The Role of Probation in Forensic Assertive Community Treatment

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Objective: **Forensic assertive community treatment (FACT) is an adaptation of the assertive community treatment model designed to prevent criminal recidivism through criminal justice collaborations. A national survey was conducted to examine FACT collaborations with probation departments.** ***Methods:*** **Members of the National Association of County Behavioral Health and Developmental Disability Directors were surveyed to identify FACT programs. Programs reporting collaborations with probation departments were contacted to provide details.** ***Results:*** **Fifty-six percent of FACT programs (15 of 27) reported collaborating with probation departments. Probation officers were assigned an average of 29±16 hours weekly, and 80% of programs (12 of 15) reported a favorable impact of collaboration on risk of patient rearrest. Only two programs reported using standard tools to formally assess recidivism risk. The most common barrier to collaboration was differences in philosophy between FACT team clinicians and probation officers.** ***Conclusions:*** **FACT collaborations involving probation departments are common and are viewed by most program leaders as helpful in reducing criminal recidivism. (*Psychiatric Services* 62:418–421, 2011)**

Forensic assertive community treatment (FACT) is an adaptation of the assertive community treatment model that bridges the gap between mental health and criminal justice services through collaboration with criminal justice agencies (1). The first published FACT study found that 69% of identified programs incorporated probation officers as treatment team members (2). Including probation officers as team members is not a part of the assertive community treatment model, yet several observations offer a rationale for this adaptation.

In 2008, a total of 4,270,917 people were receiving probationary supervision in communities across the United States (3). Evidence suggests that the prevalence of severe mental illness is high within this large population of probationers. According to a U.S. Department of Justice study, 16% of all probationers have some form of mental illness (4). Examining the prevalence of psychiatric symptoms among probationers, Crilly and colleagues (5) found significantly higher rates of psychosis and mania compared with the general population. Individuals with severe mental illness do poorly on probation compared with probationers without mental illness, with higher rates of disciplinary problems, corrective actions, and subsequent arrests and incarcerations (6). Despite development of specialized probation to manage probationers with severe mental illness (6), a central challenge for probation officers remains how to gain access to appropriate mental health services for this population.

Assertive community treatment is the recognized gold standard of care for individuals with schizophrenia, bipolar disorder, and other severe mental illnesses who have difficulty engaging with treatment (7). However, assertive community treatment by itself lacks effectiveness in reducing arrest and incarceration rates (1). Because probation is designed to prevent recidivism and it represents an accessible "community arm" of the criminal justice system, FACT adaptations have featured the development of partnerships with probation officers (2). These partnerships are reinforced by the need for probation officers to access effective mental health services for persons with severe mental illnesses who are under their supervision in the community.

Despite the rationale for collaboration, partnering of probation officers and clinicians within FACT programs raises questions about how differences in values, methods, and goals may affect patient outcomes. The only study to date that has examined the involvement of probation officers with an assertive community treatment team found that it was associated with increased incarceration rates (8). The purpose of our study was to

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examine the role of probation officers within established FACT programs, including the perceived effectiveness of collaboration with probation and barriers to collaboration.

Methods

A two-phase survey was conducted between October 2007 and June 2009 at the Department of Psychiatry, University of Rochester Medical Center. This study was reviewed by the University of Rochester Research Subject Review Board. Phase 1 began with a Web-based survey of all 676 members of the National Association of County Behavioral Health and Developmental Disability Directors (NACBHDD; www.nacbhdd.org). The survey asked members for contact information about assertive community treatment teams in their respective regions that met three FACT screening criteria: they serve only patients with histories of arrest and incarceration, they receive the majority of patient referrals from one or more criminal justice agencies, and they work in close collaboration with one or more criminal justice agencies.

The person identified by members of NACBHDD as being in charge of each program was subsequently contacted by telephone and interviewed to assess fidelity of the program's assertive community treatment component. Fidelity was assessed with six criteria from the Dartmouth Assertive Community Treatment Scale (DACTS) (9): in vivo service delivery, 1:10 staff-to-client ratio, 1:100 psychiatrist-to-client ratio, 24-hour availability for crises, time-unlimited services, and substance abuse counselor on staff. Programs were required to meet at least four of the six DACTS criteria along with the three screening criteria to qualify for study inclusion as a FACT program.

In phase 2, FACT programs were selected for further study if information gathered in phase 1 indicated that a designated probation officer attends at least 20% of all treatment team meetings. Because many FACT treatment teams meet daily, this criterion generally identified programs with probation officers who attend at least one treatment team meeting each week. FACT programs meeting the probation involvement criterion were subsequently administered a telephone survey to gather information about program structure and operation, including the role of probation officers within their treatment teams. Telephone interviews required approximately 60 minutes to complete and were conducted Monday through Friday between 9 a.m. and 9 p.m. Eastern Time. [The telephone survey instrument is provided in appendix A, available as an online supplement to this report at ps.psychiatryonline.org.]

Identified representatives from each selected program were asked to review written summaries of information gathered about their respective programs to verify accuracy of the collected data. Verified survey data were numerically coded and entered into a spreadsheet for analysis. For survey items requiring qualitative analysis, themes were identified by two research team members through separate reviews of recorded responses, and consensus was established through discussion.

Results

Ninety percent of NACBHDD members (607 of 676 members) responded to the Web-based survey. They identified 61 programs of which 27 met FACT study criteria. Fifty-six percent of programs meeting FACT criteria (15 of 27 programs) reported incorporating close working relationships with probation officers. Thirteen of the 15 (87%) FACT programs began operation on or after 1998 (appendix B at ps.psychiatryonline.org). The programs received patient referrals from multiple sources, most commonly local jails (appendix C at ps.psychiatryonline.org). Of patients across all programs, 70%±14% were men, 55%±28% had diagnoses of schizophrenia or schizoaffective disorder, 25%±20% had bipolar disorder, and 77%±33% had a co-occurring substance use disorder. In addition to having axis I diagnoses, 20%±21% of patients had an axis II diagnosis of antisocial personality disorder and 66%±38% had antisocial personality traits. An average of 61%±39% of patients were homeless upon admission to the FACT program, and 40% of programs (six of 15) incorporated residential services to assist homeless clients.

Twelve programs (80%) required a history of misdemeanor arrests or convictions for admission to FACT, and 11 programs (73%) admitted patients with histories of violent crime. Programs reported that 93%±15% of patients had previously been in jail or prison, 47%±34% had previous felony convictions, and 23%±22% had histories of violent crimes, such as murder, rape, and assault. Programs also reported that an average of 75%±27% of patients were on probation and that 16%±29% were on parole when admitted to their respective FACT programs. Only two programs reported using standardized risk assessment tools such as the Level of Service Inventory (10) to assess the risk of future criminal recidivism.

Probation officers had worked in their respective FACT programs an average of 4.5±3.8 years at survey time. They attended an average of 57%±42% of treatment team meetings across all programs, and 87% of programs (13 of 15) described the officers as actual treatment team members. Most programs (73%, N=11) noted that their collaborating probation officers had received some form of mental health training, usually brief educational sessions conducted by state or local mental health organizations. [Appendix D at ps.psychiatryonline.org provides details about the training, time commitments, and funding of FACT program probation officers.]

Probation officers worked in the FACT programs an average of 29±16 hours per week. Nine FACT programs (60%) had a full-time probation officer. According to program representatives, the four primary responsibilities of probation officers were serving as a court liaison; obtaining collateral information, including criminal records; performing drug testing; and performing community outreach. Two-thirds of probation officers performed community outreach in conjunction with team clinicians. Probation officers were generally assigned only patients on the team who were serving probation sentences. Four programs (27%) noted that their pro-

bation officers also provided input to team clinicians about other patients, usually patients who had previously been on probation.

Program representatives reported high levels of agreement between clinicians and probation officers about when to use legal sanctions, such as arrest or incarceration. Ten (67%) reported that they usually agreed, three (20%) reported that they always agreed, and two (13%) programs reported that they sometimes agreed. Program representatives also reported a positive (seven of 15 programs, 47%), very positive (six programs, 40%), or neutral (one program, 7%) impact of probation involvement on their patients' risk of rearrest. One program in its first year of operation reported that having a probation officer on the team increased patients' risk of arrest and hospitalization. Of the nine programs with a full-time probation officer, perceptions regarding levels of agreement, helpfulness, and risks of arrest and hospitalization followed a distribution similar to that in the programs with part-time probation officers.

The most commonly reported barrier to effective collaboration reported in 73% of programs (11 of 15) was a difference in the philosophy and approach of FACT program clinicians and probation officers. Program representatives generally described clinicians as being more health oriented and diplomatic with patients, whereas they described probation officers as more public safety oriented and directive with patients. One team struggled to keep roles clear yet integrated; the mental health staff took on a monitoring role, and the probation officer functioned more as a case manager. Other barriers included limited funding and limited access to probation officers whose primary offices were located off site rather than being colocated with FACT program clinicians. [Additional patient data and study details are provided in appendices E and F at ps.psychiatryonline.org.]

Discussion

Given the large number of persons on probation in the community and the high prevalence of mental illness among probationers, interactions between probation officers and community mental health staff are common (6). Specialty probation has recently emerged to better manage probationers with severe mental illness, but its effectiveness at preventing recidivism is likely to depend on the effectiveness of treatment and support services at addressing recidivism risk factors (11). It is not surprising that evidence is mixed about whether specialty probation can prevent recidivism (6) given the shortcomings of today's mental health services. In the first state-by-state report on the nation's mental health system, the United States recently received a D grade because of multiple deficiencies (12).

Because FACT teams target patients who are involved in the criminal justice system, they are an ideal point of interface for specialty probation. This partnership appears to be mutually beneficial. FACT clinicians can gain access to legal leverage to promote treatment adherence (13), and probation officers can access therapeutic alternatives to the use of punitive sanctions in managing probation violations. The finding that FACT program representatives view probation involvement as helpful is consistent with the conceptual framework that combining legal leverage with accessible care that targets recidivism risk factors will reduce recidivism (11). However, the finding that only two of 15 programs used standardized risk assessment tools is noteworthy given the high prevalence of recidivism risk factors among FACT patients (14). These findings suggest that FACT programs can benefit by further incorporating interventions that will both identify and address risk factors for criminal recidivism.

The most commonly reported barrier to collaboration was that probation officers tend to view their mission as promoting public safety, whereas clinicians generally view their mission as promoting patient health. This philosophical gap is likely to widen given national trends for probation to become more law enforcement oriented rather than social work oriented (15). These observations suggest the need for cross-training within FACT programs that includes discussion of respective values, methods, and goals rather than just sharing basic information about mental health and criminal justice systems.

This research was the first to examine FACT programs that feature probation officers as treatment team members, a subset of programs originally identified in the national FACT study (2). However, several important limitations are noteworthy. Because NACBHDD covers only 32 states, more FACT programs are probably operating across the United States than those identified in this study. Also, only six items from the DACTS were selected for screening purposes. Although this method screened out basic case management programs, using selected items may have allowed for inclusion of some FACT programs with low DACTS fidelity. In addition, it is important to note that this study assessed only the perceptions of FACT program leaders. The perceptions of probation officers themselves were not examined. Comparing probation officers' and clinicians' perceptions would inform our understanding of the advantages and challenges of collaboration and could provide clues about how best to develop collaborative partnerships within FACT programs.

Conclusions

FACT programs often feature close working partnerships with probation officers, and this collaboration is generally viewed by FACT program leaders as helpful in reducing criminal recidivism. Organizations that are planning to start a FACT program should consider the possibility of establishing collaborations with their local probation departments. Further research is needed to understand factors contributing to the effectiveness of such collaborations in preventing recidivism and promoting recovery among service recipients who are involved in the criminal justice system.

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