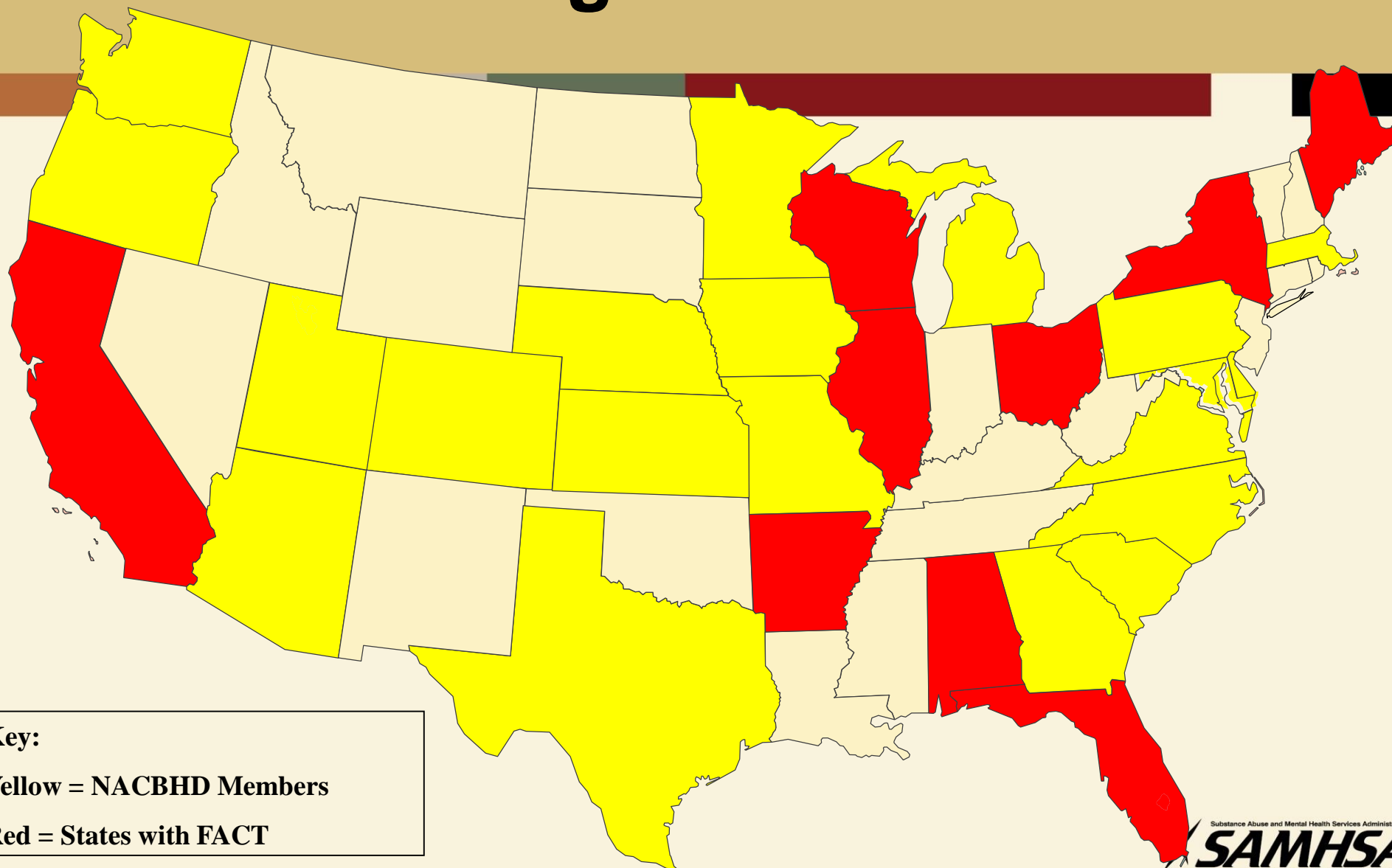
Project Link was selected in the category of large academically or institutionally sponsored programs. The winner of the award for small community-based programs is described in a separate article on page 1473. The awards were presented on October 29 during the opening ses-

Forensic Assertive Community Treatment *Psychiatric Services 55:1285-93, 2004*

- First published study of “FACT”
- National survey of 314 county behavioral health directors
- ACT teams identified:
 - *Required criminal history for enrollment*
 - *Criminal justice partnership*
 - *CJ agency as main referral source*



FACT Program Locations



Key:

Yellow = NACBHD Members

Red = States with FACT

Key Findings

- 1. Great variability between “FACT” programs.**
- 2. Encouraging data but no rigorously controlled studies of FACT.**

2008 NIMH R34 Grant:

Developing the R-FACT Model

■ **STANDARDIZE:**

- *FACT focus groups in NY, OH, CA*
- *Expert opinion and stakeholder input*
- *13 years of prototype experience*

**Fidelity Scale
Rater's Guide**

■ **TEST:**

- *Randomized controlled trial*

R-34 Study Design

- **70 subjects with psychotic disorders recruited from the Monroe County Jail and Criminal Court System.**
- **All had misdemeanor convictions and were eligible for Conditional Release.**
- **Randomly assigned to receive R-FACT or ETAU for 1 year.**

R-34 Study Groups

- **R-FACT**

- *High fidelity to R-FACTS*
 - **Criminogenic risk factors were identified and targeted**
 - **All subjects received judicial monitoring**

- **ETAU**

- *Enhanced treatment as usual*
 - **All subjects received expedited referrals**
 - **Each subjects was assigned a case manager**

R-34 Data Sources

- **Mental Health Service Utilization**
 - *Monroe County Office of Mental Health*
- **Criminal Justice Service Utilization**
 - *Monroe County Jail*
 - *NYS Division of Criminal Justice Services*



Preliminary Findings

BASELINE DATA	R-FACT (n=35)	ETAU (n=35)
Age	37.7 (11.9)	33.7 (10.6)
Male Gender	63%	60%
African-American	66%	86%
Caucasian	31%	14%
Never Married	86%	83%
Unemployed	91%	97%
Less than HS	46%	63%
Schizophrenia	51%	46%
Co-Occurring Substance Use	83%	80%
LSI-R	26.0 (7.1)	26.0 (7.9)
Jail Days, Year Prior	68.6 (96.0)	65.4 (82.6)

Preliminary Finding 1:

Significantly Fewer Convictions and Jail Days

	TOTAL CONVICTIONS	TOTAL JAIL DAYS	MEAN (SD) JAIL DAYS PER PATIENT
ETAU	33	1522	43.5 (58.3)
R-FACT	14	751	21.5 (25.5)
P-Value	P<.04	P<.05	P<.05

Preliminary Finding 2:

Significantly Fewer Hospitalizations



	TOTAL HOSPITALIZATIONS	TOTAL HOSPITAL DAYS	MEAN (SD) HOSPITAL DAYS PER PATIENT
ETAU	33	832	23.8 (63.3)
R-FACT	10	155	4.4 (14.9)
P-Value	P=.03	P=.09	P=.09

Preliminary Finding 3:

Significantly Better Treatment Retention

VARIABLE	R-FACT	ETAU	STATISTIC
Days In Treatment All Subjects (Mean/SD)	337.9 (63.4)	174.2 (140.5)	P<.01

R-FACT

OPERATIONS

Robert L. Weisman, DO

Associate Professor of Psychiatry, URM

Co-Director, Steinberg Fellowship in Psychiatry and Law

R-FACT Team:

**“Coming together is a beginning,
keeping together is progress,
working together is success.”**

-- Henry Ford

R-FACT Goals

- *To prevent recidivism and promote recovery among patients with severe mental illness and criminal justice involvement*

Re-entry Checklist:

Domains

- **Mental health services**
- **Psychotropic medications**
- **Housing**
- **Substance abuse services**
- **Health care and benefits**
- **Employment**
- **Income support/benefits**
- **Food/clothing**
- **Transportation**
- **Other (child care needs of women...)**

Diversion Programs

Utilize Legal Authority to Promote Compliance

- **Dependent upon:**
 1. *The effectiveness of the treatments and services that clients are leveraged to receive*
 2. *The ability of behavioral health and criminal justice professionals to collaborate*

Steadman et al 1999; Hiday 2003; Swartz and Swanson 2004; Loveland and Boyle 2007; Lamberti 2007

Who is R-FACT for?

- **Adults age 18 years or older**
- **Diagnosis of a Serious Mental Illness:**
 - *“Psychotic Disorder” (Schizophrenia, Schizoaffective Disorder, Delusional Disorder, etc.)*
 - *High prevalence of co-occurring disorders*
- **Individuals facing a violation, misdemeanor, felony, probation, parole, AOT and under other conditional release status**
- **Eligible for a plea agreement per:**
 - *DA, PD and Judge*
- **Key Referral Source:**
 - *Criminal court, probation, parole, AOT*
 - *SPOA oversight*

R-FACT Principles

- **Partnership between criminal justice and clinical service providers**
- **Adherence monitoring**
- **Clinically informed decision making**
- **Problem solving approaches to behavior problems**

Elements of R-FACT:

- 1. Program Development**
- 2. Hiring of Qualified and Savvy Staff**
- 3. R-FACT Staff and Cross Training (Staff development)**
- 4. Forensic Collaborative Integrations**
- 5. Regional Clinical Networks**
- 6. Residential Services**
- 7. Day Programming, S/A and Vocational Supports**
- 8. Transportation Planning**
- 9. Client Finances/Wraparound Dollars**
- 10. Transition and Step-down planning**

Day-to Day R-FACT

- **Daily treatment team meetings**
- **Daily participant criminogenic, psychosocial and clinical assessments based on CIAF**
- **Basic necessity supports (food, clothing, shelter)**
- **Continuity of care and goal-based planning**
- **CJ reporting relationships and follow up**
- **Court/CJ advocacy and liaison**
- **Family and vocational support**
- **CBT-based groups**

Outreach:



R-FACT Staff and Cross Training

- **R-FACT philosophy**
- **Cross-Training**
 - *Forensic Release*
 - *CJ System*
 - *Courts and SPMI Individuals*
 - *Basic Mental Health Dx, Dual-Dx, Rx, Relapse Prevention*
 - *Person-Centered and Recovery Focus*
 - *Residential Providers*
- **Safety and Violence Education: (SAVE) Curriculum**
 - *Initial and refresher training for management of at-risk individuals*
 - *Articles, study guides and role-play*
 - *Online resource*



Forensic Collaborations:

- **Courts**
- **Jails/Prisons**
- **Local CJ and Law Enforcement**
- **Parole/Probation/ATI/Day Reporting**
- **Pre-trial services**
- **Mandated Treatment Programs**
- **Conditional Release Contracts**

Regional Clinical Networks

- **Hospital/Clinic/Rehabilitation Programs**
 - *Leverage existing resources*
 - *Emergency Room*
 - *Inpatient Psych*
 - *PHP*
 - *Dual-Dx and Rehabilitation*
 - *Day Treatment (PROS)*
- **Administrative and Provider**
 - *Buy-in?*
- **Collaborative service agreements**
 - *Treatment & Shared-Risk*
- **Identified Primary Care services**

Residential Services

#1 Challenge

- **Utilize existing housing**
- **Develop new housing alternatives**



Programming:

- **Type**
 - *Dual Diagnosis – Vocational – Educational – Wellness – CBT for Offenders*
- **Conditional Releases**
 - *Synchronized with treatment plans!!!*
 - *30 hr/week programming required*
- **On-Call programming**
- **Transitional planning – *must***

Finances/Wraparound Dollars

- Reinstating entitlements
- Third party (representative) payees
- Billing/Registration
- Needs:
 - *Housing*
 - *Clothing, food, necessities*
 - *Medication*

Highly Charged and Motivating Issues

Strategies Incorporating Legal Leverage

- Mandatory Outpatient Treatment Programs
- Police-based Jail Diversion Programs
- Pre-trial Diversion Programs
- Mental Health Courts
- Drug Courts
- Probation
- Parole

R-FACT Lessons Learned

- **Train staff to provide comprehensive assessment and service delivery**
- **Consider dual-agency in treatment team roles**
 - *CJ/MH*
- **Develop mechanisms that facilitate system integration, communication and trust**
- **Provide intensive community supervision of enrolled clients**
- **Maintain a recovery-focused approach with dual-diagnosis capability**
- **Engage clients in transition planning and identify the resources that will be needed upon program completion**

Key to R-FACT Success:

“Be humane, flexible and adaptive in the presence of the law...”

**Honorable Justice John E. Elliott
City Court Judge, Rochester, NY
FACT Docket, 2011**



R-FACT

CASE VIGNETTE

Abigail Timberlake-McCormick, MS
R-FACT Team Liaison
Department of Psychiatry,
University of Rochester Medical Center

History

- **23 year-old African American man, enrolled 7/2012**
- **The oldest of five children all over 18 years of age and living with their mother.**
- **Reported good grades when in High School**
- **High School Football player and ran track**
- **Dropped out of High School in the 11th grade.**

Prior to R-FACT Intervention

- **Family reports that for the two years prior to R-FACT enrollment conflictual relationships that sometimes resulting in violence.**
- **Completed GED.**
- **Completed 22 credits at local Community College.**
- **A two month inpatient Psychiatric Hospitalization as a result of wielding an axe in the street.**

Enrollment to Three Months:

Engagement

- **Linked to Medical provider.**
- **Sporadic appointment adherence.**
- **Missed a court appearance.**
- **Sanctioned by the Judge with two days of incarceration to reinforce treatment agreements.**
- **Closed from traditional CD treatment and began R-FACT/MICA groups.**

Three Months to Six Months

- **Medical concerns addressed follow up completed.**
- **Agreed to injectable anti-psychotic medication.**
- **Moves from Family home to Mental Health group home.**
- **Positive symptoms abate, negative symptoms lessen but persist.**

Six Months to Nine Months

- **Receives second sanction in the form Choices and Changes. A one week program offered by the treatment courts that focuses on decision making.**
- **Begins modified Moral Reconciliation Therapy Groups in R-FACT.**
- **Cognitive function begins to improve. Better concentration, memory and information processing.**

Nine Months to One Year

- **Approved for SSI**
- **Family conflict presents around finances, Family therapy provided.**
- **Reduction of Cannabis Use, periods of abstinence.**
- **Adherent to group home rules. ADL skill development in organization of self and expectations, personal hygiene and chores.**

Twelve Months to Eighteen Months:

Maintenance

- **Completed R-FACT expectations successfully. Received a ACD.**
- **Left the group home and returned to family home.**
- **Can now articulate his goals and desires, and make realistic plans for attainment.**
- **Begins to explore healthy choices for entertainment and recreation.**

Eighteen Months to Two Years

- **Now able to identify breakthrough symptoms and ask for psychiatric assistance appropriately.**
- **Continues to reside with family without conflict with mother.**
- **Negative symptoms are minimal.**

Two Years to Thirty Months

- **Goals change to pro-social goals, getting an apartment, budgeting and financial management, educational and vocational.**
- **Asks for assistance regarding MICA issues and recognizes that it is a barrier for his wellness plan.**
- **Begins to bring agenda written down to therapy appointments.**
- **Able to problem solve, viewing both sides of a problem.**

Thirty Months to Present: Transition

- **Actively pursuing vocational goal of being a security guard.**
- **On waiting list for desired apartment.**
- **Successfully problem solving in family when dynamics are difficult without violence, or exacerbation of his symptoms.**
- **The discussion of transition to a lower level of care in the next six to twelve months has begun.**

• Q & A

Behavioral Health is Essential To Health



Prevention Works



Treatment is Effective



People Recover