Evaluation of the Forensic Assertive Community Treatment Program

Prepared by Genevieve Rowe and Laurie Sylla

King County

Department of Community and Human Services
Mental Health, Chemical Abuse and Dependency Services Division

March 2012

EXECUTIVE SUMMARY

Introduction

The King County Forensic Assertive Community Treatment program (FACT) is an enhancement of an evidence-based practice to serve adults with serious mental illness, who also have a history of homelessness or who are at high risk of becoming homeless, and have extensive criminal histories. FACT provides housing and intensive community-based recovery oriented services with the goal of reducing use of the criminal justice system, reducing use of inpatient psychiatric services, improving housing stability and promoting community tenure. During the period documented in this report, 2008 through 2011, FACT was funded by the Washington State Department of Commerce's Homeless Grant Assistance Program (HGAP) and the Veterans and Human Services Levy, administered by King County Mental Health, Chemical Abuse and Dependency Services Division (MHCADSD), and implemented by Sound Mental Health (SMH). A total of 56 individuals have been served by FACT; the first 51 individuals to be enrolled are the subjects of this evaluation.

Evaluation Design

The FACT program targeted a population with very high use of the King County Correctional Facility – 252 individuals who combined for a total of 3491 bookings and 50,708 days incarcerated during a 33 month period. Since the number of potential enrollees was much higher than the capacity of FACT, half of the target population was randomly allocated to a comparison group who would receive services as usual and half became the pool of eligibles referred to FACT. This process resulted in a very rigorous evaluation design. When comparing FACT outcomes to the comparison group, differences in FACT are more likely attributable to the program rather than resulting from changes in the larger treatment and criminal justice systems.

Findings

FACT achieved its primary goal of reducing criminal justice system utilization. FACT participants achieved statistically significant reductions in combined jail and prison bookings and days in the first year. These reductions are sustained through the second and third years. Of note is that FACT participants averaged higher criminal justice system utilization in the year prior to enrollment than non-enrollees in the eligible pool. The agency providing FACT services, SMH, enrolled those with the highest need for services and achieved these reductions.

- FACT participants experienced a 45 percent reduction in jail and prison bookings in the first year. Average bookings per person dropped from 5.2 in the year prior to FACT enrollment to 2.9 during the first year of FACT. This is a statistically significant decline.

- FACT participants also experienced a statistically significant decline in days incarcerated. Total days in either jail or prison dropped from 5952 in the year prior to FACT enrollment to 3664 during the first year of FACT; a 38 percent reduction. Average days incarcerated per person dropped from 117 in the year prior to FACT to 72 in the first year post-FACT – a reduction of more than six weeks per person.

FACT participants also reduced their utilization of inpatient psychiatric services, although the decrease was not statistically significant.

- During the first year of FACT, psychiatric hospital admissions declined 25 percent and psychiatric hospital days declined 44 percent – large, but non-statistically significant, declines. Use of psychiatric hospital services was low; fewer than half of the participants had any use during the evaluation period. Among those who were hospitalized the range of change varied widely including some increases in admissions and days. The small number of users and the wide variation in utilization makes changes difficult to detect statistically.

In the first year of program participation, FACT enrollees significantly decreased their amount of time institutionalized as measured by combined days in jail, prison or inpatient psychiatric hospital. Combining these outcomes will show whether declines in criminal justice system use is offset by increases in inpatient psychiatric hospital use.

- FACT participants reduced total days institutionalized from 7200 in the year prior to enrollment to 4442 in the first year post – a statistically significant 38 percent decrease. Thirteen of the 51 participants measured had reduced their days institutionalized to zero in the first year.

- On average participants were institutionalized for 141 days in the pre-FACT period – approximately 20 weeks per person. In the first year post-FACT, average days institutionalized dropped to 87 – a decline of more than seven weeks per person.

- Subsequent years show no statistical change but there are slight fluctuations. After the initial declines, FACT participants remain institutionalized on average for two to three months each year.

The decreases in days institutionalized translates to significant increases in days in the community for FACT participants. Additionally, this increase in community exposure did not increase the likelihood of an incarceration. The booking rate per month of community exposure declined for FACT participants – a very positive result.

- Bookings per month of community exposure declined from .7 to .3 per person per month in the first year – a statistically significant decline.

When evaluated next to the random comparison group receiving services as usual, FACT participants have better, more consistent results.

- The comparison group also reduced jail and prison bookings and days but the reduction in days was less than for FACT and was not statistically significant.

- Like FACT, there were no statistically significant reductions in use of inpatient psychiatric hospital services by the comparison group. Use of this service was generally low by both FACT and the comparison group making statistical changes harder to detect.

- Reductions in days institutionalized for the comparison group were not as great as those experienced by FACT participants. Conversely, increases in days in the community were not as great for the comparison group as FACT.

Key Qualitative Findings

- Despite differing system cultures and goals, FACT successfully bridges the judicial, detention, and treatment systems. Through provision of 24/7 crisis intervention and support services in client homes, in jail, at the agency, and on the street, FACT increases continuity of care, expands housing options, and reduces client institutionalization.
- Many FACT clients need extensive assistance learning how to appropriately use housing (e.g. toileting hygiene, food/garbage management, safety, neighbor relations, etc.) and often need to be re-housed multiple times before they are successfully stabilized.
- Stable housing contributes to reduced incarceration, improved quality of life, and the ability of clients to begin to focus on recovery. Overall, clients greatly valued housing.
- Clients' ability to engage with staff, take their medications, and avoid drug use predict their ability to be successful.
- Building upon the existing program foundation with better fidelity to the ACT model will likely continue to improve outcomes and quality of life for participants and open up the program to others who need this level of service.

The qualitative evaluation revealed that collaboration with the criminal justice system, especially the courts, is critical to achieving these positive outcomes. While significant changes

in quantitative outcomes were not usually found after the first year, the qualitative evaluation results describe other positive changes that were occurring once a participant was housed in the community. Participants were becoming more integrated in the community, learning to care for themselves, to shop and cook, make and keep appointments, feeling safer, and beginning to set personal goals and plan for the future.

The evaluation shows that housing this population is challenging and that housing stability may take time to achieve. At the end of the evaluation period, 23 FACT participants had been stable in housing for a year or more. Only sixteen FACT participants had been continuously housed since their first placements. Housing challenges included initial resistance from participants around housing, finding appropriate housing options for this population, and teaching participants skills necessary to live independently.

Overcoming these challenges was worthwhile as housing was perceived as making an extraordinary difference for FACT participants by all who contributed to the qualitative evaluation. Stakeholders spoke to noticing reduced incarcerations, the ability to address other issues, increased motivation to stay out of jail, and improved treatment compliance when participants were housed. Staff spoke to stability, increased medication compliance, ease of finding clients and helping them to meet their obligations and appointments, reductions in jail time, and improved physical and emotional health when clients were housed. Participants spoke to peace of mind, privacy, freedom, safety, and self-worth. All participants interviewed unanimously endorsed having their own place as very important to them.

Recommendations

The FACT program has made substantial progress toward its primary objectives of stabilizing participants in the community, promoting recovery, and reducing use of the criminal justice system. The intent of these recommendations is to build upon this existing foundation in ways that improve outcomes and quality of life for participants and open up the program to others who need this level of service.

- Improve FACT's fidelity to the evidence-based ACT model including:
  - Expand chemical dependency treatment via the evidence-based IDDT model
  - Implement person centered individual treatment plans
  - Expand vocational services and rehabilitative services
  - Implement the exit and graduation strategy

- Continue collaboration between FACT and the criminal justice system to further reduce use of the criminal justice system.

- Design step-down support services for FACT participants who may not need FACT level services, but are not yet ready for graduation. As participants become more stable in the community, a level of support that is less than FACT but greater than standard outpatient mental health services may be more appropriate. The goal is twofold - promote recovery and independence in participants and make FACT available to more who need this intensive level of treatment.

- Review FACT staffing to determine if the current configuration meets the needs of a forensic ACT program. The additional criminal justice system tasks and safety concerns related to this population may require changes to the standard ACT staffing model.

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Introduction

Background

King County and many other jurisdictions across the country struggle with high numbers of severely mentally ill individuals who are frequently incarcerated. This population tends to have high service needs but low service engagement. Most are homeless or at very high risk of homelessness. A proven strategy for helping this population and reducing their use of high end services has not been definitively identified.

In 2006, the King County Mental Health, Chemical Abuse and Dependency Services Division (MHCADSD) reviewed relevant research looking for effective community-based programs for high utilizers of the criminal justice system. There were two primary objectives:

1. The program should bring stability to participants and promote their recovery.
2. The program should reduce their use of the criminal justice system.

Criminal justice program managers at MHCADSD also reviewed local data related to this population. The data strongly indicated that the vast majority would be homeless at program entry. The data also suggested that if not funded directly by a program, housing this population would be very difficult and this would negatively impact program outcomes. MHCADSD managers believed it was critical to include housing in the model.

Based on the information available, MHCADSD designed a program to serve this population – the King County Forensic Assertive Community Treatment program (FACT).

Program Description

FACT modified the evidenced-based practice, Assertive Community Treatment (ACT) program for a forensic (i.e. high criminal justice system involved) population. ACT had previously been shown to reduce hospitalizations and emergency room visits for severely mentally ill adults. Prior adaptations of ACT for forensic populations had shown promise in reducing criminal justice system involvement, although the results had not been consistent. The goal of the King County FACT program was to achieve traditional ACT outcomes as well as reduce use of criminal justice services.

King County FACT included all elements of a high fidelity ACT model program. All outpatient services were to be provided by the team, not brokered. In addition, the team was to be mobile,

traveling to meet clients and provide services in a community setting, rather than having the client come to an office. Services were to be provided to clients seven days a week, 24 hours a day, every day of the year. Services were to be provided using the transdisciplinary team model approach and were to include:

- Medication management
- Case management
- Chemical dependency treatment
- Mental health treatment
- 24-hour crisis services
- Vocational training

Fidelity to the ACT model would be assessed by the Washington Institute for Mental Health Research and Training (WIMHRT) using the Tool for Measurement of Assertive Community Treatment, TMACT.

In addition to the criteria for a high fidelity ACT model program, FACT included the following:

- Participants were identified through the criminal justice system.
- Participants had extensive criminal justice histories.
- The team included members with criminal justice system expertise.
- The team included a Forensic Peer Support Specialist.
- Supported housing was available for all participants.

In order to ensure that participants had access to housing, the Seattle and King County Housing Authorities partnered with MHCADSD to provide dedicated housing vouchers to participants. To help ensure that housing provided by FACT was indeed 'permanent', these vouchers could stay with the individual after graduation from FACT.

Funding FACT

MHCADSD applied for and received State 2163 funds (Homeless Grant Assistance Program or HGAP) for the development and implementation of FACT. This funding became available in July 2007. Additional funding for FACT was provided by the King County Veterans and Human Services Levy. Through a competitive bid process, Sound Mental Health (SMH) became the agency responsible for implementing the FACT program in King County. SMH was awarded the contract and began providing FACT services in January 2008.

The original HGAP funding for the FACT program included funds for a part-time evaluator. This funding was available through December 2010. Evaluation funding was continued through December 2011 by means of a grant from the Corporation for Supportive Housing. This second

funding allowed for the inclusion of a detailed qualitative evaluation component. This combined funding allowed for a comprehensive and robust evaluation of FACT.

Report Overview

This report describes the FACT evaluation from design to results. A description of the program model and its implementation is provided. The section describing the quantitative evaluation includes the process of identifying the target population and allocating individuals to case and comparison groups. Quantitative outcomes for FACT participants are presented followed by outcomes for the comparison groups. Qualitative evaluation findings are also presented in detail. Conclusions and recommendations are presented last.

Designing and Implementing FACT in King County

FACT Program Model

The King County FACT program was designed to be a full fidelity ACT model program with enhancements to serve a forensic population. The ACT model, which was briefly described earlier, is described in detail by the Assertive Community Treatment Association on their website - www.actassociation.org. The King County FACT program design included all ACT principles identified by the National Alliance on Mental Illness (NAMI):

Principles of Assertive Community Treatment

- Services are targeted to a specific group of individuals with severe mental illness
- Team members directly provide individualized, flexible, and comprehensive treatment, support and rehabilitation services, including:
  - Mobile crisis interventions
  - Illness management and recovery skills
  - Individual supportive therapy
  - Substance abuse treatment
  - Skills teaching and assistance with daily living activities
  - Assistance with natural support networks
  - Supported housing
  - Help accessing benefits, transportation, medical care, etc.
  - Medication prescribing, administration and monitoring
  - Peer supports
- Team members share responsibility for consumers served by the team
- Small staff to consumer ratio (approximately 1 to 10)
- Majority of contacts are in community settings
- No arbitrary time limits on receiving services
- Services are available on a 24/7 basis

Results of ACT fidelity reviews are presented later and show that these principles have been implemented moderately well in the King County FACT program.

The forensic enhancements to ACT that were required to make the King County program FACT were:

- Participants were identified through the criminal justice system.
- Participants had extensive criminal justice histories.
- The team included members with criminal justice system expertise.
- The team included a Forensic Peer Support Specialist.

These forensic features were selected based on local experience with this population and what the literature suggested were critical ACT modifications to address criminal justice outcomes. Since the time the King County program was designed and implemented, a compendium of FACT programs was published (Reentry Planning for Offenders with Mental Disorders: Policy and Practice; Dlugacz, Henry A., M.S.W, J.D., editor; Chapter 7: Forensic Assertive Community Treatment: Origins, Current Practice, and Future Directions; Lamberti, J. Steven, M.D., and Weisman, Robert L., D.O.; Civic Research Institute, Kingston, NJ, 2010). This document describes how FACT differs from ACT and the components usually seen in FACT programs.

The main features that distinguish FACT from ACT are:

- FACT serves clients with substantial criminal histories
- FACT teams work closely with the criminal justice system

Without a standard model, FACT programs nationwide show some variation in design and in how they operate. Half of the programs had residential components. Seventy-one percent included probation officers as team members. Other points of collaboration with the criminal justice system included correctional facilities, parole, courts, and law enforcement. Seventy-five percent had a credentialed addictions counselor on the team.

As part of their collaboration with the criminal justice system, FACT teams incorporate the use of legal leverage where an agent of the criminal justice system (judge or probation officer) uses their authority to compel individuals to follow through with treatment. This practice goes beyond the assertive engagement seen in standard ACT model programs.

Comparing King County FACT with other FACT programs described in this publication shows a great deal of similarity. King County FACT definitely serves clients with substantial criminal histories and works closely with the criminal justice system. Points of collaboration with the criminal justice system are the same, but there isn't a probation officer on the team. Eligibility for King County FACT was determined by prior criminal history. At the point someone was enrolled they may not have been coming directly out of a correctional facility or even under court supervision – although many were. Additionally, clients could have been aligned with a variety of courts – Superior Court, any of the municipal courts throughout the county, District Mental Health Court, and any of the municipal mental health courts in King County. When appropriate, the team collaborated with court and supervision staff but did not have them join the team. Working with multiple jurisdictions is one of the areas where the King County FACT program differs from most other FACT programs in the country. The King County FACT team does include a credentialed addictions counselor.

Legal leverage has been used in King County FACT; however this has sometimes been a struggle. The team has not always been comfortable when applying legal leverage, as it may be seen as conflicting with the harm reduction approach traditionally used by ACT. The team and key-informants from the criminal justice system describe this divergence in the qualitative evaluation findings.

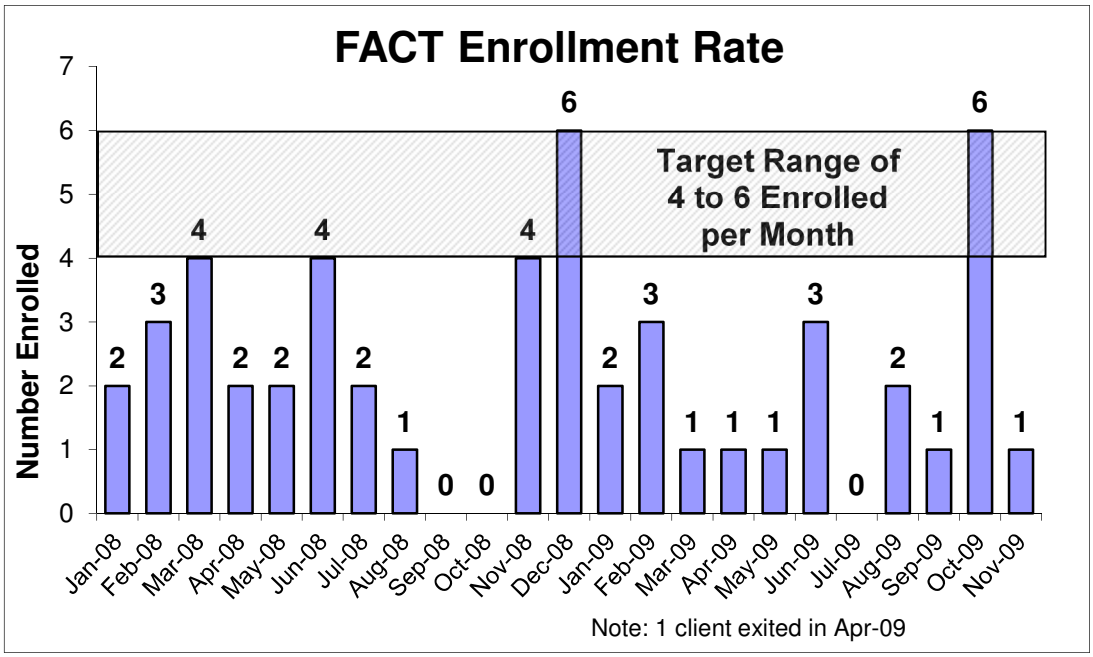
Implementation

Consistent with the ACT model, the FACT team provided outreach to all potential participants through an assertive engagement process. In King County, there were two levels of program participation:

1) Engagement, and
2) Full enrollment.

At the engagement level, the FACT team sought out potential participants (often while still in jail) and used motivational interviewing techniques to engage and motivate individuals into FACT services. Those who agreed to have the FACT team as their mental health treatment provider were considered fully enrolled and moved to the second level. Once FACT participants were fully enrolled, they were to be housed quickly and provided with ongoing assertive engagement into the comprehensive services provided by the team.

FACT began engaging clients in January 2008 and enrolled the first participants by month's end. The team was given a list of individuals who met forensic criteria and passed a preliminary diagnostic eligibility screen. (The process for identifying individuals on this list is described in a later section.) The team located and engaged individuals from this list. The enrollment rate was slower than expected. Instead of the ACT standard of four to six per month, average enrollment was 2.3 per month. The program reached its capacity of 50 participants in November 2009.



Many of the FACT participants were enrolled while in jail or psychiatric hospital. This created an opportunity for many enrollees to be housed directly upon release without returning to homelessness. This also created a few situations where clients were enrolled for a period of time while institutionalized.

Program Retention

The first FACT participants were enrolled in January 2008 and the program reached capacity of 50 in November 2009. One early enrollee exited the program in April 2009 and was replaced so that by November 2009 a total of 51 individuals had been served. Forty four (86.3 %) of these participants were still enrolled when the evaluation period ended on September 30, 2011.

Seven participants exited FACT during the study period. One of the seven "graduated" to a program with a less intensive level of service. This first graduate had been in the FACT program for just over 3 years. The reasons for all seven FACT exits are shown below. Note that participants who exited the program are included in the evaluation.

Number of Participants	Exit Reason	Program Duration
1	Long-term jail or prison sentence	< 1 year
3	Long-term jail or prison sentence	Between 1 and 2 years
1	Long-term jail or prison sentence	Between 2 and 3 years
1	Lost to contact	> 3 years
1	Graduated	> 3 years

The FACT program's record of retaining participants has been outstanding with a three year retention rate of 90 percent.

- The one year retention rate is 98 percent; 50 of 51 enrollees remained in the program for at least one year. The one client who exited did so after completing 356 days in the program.
- The two year retention rate is 92.2 percent; 47 of 51 enrollees remained in the program for at least two years.
- The three year retention rate is 90.2 percent; 46 of 51 enrollees remained in the program for at least three years.

As of September 30, 2011 there were 48 active FACT participants. Four participants had been in the program for less than one year and are not included in this evaluation. Of the remaining 44 participants, five had been in FACT between one and two years, 23 had been in the program between two and three years, and 16 had been in FACT for three years or more.

Program Duration	Number of Current Enrollees in Evaluation	Number of Current Enrollees not in Evaluation
< 1 year		4
Between 1 and 2 years	5	
Between 2 and 3 years	23	
> 3 years	16	

FACT Staffing

FACT staffing was designed to be consistent with a high fidelity 50-consumer ACT model program – at 7.0 FTE direct clinical staff per 50 consumers. The program started in 2008 with the following contract requirements for staffing the team:

- Team Lead Mental Health Professional (1.0 FTE)
- Registered Nurse (1.0 FTE)
- Mental Health Professional (1.0 FTE)
- Bachelor level Mental Health Case Manager (1.0 FTE)
- Bachelor or Master level Chemical Dependency Specialist (1.0 FTE)
- Vocational Specialist (1.0 FTE)
- Forensic Peer Specialist (1.0 FTE)
- Psychiatric Prescriber (Psychiatrist or Advanced Registered Nurse Practitioner) (0.4 FTE)
- Program Assistant (0.75 FTE)

Experience working with mentally ill offenders and with the King County criminal justice system was required for the Team Lead. The initial team had very limited experience with ACT model programs, so within the first few weeks of implementation the team attended an ACT training conducted by the Washington Institute for Mental Health Research and Training (WIMHRT).

Contract requirements for the FACT team staff configuration were modified over the course of the program to respond to what was needed. In the second year an additional .5 FTE Registered Nurse was added to the team and the Program Assistant was increased to 1.0 FTE. Another addition to the team late in year three was a .5 FTE Boundary Spanner. The Boundary Spanner is located in the Seattle Municipal Court House and provides coordination between the team and the courts.

The FACT team was not completely staffed for the first ten months of program operations. The program began in January 2008 without the Chemical Dependency (CD) Specialist, the Program Assistant, and the Psychiatric Prescriber. The Forensic Peer Specialist position was partially filled with a .5 FTE. These vacancies continued until May 2008 when the Program Assistant joined the team and a .1 FTE Psychiatric Prescriber partially filled the intended .4 FTE prescriber position. July 2008 brought a second .5 FTE Forensic Peer Specialist that filled that position and a CD Specialist was hired. The Psychiatric Prescriber position was filled in November with two .2 FTE staff. Turnover within the team in addition to the staff who were not yet hired in time for the first ACT training necessitated a second ACT training early in the second year.

The team has experienced significant turnover in critical positions. The team lead was replaced three times in a two year period, resulting in four individuals filling this important role. The CD Specialist position has been vacant for eight months and has been occupied by four different individuals. There have been four Mental Health Case Managers and three Vocational Specialists. None of the new hires have had ACT experience.

ACT Fidelity

The foundation of the King County FACT program is a full fidelity ACT program. Understanding that a faithful replication of an evidence based model is critical to achieving its intended outcomes, MHCADSD contracted for ongoing fidelity reviews of FACT. Three fidelity reviews have taken place. All were conducted by WIMHRT using the TMACT fidelity scale.

The initial fidelity review took place in January 2009, approximately one year after the FACT team began enrolling and serving participants. The team scored 4.20 out of a possible 5.0. This score suggested that FACT was implementing ACT with a moderate level of quality and adherence. This baseline score of 4.2 for a new ACT team was considered very positive.

The initial review found that the team was well staffed, strong and cohesive. Strengths included fully embracing Integrated Dual Disorder Treatment (IDDT) principles, use of motivational interviewing, and a harm reduction approach. The team recognized the importance of treatment plans and Peer Specialists were beginning to work with clients on Wellness and Recovery Action Plans (WRAPs).

The fidelity review team made several suggestions to help FACT become closer to ACT. Suggestions included:

- Chemical Dependency and Vocational Specialists spend more time providing services related to their specialty areas.
- Have more contact with clients in the community.
- Focus more on individual treatment rather than group treatment.

- Work with hospitals and other institutions to ensure continuity of care.

The review team noted that the Vocational Specialist spent most of their time in case management and other general services. They also noted that substance use was a big concern for many FACT clients and that it would be challenging for the team to comprehensively address all substance use issues. While the FACT team recognized the importance of treatment plans to inform client schedules, the review team felt staff schedules were driven more by emerging needs and tended to shift throughout the day. ACT recommends that individual treatment plan goals drive each client's weekly schedule, which ultimately drives the team's daily schedule. The review team noted that as initial legal and case management activities decline for clients as they become more stable in the community, FACT should shift to more therapeutic and varied interactions. FACT should ensure that service contacts with each client beyond case management and medication delivery were delivered by an appropriate variety of team members.

The second fidelity review took place just over a year later in February 2010. The score received in this review was lower, 3.63 out of 5.0. In the second review the FACT team showed many strengths including the use of Moral Reconation Therapy. The area with the lowest score in this review involved person-centered planning practices.

The reviewers recommended the FACT team conduct treatment planning meetings to develop/update a plan for each client. The client should be involved and the plan should be geared toward the client's goals rather than symptoms. It was suggested that Peer Specialists be involved as they would bring the voice of recovery to the process. The client's monthly schedule would be determined based on this plan.

The review team also recommended that the person-centered treatment planning process be used to identify those clients in need of more direct rehabilitation services (e.g. services to develop ADL skills, social skills, safety and planning skills).

The reviewers also suggested that substance use treatment (IDDT) be expanded to more clients and that more vocational services be provided, specifically supported employment.

The review team recommended that a graduation process be developed. This process should be a gradual step-down to less intensive services. Clients would be monitored and could return to FACT if needed.

A third fidelity review was conducted in November 2011. The fidelity score remained unchanged at 3.62. Using individual treatment plans to drive schedules and protecting specialist's time to provide specialty services are still items of concern. Lack of improvement in fidelity, and the continued inability of the program to score in the high fidelity range are of concern.

Summary

The King County FACT program was designed as a full fidelity ACT model and has been implemented to a moderate degree of fidelity. The forensic enhancements are very consistent with those of the majority of other FACT programs nationwide. While a probation officer is not on the team, FACT works very closely with all court related staff.

Although the program took longer than expected to reach capacity, FACT has been very successful at retaining those enrolled. FACT has begun to graduate participants to less intensive services.

The next section examines how well the FACT program has done in reaching its intended quantitative outcomes.

Quantitative Evaluation

The Forensic Assertive Community Treatment (FACT) program in King County, WA was designed to bring Assertive Community Treatment (ACT), an evidence-based, team treatment approach for providing comprehensive, community-based psychiatric treatment, rehabilitation, and support, to a population of adults with severe and persistent mental illness and an extensive forensic history. A primary focus of the quantitative component of the FACT evaluation is to demonstrate the effectiveness of the FACT program in reducing utilization of the criminal justice system and reducing use of high intensity psychiatric services in this population. If these outcomes are achieved, program participants will increase their time spent in the community with the potential for more normative activities. This section presents the quantitative evaluation results related to these outcomes – jail utilization, psychiatric hospital utilization, and days in the community.

Quantitative Evaluation Design

To set the context for this analysis, the quantitative evaluation design is presented. This includes the process of selecting the target population and assigning individuals to study and comparison groups; a review of the demographic characteristics of the target population, as well as study and comparison groups; and the process of refining the comparison group.

Defining and Selecting the FACT Target Population

With the intent of serving those most in need, the FACT program sought to identify individuals with frequent incarcerations and evidence of severe mental illness. The population targeted for FACT services was initially identified through King County Department of Adult and Juvenile Detention (DAJD) records. DAJD analyzed its booking history and provided the King County Mental Health, Chemical Abuse and Dependency Services Division (MHCADSD) with a report of those individuals who met the following criteria:

- Must be a frequent user of the King County jail during the previous 33 months. Frequent user is defined as
    - Rapid Cycling - at least five misdemeanor (non-DUI) bookings in any rolling 12 month period and at least 12 releases overall

      OR

    - Long Stay/Rapid Cycling - at least five misdemeanor (non-DUI) bookings in any 12 month period and at least one misdemeanor booking with a length of stay over 30 days
        - AND
    - At least one misdemeanor (non-DUI) booking in the last 12 months.
- Evidence of serious and persistent mental illness, as defined by being detained on the 7th floor of King County jail or a presence of a psychiatric flag for at least one booking.
- Subjects were excluded if their criminal history includes arson, methamphetamine manufacturing, or if they are a Level III sex offender or an unregistered sex offender.

The initial population identified by DAJD then underwent a diagnostic review. Subjects were excluded if they did not meet diagnostic criteria for the ACT model. Diagnostic criteria appropriate for ACT are individuals with severe and persistent mental illness; specifically Axis I disorders such as bipolar disorder, schizophrenia, schizoaffective disorder, and major depressive disorder. Program staff reviewed existing MHCADSD records to rule out subjects with a primary diagnosis of substance abuse, primary diagnosis of an Axis II developmental or personality disorder, or primary diagnosis of major depression without psychosis. If diagnosis information was insufficient to rule out a subject they were retained in the pool. Final confirmation of diagnostic criteria was done at engagement by the FACT team prior to enrollment.

Using the above criteria, an initial target population of 141 individuals was identified in December 2007, prior to the implementation of FACT. This process was repeated three times; in March 2008, November 2008, and in April 2009, to identify additional subjects who had recently met criteria for inclusion in the target population. A total of 252 individuals were identified for the FACT target population.

It is interesting to note that applying the first criteria – frequent user of King County jail - alone identified a total of 489 individuals. Applying the diagnostic criteria ruled out almost half (48%) of those selected with forensic criteria only. One clear implication of this is that almost half of the highest users of King County's jails do not meet criteria for an ACT model program and need alternative interventions.

Subjects could also be referred from King County Municipal Jails. These subjects were required to meet the same criteria as applied to the DAJD subjects. Five subjects entered the FACT program as a result of a municipal jail referral.

Selecting Case and Comparison Groups

With a program capacity of 50 individuals, it quickly became apparent that the population of those eligible for FACT far exceeded those who could be served. This created an opportunity for a more rigorous evaluation design.

The FACT target population was randomly divided into two groups. One group was randomly selected to be a comparison group. This random comparison group received usual services available to them in the jail and in the community, including any special programs for which they were eligible, with the exception of FACT services. The identity of individuals in this random comparison group (RCG) was completely invisible to the system and did not in any way affect how they were served. Only evaluation staff had this information.

The second group became the pool of potential FACT enrollees. The FACT Team engaged individuals on this list to offer them FACT services. Not all outreach efforts resulted in an individual's enrollment in FACT. FACT is a voluntary program and while engagement is 'assertive', individuals have the right to refuse services. Individuals also declined if they were participating in other programs or were receiving outpatient benefits and did not wish to change. Engagement was also sometimes unsuccessful due to the diagnoses and degree of mental disorganization of some in this population. This pool is also the source of a second comparison group. Individuals from this pool who did not enroll in FACT were also evaluated. This group is referred to as the Non-Enrolled Group (NEG).

Target Population Criminal Justice Utilization

The utilization of the King County Correctional Facility and the Maleng Regional Justice Center by the target population is extensive. During the period of time when FACT eligibility was being determined, the target population combined for a total of 3491 bookings and 50,708 days in jail. Seventy-four percent of the bookings were for misdemeanor offenses and 26 percent of the bookings included felony charges.

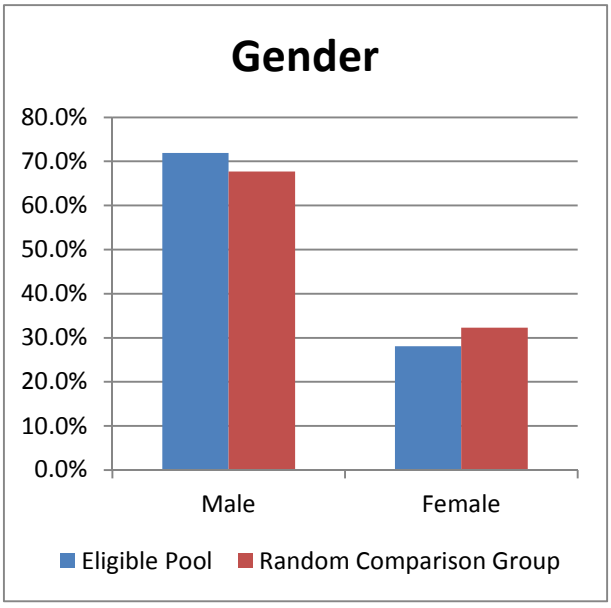
There were no differences in criminal justice utilization between the case and comparison groups. The 124 individuals in the random comparison pool combined for a total of 1735 bookings and 24,658 days in jail. The average number of bookings per individual was 14 and the average number of jail days was 198.9. The 128 individuals in the case pool combined for 1756 bookings and 26,050 days. This averaged to 13.7 bookings and 203.5 jail days per individual.

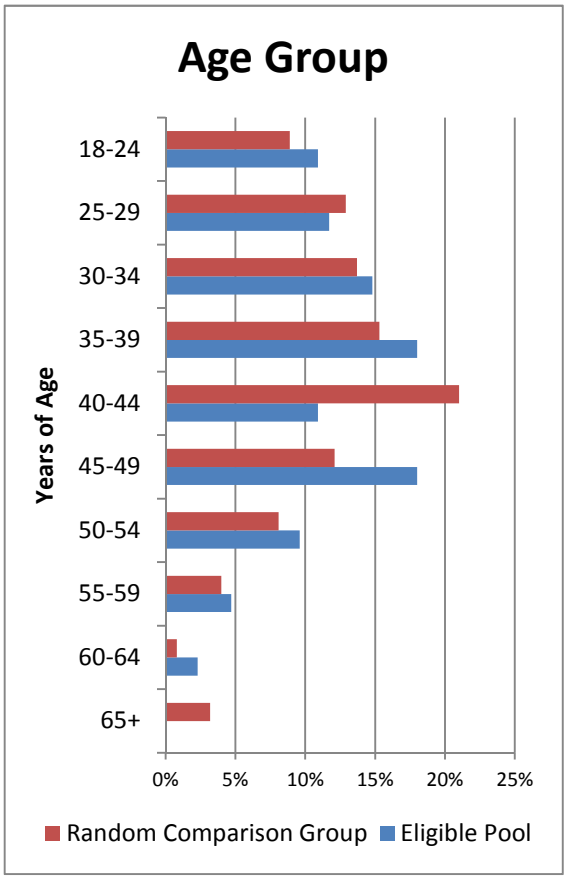
Demographic Characteristics

This section describes the demographic characteristics of the target population. These characteristics are broken down by the two main pools of individuals – the eligible pool from which subjects are engaged and the randomized comparison group.

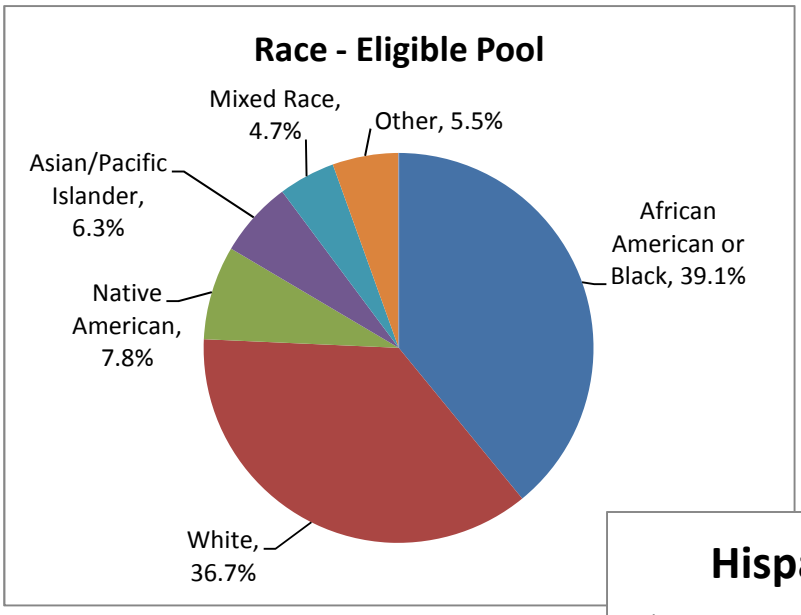
There are 252 individuals in the target population; 128 in the eligible pool and 124 in the randomized comparison group. The target population is approximately 30 percent female and 70 percent male. The average age is 39. The majority are of either African American/Black or White race and approximately eight percent are of Hispanic ethnicity. About 42 percent have less than a high school education.

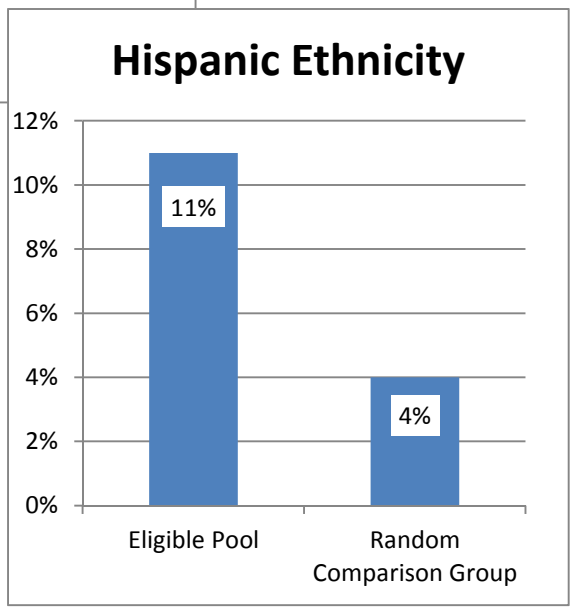
Randomization does not guarantee that samples will have the same characteristics as the population as a whole. Demographic characteristics of both randomly selected groups are shown to see how similar they are demographically and to identify any potential biases that may have been introduced.





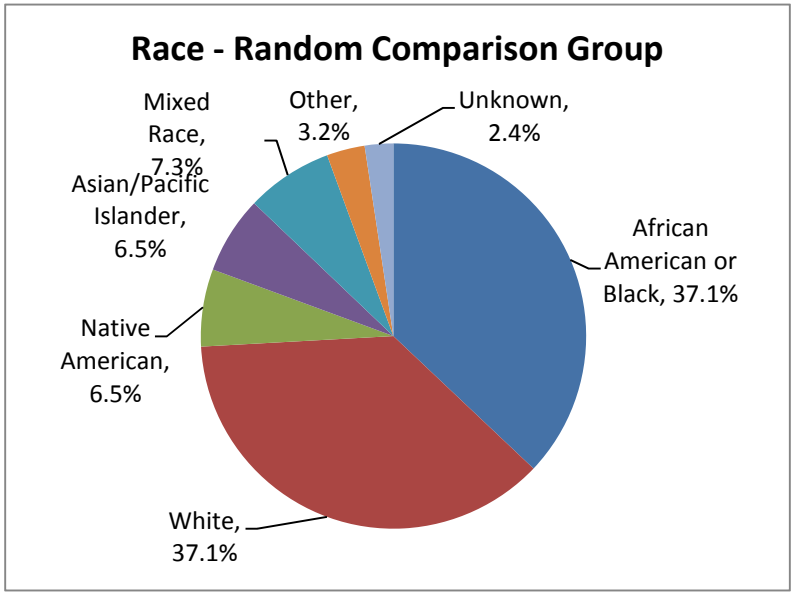
The target population divided fairly equally demographically between the two main pools. There are slightly fewer females in the eligible pool. The average age of the eligible pool is 38.8 years which is very close to the average age of 39.2 of the random comparison pool. The age distribution is similar between the two groups. There is a 10 percent difference between the two groups in the age 40 to 44 age bracket which statistics show is due to random chance.

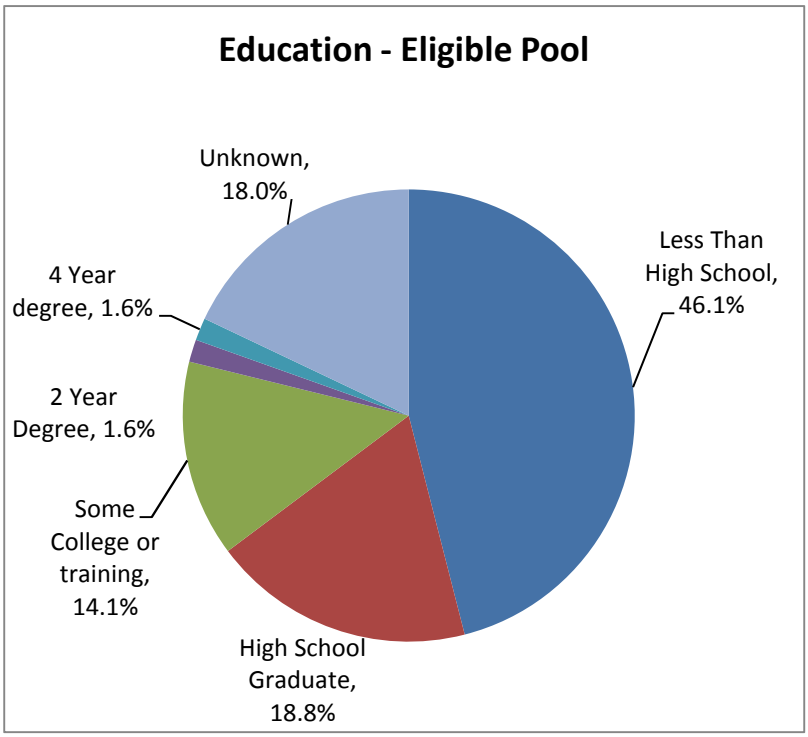




There are slightly more individuals of mixed race in the random comparison pool. Otherwise the distribution of races is very similar between the two groups with only one or two percent difference between them.

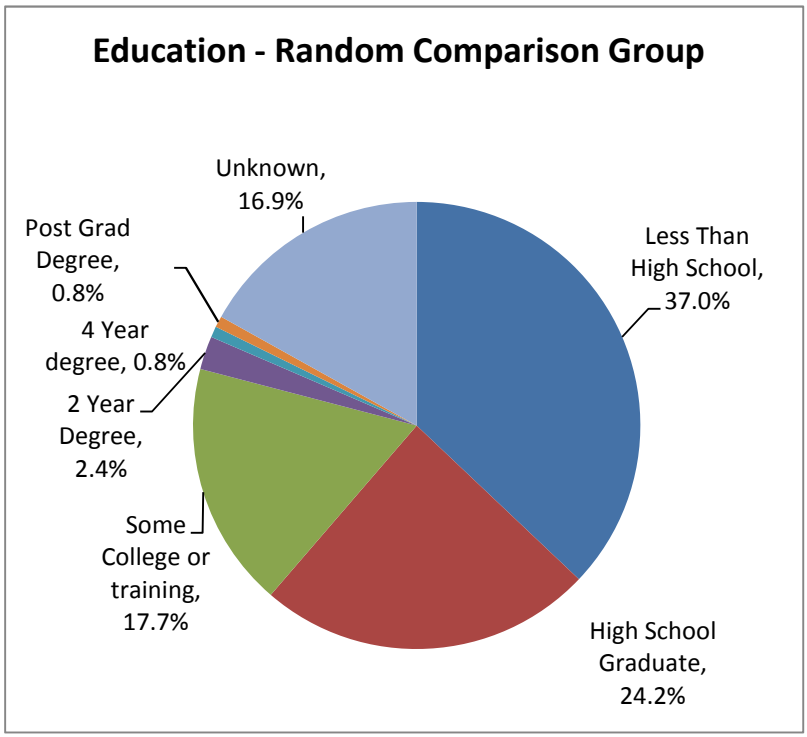
There is a difference in the distribution of Hispanic ethnicity. The eligible pool has six percent more individuals of Hispanic ethnicity than the random comparison group.





Individuals in the eligible pool are less educated than the random comparison group. Almost half (46%) of the eligible pool has less than a high school education. This is nine percent more than the random comparison group with 37 percent having less than a high school education.

Fewer in the eligibility pool have high school degrees. Approximately 19 percent of the eligible pool has a high school diploma compared to the random comparison group with 24 percent.



Although there are slight differences between the two groups, there is nothing to suggest that they are not comparable demographically.

Comparison Group Limitations

It should be noted that individuals in the comparison groups cannot be 'controlled'. They received a wide range of services from none to comprehensive programs very similar to FACT - all representing treatment as usual. This range of services may have resulted in a wide variation of individual outcomes that may affect the ability to detect differences from the FACT group. Individuals in the comparison groups are not actively tracked. If there were no incarcerations within the county or documented services used during the period of study, there may not be any way for us to determine if an individual actually had no incarcerations, received no service, or left the area.

Refining the Random Comparison Group

We were able to determine from mental health service records that some subjects in the RCG left the area during the study period. A process was undertaken to identify these individuals and remove them from the comparison group in an attempt to improve comparability. Individuals who did not have any jail or hospital use or any mental health services use in the post period were removed from the comparison group. Individuals with an exit reason for a mental health service showing they had left the area were also removed.

Additionally, we learned from the enrollment process that approximately 40 percent of the pool of potential FACT participants screened out as not diagnostically eligible. A detailed review of all diagnosis information in the MHCADSD mental health services database for individuals in the RCG was conducted and anyone who did not have a qualifying diagnosis was removed from the comparison group. Note that this diagnostic review differed from the initial review that created the target population. In the first review individuals remained in the population unless a specific non-eligible diagnosis was found. In the absence of an eligible diagnosis the individual remained in the population. In this second review individuals without an eligible diagnosis were removed.

A total of 24 individuals were removed from the randomized group for reasons shown below.

- Individual left area – 6
- No eligible diagnosis – 2
- No diagnostic data – 5
- Whereabouts unknown – 1
- No services or system utilization - 10

One additional individual was removed from the year three analysis because they had died during the study period. We believe that the refined randomized comparison group (RRCG)

provides the most meaningful comparison group. In the interest of transparency and using an "intent to treat" approach, evaluation results are shown for the original randomized comparison group (RCG), the refined randomized comparison group (RRCG), and the group that was 'removed' through this process (XRCG).

Quantitative Outcomes Analysis

Quantitative outcomes were measured for everyone in the target population – FACT participants, those in the eligible pool who were not enrolled in FACT (NEG), and the random comparison group (RCG). The RCG is also divided into the refined random comparison group (RRCG) and the removed random comparison group (XRCG) as described previously. FACT outcomes are presented first. Next, outcomes for the RCG and the two sub-groups, RRCG and XRCG, are compared to FACT outcomes. Lastly, NEG outcomes are compared to FACT.

FACT Outcomes Analysis

Outcomes for FACT participants are measured during a baseline period defined as 12 months prior to enrollment in FACT. These baseline measures are compared to the same outcomes measured for 12 month periods starting the first day the participant is in the community following enrollment. For most participants the first day in the community is the same as the date of enrollment. However, several FACT participants enrolled while still in jail or hospital. For these individuals their FACT start date for outcome analysis purposes is the first day in the community after their release/discharge. Using first day in the community as the start date removes any institutionalized days that result from a pre-FACT booking or admission from the post period measure. It also ensures that these individuals are available in the community to receive FACT services and support.

The FACT program completed the engagement and enrollment process in November 2009. By December 2010 there were 51 participants who had been enrolled in FACT for at least one year. Five participants were referred by a municipal jail and 46 were from the DAJD pool. By April 2011, at least 12 months had elapsed since the first day in the community after enrollment for all FACT participants.

Data for measuring quantitative outcomes are complete through June 30, 2011. First year outcomes are available for all 51 participants. Thirty-seven of the 51 participants had first been in the community for two or more years prior to this date. Outcomes for two years were measured for this group of 37. Outcomes for three years post-FACT involvement were measured for 10 of the 51 participants who were first in the community three or more years prior to June 30, 2011.

Jail Bookings and Days

The primary quantitative outcome for FACT is reduced use of the criminal justice (CJ) system. This outcome is measured by comparing jail and prison bookings before and after participating in the FACT program. The pre-FACT baseline measure is the number of jail/prison bookings and days in the 12-month period prior to FACT enrollment. The post-FACT measure is the number of jail/prison bookings and days in 12-month periods following the first day the participant is in the community after enrolling in FACT. Jail data were collected from King County Department of Adult and Juvenile Detention (DAJD), Municipal Jails (Kirkland, Issaquah, Renton, Kent, Auburn, and Enumclaw) and prison data from the WA Department of Corrections (DOC). These data were combined and unduplicated to present a single picture of CJ utilization for each subject.

All FACT participants combined experienced a total of 267 bookings and 5952 days in jail or prison in the 12 months prior to enrollment. In the year following the baseline, total bookings were reduced to 148 and jail/prison days were reduced to 3664. These declines are large, equaling a 45 percent reduction in bookings and a 38 percent reduction in days, and are statistically significant (p=.001).

JAIL and PRISON BOOKINGS and DAYS

One Year Subset (N=51)	Bookings		Days	
	Total	Average	Total	Average
Pre-FACT	267	5.2	5952	116.7
Year 1 Post-FACT	148	2.9	3664	71.8
Change Pre to Yr1 Post	-45%	-2.3**	-38%	-44.9**

** Statistically significant (p<.01)

On average, each FACT participant spent 117 days in jail or prison in the baseline year - just under four months. After the first year of FACT services, participants spent an average of 72 days incarcerated – a reduction of more than six weeks per person. Average bookings dropped from 5.2 in the baseline year to 2.9 in the first post-FACT year, and are also statistically significant (p<.01).

JAIL and PRISON BOOKINGS and DAYS

Two Year Subset (N=37)	Bookings		Days	
	Total	Average	Total	Average
Pre-FACT	213	5.8	4773	129.0
Year 1 Post-FACT	112	3.0	2687	72.6
Year 2 Post-FACT	107	2.9	2824	76.3
Change Pre to Yr1 Post	-47%	-2.7**	-44%	-56.4**
Change Yr1 to Yr2 Post	-4%	-0.1	5%	3.7

** Statistically significant (p<.01)

Of the 51 FACT participants, 37 were followed for two years after the first community date following enrollment. This subset averaged slightly more jail/prison days in the baseline year, 129 days. They averaged 73 jail/prison days in first year post-FACT and 76 jail/prison days in the second year post-FACT.

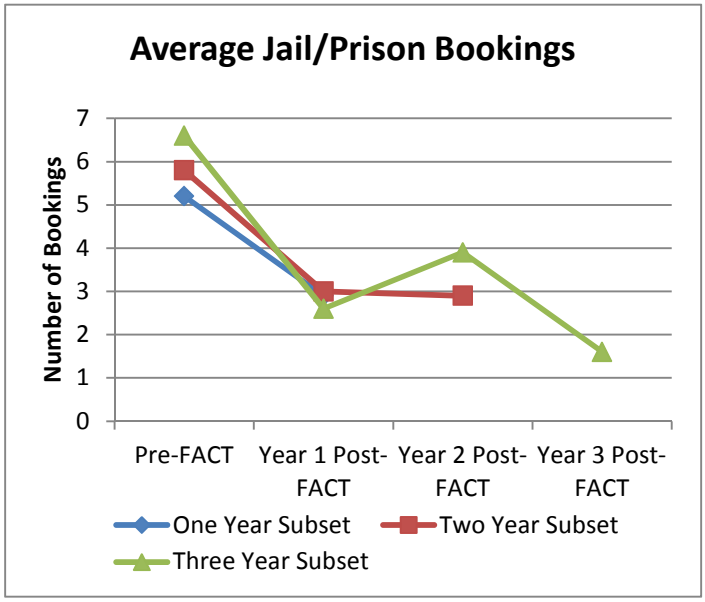
Bookings for this group averaged 5.8 in the baseline year, dropping to 3.0 in the first post-FACT year and then to 2.9 in the second post-FACT year. As with the previous subset, the declines in bookings and days from the baseline year to the first post-FACT year are statistically significant. The slight changes from the first year to the second year post-FACT are not.

JAIL and PRISON BOOKINGS and DAYS

Three Year Subset (N=10)	Bookings		Days	
	Total	Average	Total	Average
Pre-FACT	66	6.6	1194	119.4
Year 1 Post-FACT	26	2.6	513	51.3
Year 2 Post-FACT	39	3.9	487	48.7
Year 3 Post-FACT	16	1.6	523	52.3
Change Pre to Yr1 Post	-61%	-4.0**	-57%	-68.1*
Change Yr1 to Yr2 Post	50%	1.3	-5%	-2.6
Change Yr2 to Yr3 Post	-59%	-2.3	7%	3.6

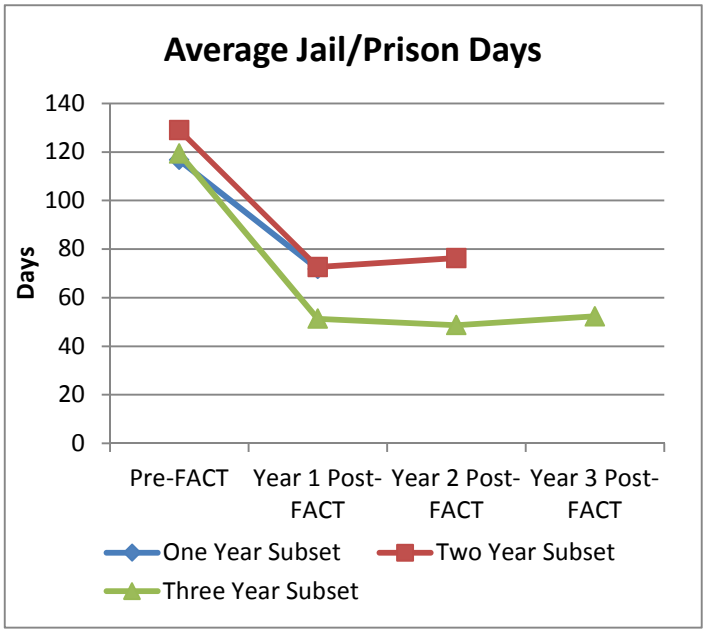
* Statistically significant (p<.05)

** Statistically significant (p<.01)



Ten FACT participants were followed for three years after the first community date following enrollment. This small subset experienced the largest declines in bookings and days from the baseline year to the first post-FACT year, 61 percent and 57 percent respectively. These declines are also statistically significant, p=.002 and p=.042. Again, slight changes from the first to second post year and from the second to third post year are not significant.

Average jail and prison bookings were reduced by approximately half for FACT participants after the first year in the program. Additional small declines are not statistically significant.



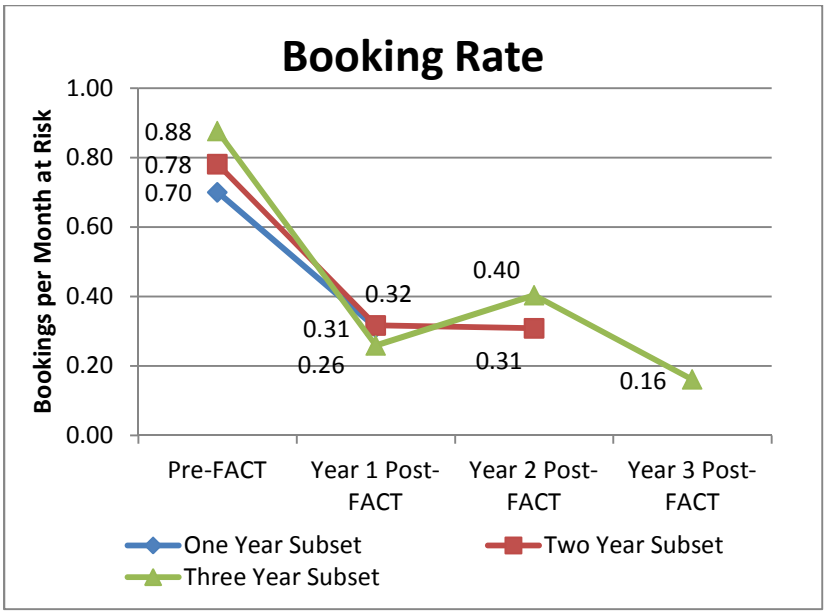
Average days in jail or prison were also significantly reduced for FACT participants in the first year. Jail/prison days in the second and third post-FACT years are statistically unchanged.

This evaluation follows all FACT participants for the entire study period regardless of whether they remain enrolled. A few participants exited the program because they were sentenced to jail or prison for six months or more. These sentences are included in results presented here.

Bookings per Days at Risk

Days in the community provide a measure of "risk" of arrest. Bookings were analyzed in the context of days an individual was 'exposed' in the community so that committing a crime or being arrested was possible. In other words, days the individual was not incarcerated or hospitalized.

In the baseline year the booking rate for all FACT participants was .7, that is, there were .7 bookings per month of community exposure. In the first year post-FACT this dropped to .31 bookings per month of community exposure, a reduction of 56 percent. This clearly shows that the likelihood of a FACT participant being arrested when they are in the community has been reduced.



For the second year subset the pre-FACT booking rate was .78 bookings per month of community exposure. In the first year post-FACT this dropped to .32 bookings per month of community exposure and in the second post year dropped to .31 bookings per month of community exposure.

The third year subset had the highest booking rate pre-FACT, .88 bookings per month of community exposure. This group experienced the largest decline in the first post year to .26 bookings per month of community exposure. Their second post-FACT year saw an increase to .4 bookings per month of community exposure and then another decline to .16 bookings per month of community exposure in the third post-FACT year.

Summary

FACT significantly reduced jail and prison bookings and days in the first year. These reductions are sustained through the second and third years. When looking at bookings per month of community exposure, the likelihood of a FACT participant being arrested when in the community has been reduced. Longer enrollment in FACT reflects greater reductions in the booking rate – 56 percent decline for the one year subset, 60 percent for the two year subset, and 82 percent for the three year subset. The declines for the one and two year subsets are statistically significant ($p<.05$). The decline for the three year subset, although larger, is not significant probably due to the small group size.

Psychiatric Hospital Admissions and Days

Another important quantitative outcome is reduced use of psychiatric inpatient services. This outcome is measured by comparing psychiatric admissions and days before and after participating in the FACT program. The pre-FACT baseline measure is the number of admissions and days hospitalized in the 12-month period prior to FACT enrollment. The post-FACT measure is the number of admissions and days in 12-month periods following the first day the participant is in the community after enrolling in FACT. Hospital data were collected directly from Western State Hospital (WSH) and from King County's community psychiatric hospitals via the MHCADSD database. These data were combined and unduplicated to present a single picture of psychiatric hospital utilization for each individual.

During the baseline period the 51 FACT participants combined experienced 32 psychiatric hospital admissions and 1248 psychiatric hospital days. During the first post-FACT year both admissions and days declined. Admissions declined to 24 and days hospitalized to 698, declines of 25 percent and 44 percent respectively. Although these declines are substantial, they are not statistically significant. Average admissions decreased from .6 to .5 and average days decreased from 24.5 to 13.7.

PSYCHIATRIC HOSPITAL ADMISSIONS and DAYS

One Year Subset (N=51)	Admissions		Days	
	Total	Average	Total	Average
Pre-FACT	32	0.6	1248	24.5
Year 1 Post-FACT	24	0.5	698	13.7
Change Pre to Yr1 Post	-25%	-0.16	-44%	-10.8

Note that averages were calculated for all, not just those who used psychiatric hospital services. Twenty-two FACT participants used inpatient psychiatric hospital services during the evaluation period. Among those who used psychiatric hospital services, average admissions decreased from 1.5 to 1.1 and days decreased from 56.7 to 31.7 in the first year post-FACT. Among users, twelve decreased the number of days hospitalized from the pre to the first year post-FACT, six increased days, and four had the same number pre and post. Admissions showed a similar pattern, eleven decreased admissions, eight increased, and three stayed the same.

The 37 FACT participants who were tracked for two years showed the same pattern of psychiatric hospital use in the first year. In the baseline year this subset had 21 admissions totaling 545 days. In the first post-FACT year admissions declined to 18 and days declined to 206. These declines of 14 percent and 62 percent respectively are not statistically significant.

PSYCHIATRIC HOSPITAL ADMISSIONS and DAYS

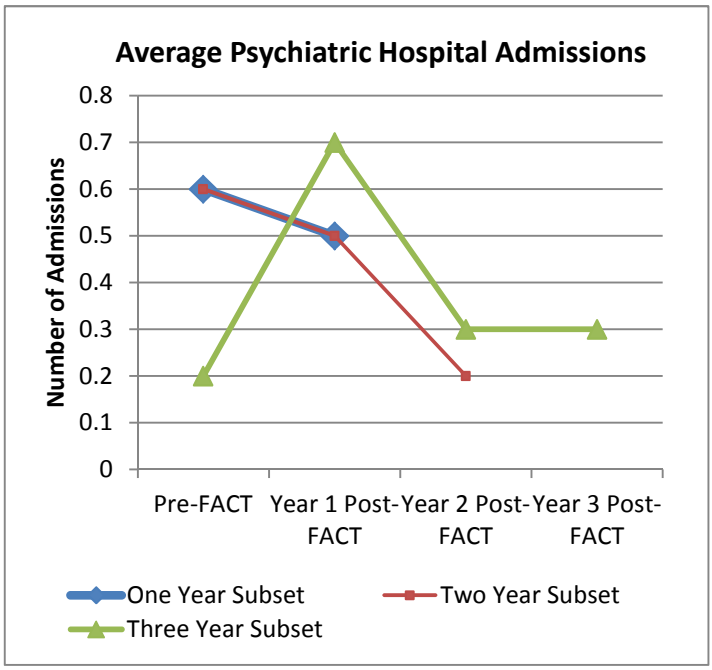
Two Year Subset (N=37)	Admissions		Days	
	Total	Average	Total	Average
Pre-FACT	21	0.6	545	14.7
Year 1 Post-FACT	18	0.5	206	5.6
Year 2 Post-FACT	8	0.2	267	7.2
Change Pre to Yr1 Post	-14%	-0.1	-62%	-9.2
Change Yr1 to Yr2 Post	-56%	-0.3	30%	1.6

In the second post-FACT year admissions for this subset continued to decline from 18 to eight. This 56 percent decline is not statistically significant. Hospitalized days for this subset increased from the first to second post-FACT years from 206 days to 267. This 30 percent increase is not statistically significant. This increase in psychiatric hospital days is driven by a very small number of participants with very long lengths of stay.

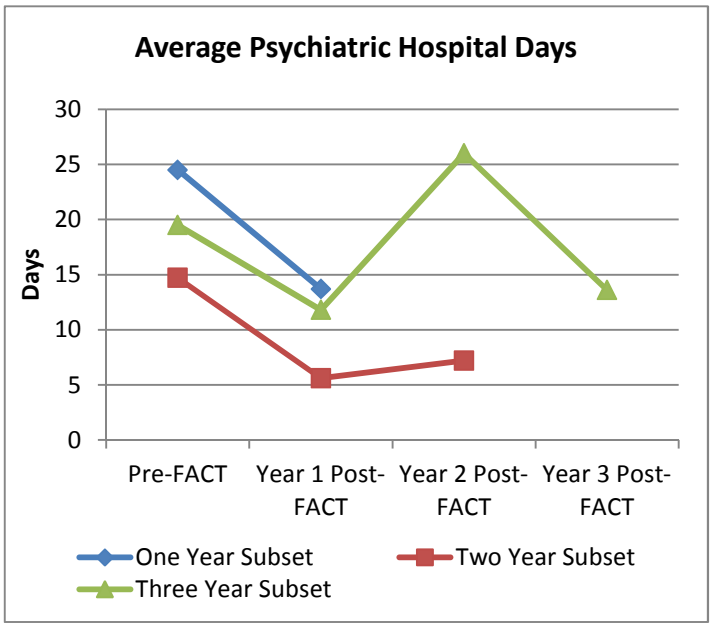
PSYCHIATRIC HOSPITAL ADMISSIONS and DAYS

Three Year Subset (N=10)	Admissions		Days	
	Total	Average	Total	Average
Pre-FACT	2	0.2	195	19.5
Year 1 Post-FACT	7	0.7	118	11.8
Year 2 Post-FACT	3	0.3	260	26
Year 3 Post-FACT	3	0.3	136	13.6
Change Pre to Yr1 Post	250%	0.5	-39%	-7.7
Change Yr1 to Yr2 Post	-57%	-0.4	120%	14.2
Change Yr2 to Yr3 Post	0%	0	-48%	-12.4

The small three year subset (N=10) contains few users of inpatient psychiatric services. The few admissions have a large variation in days. Admissions for this subset increased in the first post-FACT year, declined in the second year and remained unchanged in the third year. Hospitalized days decreased in the first post-FACT year, increased in the second, and decreased again in the third. While year to year changes for this subset are large, none are statistically significant.



The small number of FACT participants who used inpatient psychiatric hospital services and the large variation in their volume of use creates a conflicting picture. One year and two year subsets show initial declines in both admissions and days. Continued declines in admissions for the two year subset are coupled with a slight increase in days suggesting fewer but longer stays. The three year subset had fewer admissions in the pre-FACT period that increased post-FACT. Days for this subset fluctuate widely from year to year.



Very few individuals in the small three year subset have any use of psychiatric hospital services. The range in days of those who do varies widely, from three days to 260 days. The increase in days seen in Year 2 can be attributed to one individual.

Other evaluations of ACT model programs have consistently shown significant reductions in psychiatric hospitalizations. Traditionally ACT programs require at least two or three psychiatric hospitalizations in a baseline year for an individual to be eligible for enrollment. The King County FACT program emphasized criminal justice utilization and did not have the hospitalization requirement for participation. The result is that only 22 of the 51 cases had any psychiatric hospital utilization during the evaluation period. The small number of psychiatric hospital users may explain why these results are not consistent with other ACT program evaluations.

Days in the Community

Combining and unduplicating jail/prison and psychiatric hospital data provides a measure of the total days an individual is institutionalized in a restrictive setting. It also shows whether or not an individual has substituted days in a psychiatric hospital for days in jail or prison and vice versa. Conversely this process also provides a measure for the days an individual is in the community. Days in the community is an important outcome measuring the time an individual is in a non-restrictive environment with the potential to interact with family and friends, seek education or employment, enjoy leisure activities, and work on recovery.

FACT participants reduced total days institutionalized in jail/prison or psychiatric hospitals from 7200 in the baseline year to 4442 in the first year post-FACT. Average days institutionalized in the baseline period were 141.2, approximately 20 weeks. In the first year post-FACT average days institutionalized dropped to 87.1, a decline of over seven weeks. This 38 percent decrease is statistically significant (p=.002).

DAYS INSTITUTIONALIZED and DAYS in the COMMUNITY

One Year Subset (N=51)	Days Institutionalized		Days in the Community	
	Total	Average	Total	Average
Pre-FACT	7200	141.2	11415	223.8
Year 1 Post-FACT	4442	87.1	14173	277.9
Change Pre to Yr1 Post	-38%	-54.1**	24%	54.1**

** Statistically significant (p<.01)

Conversely, days in the community increased from 11415 in the baseline year to 14173 in the first post-FACT year. This 24 percent increase is statistically significant (p=.002). Average days in the community increased from 223.8 to 277.9, an increase of over seven weeks. On an individual basis, 35 FACT participants increased their days in community in the first year. Fifteen FACT participants decreased their days in community and one had no change in community days.

DAYS INSTITUTIONALIZED and DAYS in the COMMUNITY

Two Year Subset (N=37)	Days Institutionalized		Days in the Community	
	Total	Average	Total	Average
Pre-FACT	5318	143.7	8187	221.3
Year 1 Post-FACT	2893	78.2	10612	286.8
Year 2 Post-FACT	3091	83.5	10414	281.5
Change Pre to Yr1 Post	-46%	-65.5**	30%	65.5**
Change Yr1 to Yr2 Post	7%	5.4	-2%	-5.4

** Statistically significant (p<.01)

In the subset that was tracked for two years, total days institutionalized declined from 5318 in the baseline year to 2893 in the first year post-FACT. Days institutionalized increased to 3091 in the second year post-FACT. Averages are similar to the first subset, 143.7 days in the baseline period, 78.2 in the first post-FACT year, and 83.5 in the second. The decrease from baseline to the first year post-FACT is statistically significant (p<.001).

Average days in the community increased from 221.3 in the baseline year to 286.8 in the first post-FACT year and decreased slightly to 281.5 in the second post-FACT year. The 30 percent increase from the baseline period to the first post-FACT year is statistically significant (p<.001).

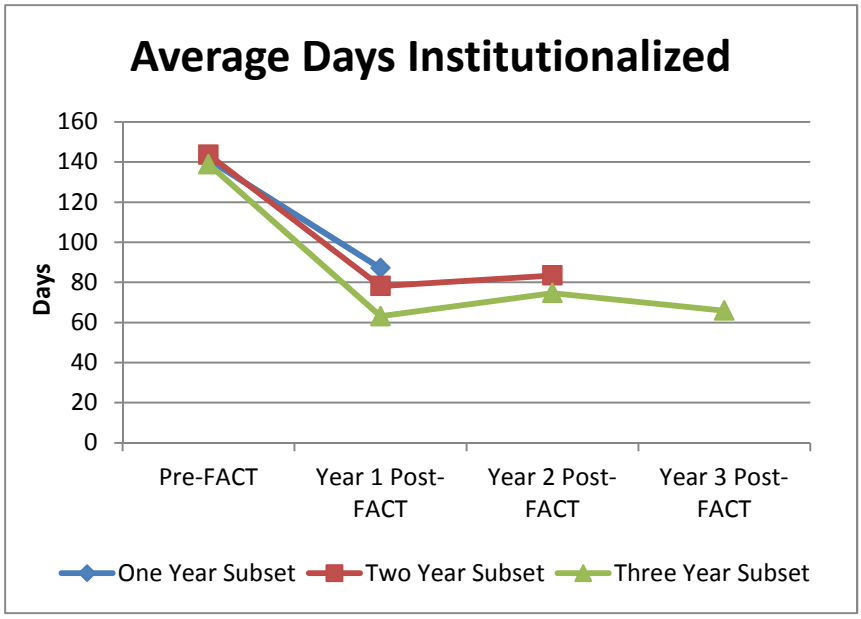
DAYS INSTITUTIONALIZED and DAYS in the COMMUNITY

Three Year Subset (N=10)	Days Institutionalized		Days in the Community	
	Total	Average	Total	Average
Pre-FACT	1389	138.9	2261	226.1
Year 1 Post-FACT	631	63.1	3019	301.9
Year 2 Post-FACT	747	74.7	2903	290.3
Year 3 Post-FACT	659	65.9	2991	299.1
Change Pre to Yr1 Post	-55%	-75.8*	34%	75.8*
Change Yr1 to Yr2 Post	18%	11.6	-4%	-11.6
Change Yr2 to Yr3 Post	-12%	-8.8	3%	8.8

* Statistically significant (p<.05)

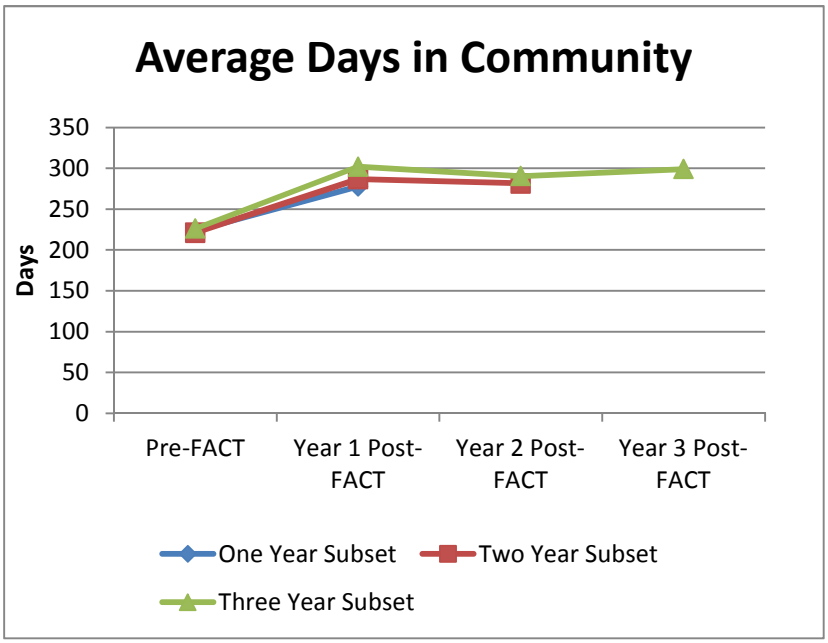
The small three year subset displays a similar pattern. Average days institutionalized declined significantly (p=.035) from 138.9 in the baseline year to 63.1 in the first post-FACT year. This is a decline of more than 10 weeks. Conversely, time in the community increased by more than 10 weeks, from an average of 226.1 days to 301.9 days in the first post-FACT year. Small changes in subsequent years are non-significant.

Summary

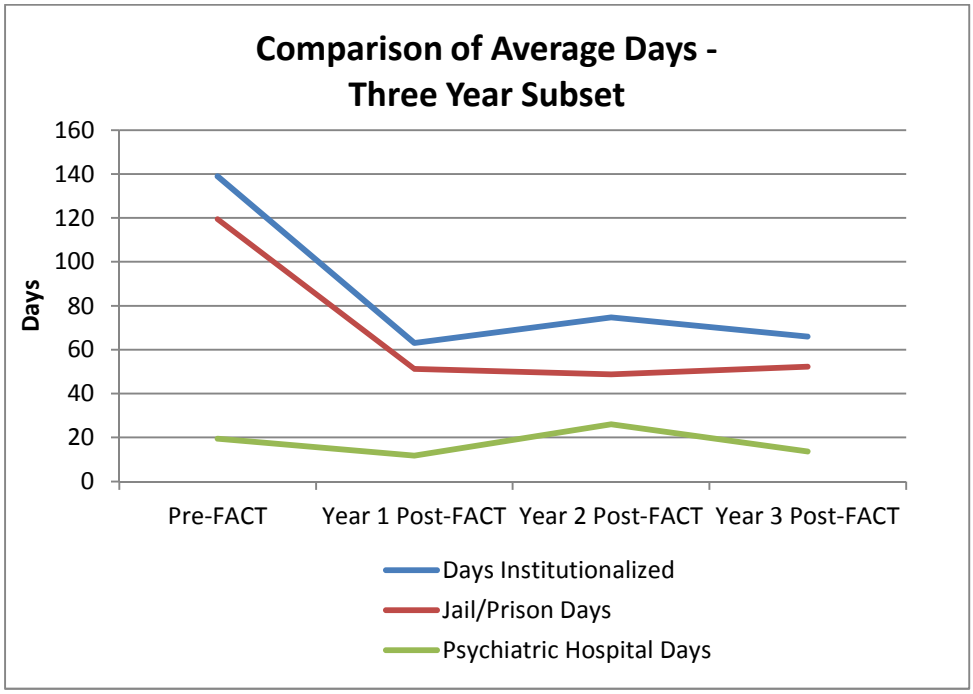


FACT enrollees significantly decreased the amount of time spent in either jail/prison or psychiatric hospital in the first year of program participation. Subsequent years show no statistical change but there are slight increases. After the initial declines, FACT participants remain institutionalized on average for two to three months each year.

After initial large increases, average days in the community plateau for FACT participants. On an individual level, 13 of 51 FACT participants had zero institutionalized days and were in the community full time in the first year. In the second year 13 of 37 were in the community full time and in the third year two of 10 were in the community all 365 days.



Examining the total days institutionalized helps put the fluctuations seen in the Three Year Subset in context. The changes in psychiatric hospital days for this subset, while proportionally large, are not great in magnitude and are not statistically significant (see page 35). When compared to the changes in jail/prison days and the overall days institutionalized, the second year post-FACT increases in psychiatric hospital days look more like the random fluctuations of a very small sample.



Housing Stability

The target population's history of serious mental illness and extensive CJ involvement indicated that all were at high risk of homelessness. Indeed, 50 of the 51 FACT participants had a history of homelessness. Forty-one had been homeless at least once in the year prior to FACT enrollment.

At the time of FACT enrollment, 36 participants were homeless, eleven were staying with family or friends on a temporary basis, and one was in a group home. Three of the 51 participants were housed with family or friends in a permanent situation.

Reported housing status at the time of FACT enrollment differs from where participants actually were. At the time of enrollment, 33 FACT participants were in jail and three were in a psychiatric hospital. Fifteen participants were in the community on the day of enrollment. An additional nine participants were in the community within two weeks of enrollment and an additional eight were in the community within the first month. Five participants were not released into the community for six months or more after enrollment in FACT.

The FACT team sought to house participants as quickly as possible. Twenty-four clients (47%) were housed on their first day in the community after enrolling in FACT. An additional 14 were housed within the first month. Two participants were housed after being enrolled for more than six months and two have never been housed while in the program.

When first housed by FACT, 33 participants were placed into permanent supported housing. Thirteen were first placed into temporary housing before moving to permanent supported housing. One participant was moved to temporary housing and chose to stay there. Two participants remained in their independent housing situation.

Stability is defined as remaining in housing for six continuous months. Of the 49 participants who have been housed while in the program, 36 have had a six month period of stable housing. Thirteen participants have never had a continuous six month period where they have been stable in housing.

On September 30, 2011, 26 FACT participants had been stable in housing for the last six months. Of these, 23 had been stable for a year or more. Sixteen FACT participants have been continuously housed since their first placements. Some of these participants have had occasional jail time, hospital stays, or inpatient chemical dependency treatment during this time, but have retained their housing throughout.

Housing stability data was not available to us for any groups other than FACT participants, so no comparisons will be made in later sections.

Analysis of the Randomized Comparison Group

This next part of the quantitative analysis looks at outcomes for the part of the target population that was randomly selected to be in a comparison group. This analysis sets the context for the FACT outcomes in that this group received 'services as usual' with the exception of the FACT program. Comparing the outcomes for this group with those of the FACT group indicates whether or not FACT provided an added benefit to the service mix. It should be noted that 'services as usual' consists of a continuum of programs from brief interventions to intensive case management with supported housing.

There were 124 individuals in the RCG. Previously in this document the process of refining the RCG to remove individuals who were no longer in the area or whose diagnostic eligibility could not be confirmed was described. One hundred individuals were in the refined randomized comparison group (RRCG) and 24 were removed, becoming the XRCG.

Defining Pre and Post Periods

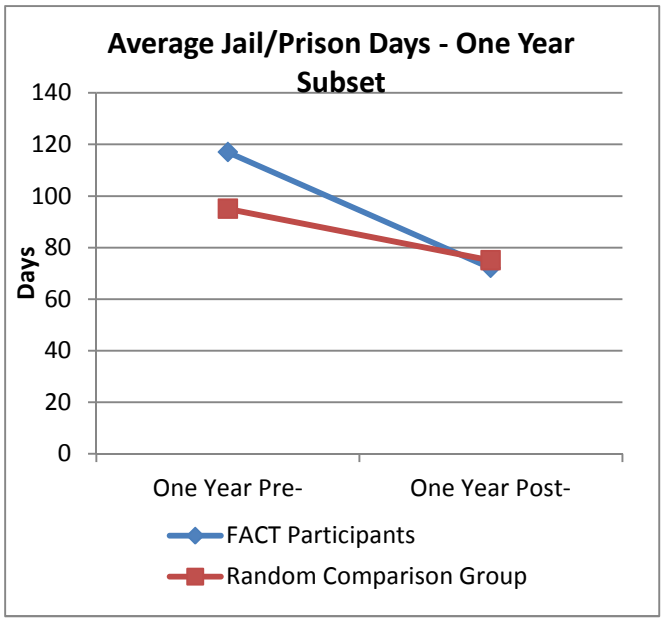
Quantitative outcomes were measured for the randomized comparison group (RCG) in 12 month periods similar to FACT. Since the comparison group does not have an enrollment date, the pre and post periods had to be defined differently. The target population was compiled from four data extracts of high utilizers of KCDAJD. The "enrollment date" for individuals in the RCG is defined as the midpoint of the interval between extracts that they were drawn from. The pre-period begins 12-months before this date and the post-periods are the 12-month intervals following this date.

Jail and Prison Bookings and Days

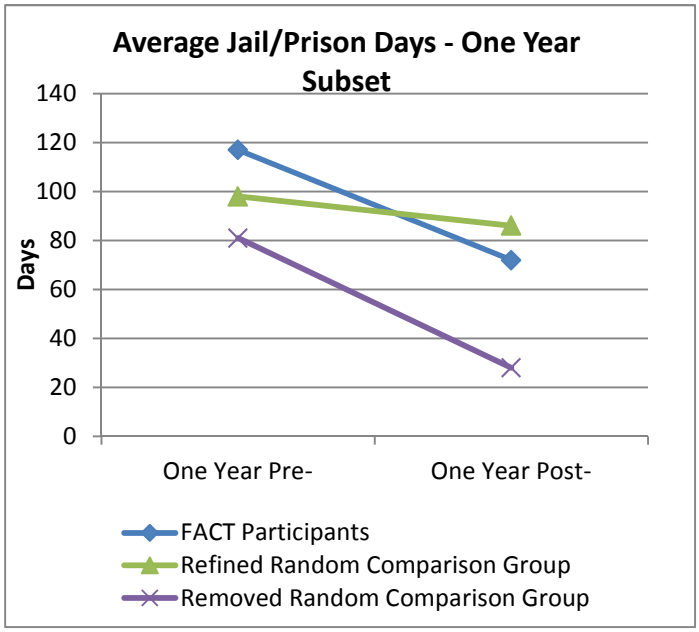
Individuals in the RCG had the same extensive forensic history as the FACT participants. The same jail/prison related outcomes were calculated for both groups.

JAIL and PRISON BOOKINGS and DAYS – One Year Subset

	One Year Pre-	One Year Post-	Change	% Change	Sig
FACT Participants (N=51)					
Average Days	117	72	-45	-38.5%	p=.000
Average Bookings	5	3	-2	-40.0%	p=.000
Random Comparison (N=124)					
Average Days	95	75	-20	-21.1%	p=.015
Average Bookings	5	3	-2	-40.0%	p=.000
RRCG (N=100)					
Average Days	98	86	-12	-12.2%	p=.200
Average Bookings	5	3	-2	-40.0%	p=.000
XRCG (N=24)					
Average Days	81	28	-53	-65.4%	p=.001
Average Bookings	4	2	-2	-50.0%	p=.002



In the first year, the RCG reduced both days and bookings. As with the FACT group, these declines are statistically significant. Declines in bookings are identical for both groups; however declines in days are greater for the FACT group. In the pre year, FACT participants spent, on average, 16 weeks in jail or prison. In the first post year this had declined to 10 weeks. The RCG reduced average time in jail or prison from approximately 13 weeks to 10 weeks.



When separating the RCG into the RRCG and the XRCG, the XRCG shows a very steep decline in jail/prison days. This is what would be expected if most members of this group were no longer in the area.

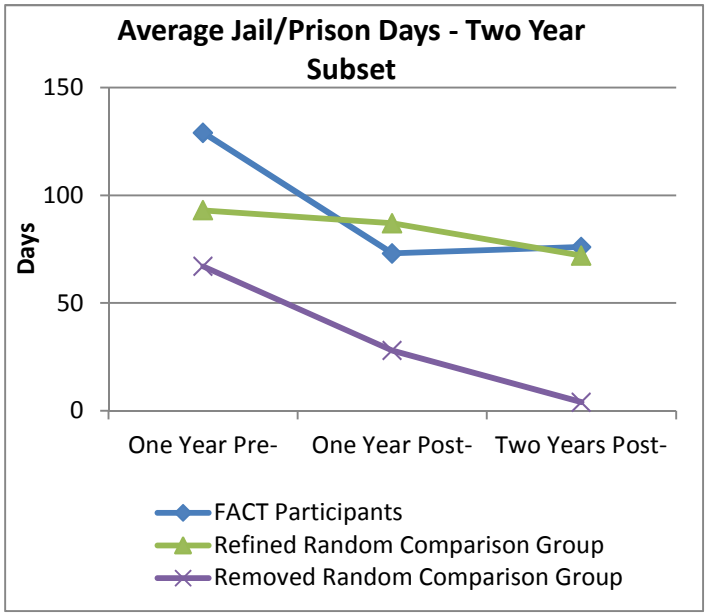
The 100 individuals in the refined randomized comparison group (RRCG) experienced the same significant declines in jail/prison bookings in the first post year; however, the decline in days is not as great and is not statistically significant.

The subset of those in the study for two post years consisted of 37 FACT participants and 94 in the randomized comparison group. Of the 94 in the randomized control group, 77 were in the RRCG and 17 in the XRCG.

JAIL and PRISON BOOKINGS and DAYS – Two Year Subset

	Bookings			Days		
	One Year Pre-	One Year Post-	Two Years Post-	One Year Pre-	One Year Post-	Two Years Post-
FACT (N=37)						
Average	6	3	3	129	73	76
Change		-3*	0		-56*	4
%Change		-50%	0%		-43%	4%
RCG (N=94)						
Average	5	3	2	88	76	60
Change		-2*	-1		-12	-16
%Change		-40%	-33%		-14%	-21%
RRCG (N=77)						
Average	5	3	3	93	87	72
Change		-2*	-1		-6	-15
%Change		-40%	0%		-6%	-17%
XRCG (N=17)						
Average	4	2	>.5	67	28	4
Change		-2*	-1*		-39*	-23
%Change		-50%	-100%		-58%	-86%

* Statistically significant ($p < .05$)

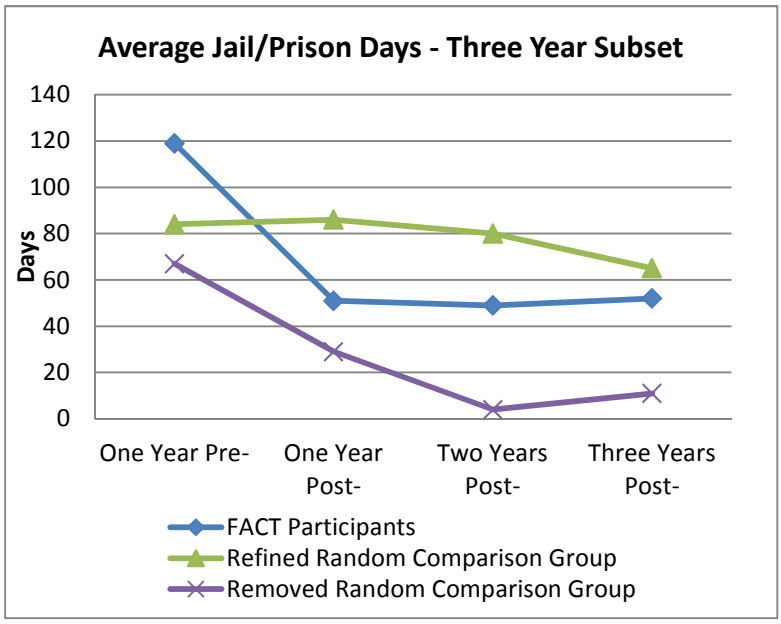


All groups show significant declines in bookings from the pre to first year post periods. Only the XRCG has a decline in bookings in the second year, which is consistent with many in this group leaving the area during the study period. Significant declines in days are only seen for the FACT group and the XRCG in the first year. Declines in jail days for the RRCG were non-significant.

The subset of those in the study for three post years consists of 10 FACT participants and 69 in the randomized comparison group.

	Bookings				Days			
	One Year Pre-	One Year Post-	Two Years Post-	Three Years Post-	One Year Pre-	One Year Post-	Two Years Post-	Three Years Post-
FACT (N=10)								
Average	7	3	4	2	119	51	49	52
Change		-4*	1	-2		-68*	-3	4
%Change		-57%	33%	-50%		-57%	-4%	6%
RCG (N=70)								
Average	4	3	3	2	81	74	64	53
Change		-1*	0	0		-8	-10	-11
%Change		-25%	0%	-33%		-9%	-14%	-17%
RRCG (N=53)								
Average	5	3	3	3	84	86	80	65
Change		-1*	0	0		2	-6	-15
%Change		-40%	0%	0%		2%	-7%	-19%
XRCG (N=16)								
Average	3	2	1	1	67	29	4	11
Change		-2*	-1*	0		-38*	-25	7
%Change		-33%	-50%	0%		-57%	-86%	175%

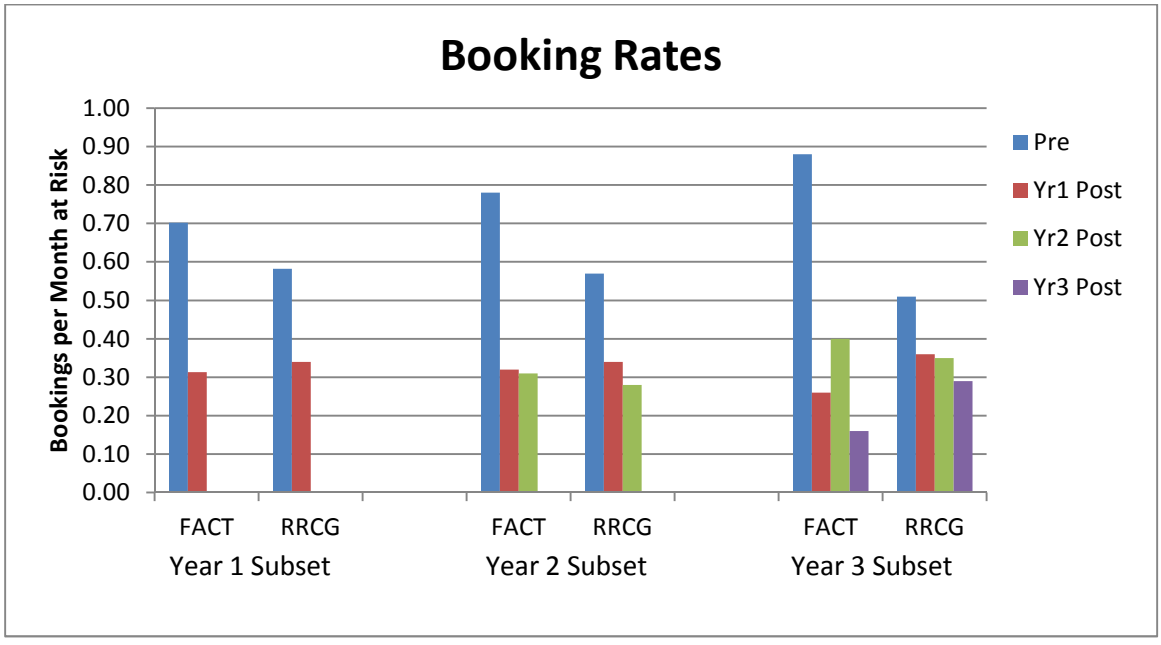
* Statistically significant ($p < .05$)



The FACT group experienced significant declines in jail/prison bookings and days in year one. No significant changes in bookings or days were seen in subsequent years. The three year RRCG subset only sees a significant decline in jail/prison bookings in the first year. No other significant changes in jail/prison days or bookings were found in the RRCG. Note the increase in days among the XRCG. Mental health service records show a few individuals who had left the county returned in 2010.

Over the three year period, FACT participants in the three year subset reduced their number of days in jail or prison by more than half, while the RRCG reduced jail or prison days by about 20 percent during the same time frame. FACT participants in this subset also had a greater reduction in jail or prison bookings.

Among all subsets, the booking rate per month at risk (month in the community) shows that FACT participants had higher rates in the pre period and had proportionally larger reductions in the post periods.



Summary

Services as usual resulted in significant declines in jail and prison bookings and days for the RCG. Declines are proportionally not as great as those seen for FACT. The one year FACT subset experienced a six week reduction in days, which is twice the three week reduction experienced by the RCG. When examining the RRCG, the reduction in days was two weeks and no longer statistically significant. The two year and three year RCG subsets saw significant declines in bookings but not days in the first year, while FACT consistently saw reductions in first year days for all subsets.

Among all subsets, the FACT group experiences a higher number of jail/prison days in the pre year than the comparison groups. This may be an artifact of how eligible individuals were contacted by the FACT team resulting in the highest jail utilizers being enrolled in the program. This issue is discussed further on page 50.

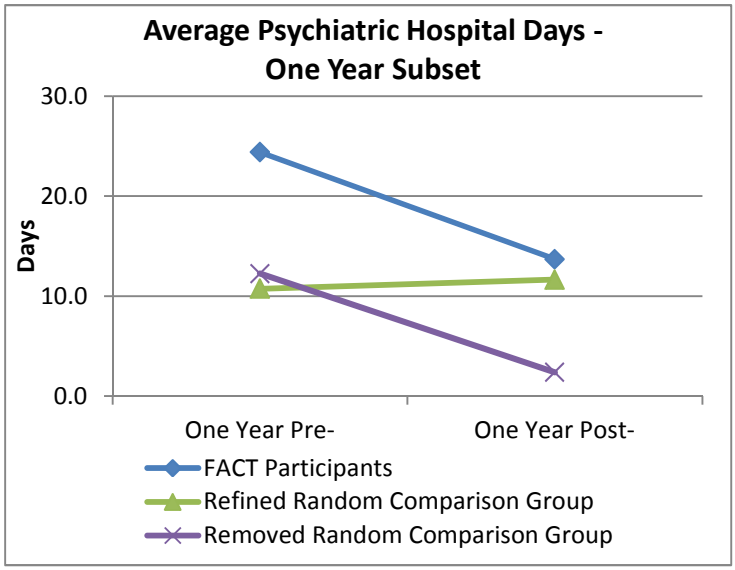
Psychiatric Hospital Admissions and Days

Psychiatric admissions and days were measured for the pre and post periods previously defined. Hospital data were collected directly from Western State Hospital (WSH) and from King County's community psychiatric hospitals via the MHCADSD database. These data were combined and unduplicated to present a single picture of psychiatric hospital utilization for each group.

There was slightly more hospital utilization among FACT participants during the baseline period. Average days for the FACT group were 24.5 and 11.0 for the RCG. Note averages were calculated for all, not just those who used psychiatric hospital services. In the one year post period there were no significant changes in psychiatric hospital utilization found.

Psychiatric Hospital Admissions and Days - One Year Subset

	One Year Pre-	One Year Post-	Change	% Change	Sig
FACT Participants (N=51)					
Average Psychiatric Hospital Admissions	0.6	0.5	-0.2	-25%	NS
Average Psychiatric Hospital Days	24.5	13.7	-10.8	-44%	NS
Random Comparison (N=124)					
Average Psychiatric Hospital Admissions	0.5	0.4	-0.1	-25%	NS
Average Psychiatric Hospital Days	11.0	9.9	-1.2	-11%	NS
Refined Random Comparison Group (N=100)					
Average Psychiatric Hospital Admissions	0.5	0.4	-0.1	-18%	NS
Average Psychiatric Hospital Days	10.7	11.7	0.9	9%	NS
Removed Random Comparison Group (N=24)					
Average Psychiatric Hospital Admissions	0.4	0.2	-0.3	-60%	NS
Average Psychiatric Hospital Days	12.3	2.4	-9.9	-81%	NS



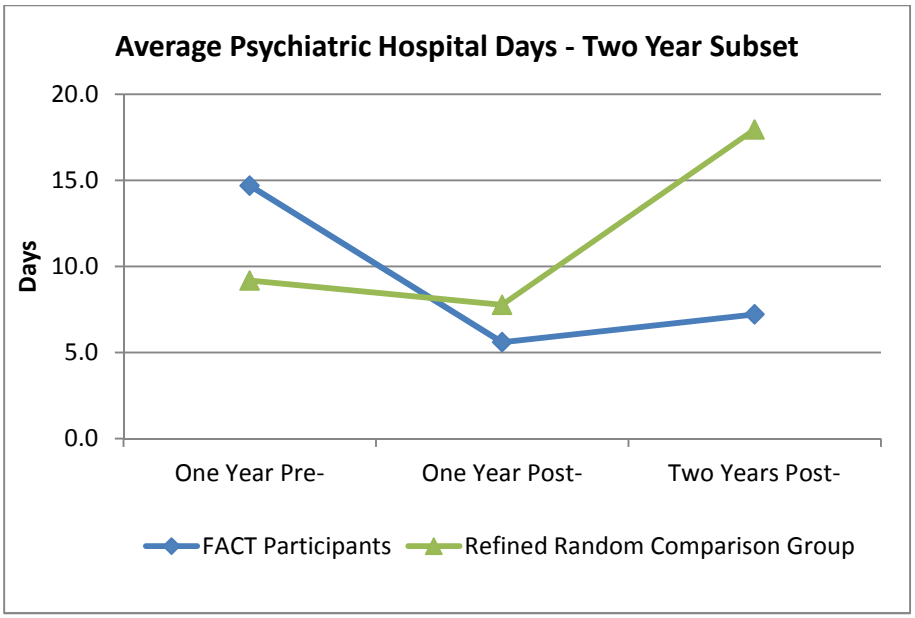
Although not statistically significant, the magnitude of the decline in hospital days for the FACT group is four times that of the RCG. The RRCG experienced a non-significant increase in days.

The second year FACT subset saw admissions decline in both post years. Days for the FACT group declined in year one post and increased in year two. The RRCG saw declines in both admissions and days in the first post year and increases in admissions and days in the second post year. The increase in days from year one post to year two post in the RCG and the RRCG was statistically significant. Other changes were not statistically significant.

Average Psychiatric Hospital Admissions and Days - Two Year Subset

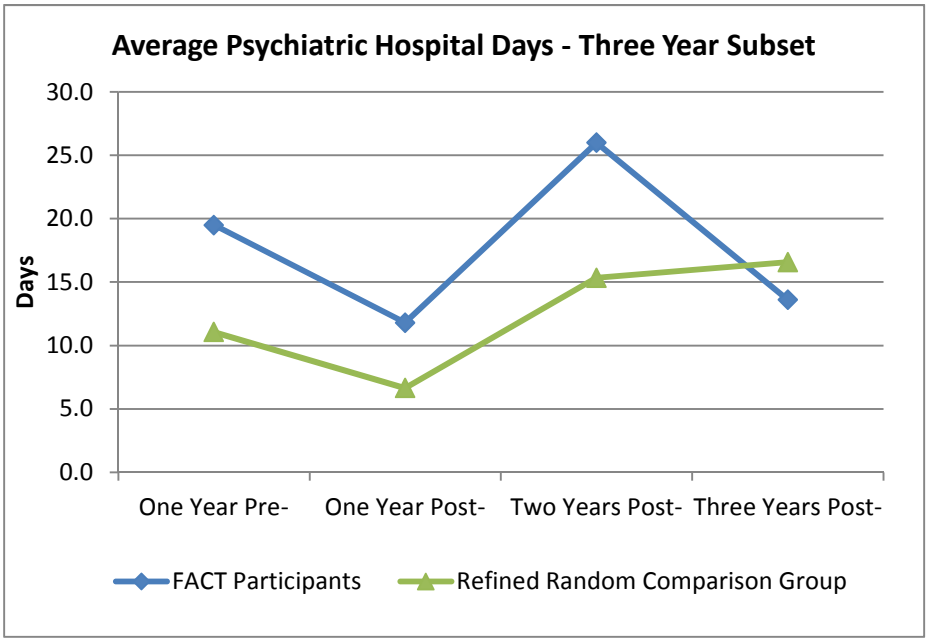
	Admissions			Days		
	One Year Pre-	One Year Post-	Two Years Post-	One Year Pre-	One Year Post-	Two Years Post-
FACT (N=37)						
Average	0.6	0.5	0.2	14.7	5.6	7.2
Change		-0.1	-0.3		-9.2	1.6
%Change		-14%	-56%		-62%	30%
RCG (N=94)						
Number	0.5	0.4	0.4	10.2	7.0	17.3
Change		-0.1	0.1		-3.2	10.4*
%Change		-23%	24%		-32%	149%
RRCG (N=77)						
Number	0.5	0.4	0.5	9.2	7.8	18.0
Change		-0.1	0.1		-1.4	10.2*
%Change		-19%	27%		-15%	131%
XRCG (N=17)						
Number	0.4	0.2	0.2	14.8	3.4	14.5
Change		-0.2	0.0		-11.4	11.1
%Change		-43%	0%		-77%	332%

* Statistically significant ($p < .05$)



In the year three subset there were no significant changes detected for any group. The changes that are seen vary widely and reflect small numbers of users.

Average Psychiatric Hospital Admissions and Days - Three Year Subset								
	One Year Pre-	One Year Post-	Two Years Post-	Three Years Post-	One Year Pre-	One Year Post-	Two Years Post-	Three Years Post-
FACT (N=10)								
Average	0.2	0.7	0.3	0.3	19.5	11.8	26.0	13.6
Change		0.5	-0.4	0.0		-7.7	14.2	-12.4
%Change		250%	-57%	0%		-39%	120%	-48%
RCG (N=70)								
Average	0.6	0.3	0.5	0.3	12.0	5.8	15.1	15.2
Change		-0.2	0.1	-0.2		-6.1	9.3	0.1
%Change		-40%	42%	-35%		-51%	159%	1%
RRCG (N=53)								
Average	0.6	0.4	0.6	0.4	11.1	6.6	15.3	16.6
Change		-0.2	0.2	-0.2		-4.4	8.7	1.2
%Change		-39%	50%	-33%		-40%	131%	8%
XRCG (N=16)								
Average	0.4	0.3	0.3	0.1	15.7	3.6	15.4	11.8
Change		-0.2	0.0	-0.1		-12.1	11.8	-3.6
%Change		-43%	0%	-50%		-77%	332%	-23%



Summary

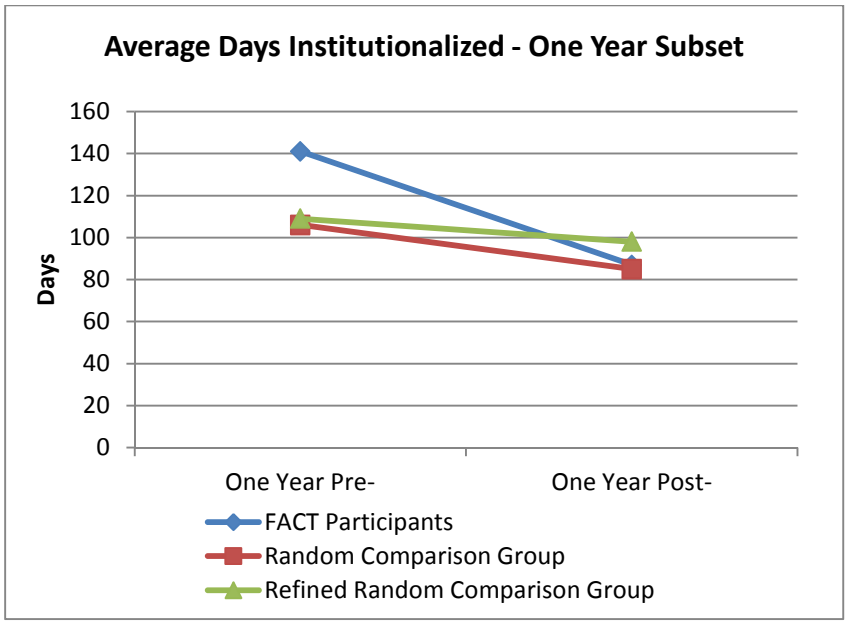
Like the FACT group, the RCG and the RRCG do not show any statistical change in psychiatric hospital use in the first year. The two year subset experiences an increase in days from the first to the second years. This increase is larger in the RCG and the RRCG and is statistically significant. The small number of users and the wide variation in days makes changes difficult to detect statistically.

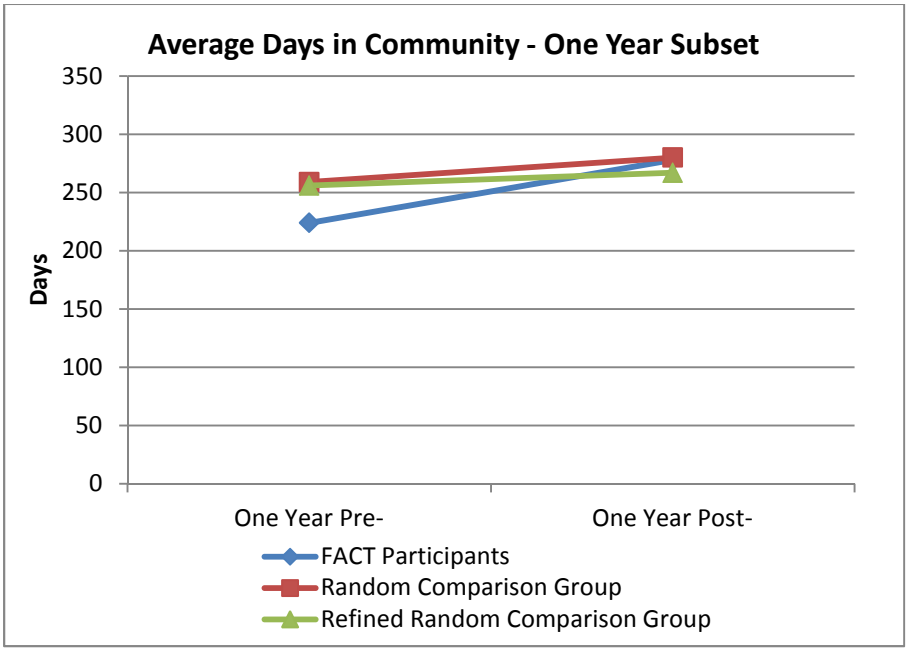
Days in the Community

Jail and hospital data were combined and unduplicated to calculate the total days an individual was institutionalized in a restrictive setting during the evaluation period. Conversely, this indicator also provides a measure for the days an individual is in the community.

Days Institutionalized and Days in the Community - One Year Subset	One Year Pre-	One Year Post-	Change	% Change	Sig
FACT (N=51)					
Average Days Institutionalized	141	87	-54	-38%	p=.002
Average Days in the Community	224	278	54	24%	p=.002
RCG (N=124)					
Average Days Institutionalized	106	85	-21	-20%	p=.017
Average Days in the Community	259	280	21	8%	p=.017
RRCG (N=100)					
Average Days Institutionalized	109	98	-11	-10%	p=.268
Average Days in the Community	256	267	11	4%	p=.268
XRCG (N=24)					
Average Days Institutionalized	93	30	-62	-68%	p=.000
Average Days in the Community	272	335	62	23%	p=.000

Both FACT and the RCG significantly reduced average days institutionalized in the first post year; reductions of 38 percent and 20 percent respectively. Conversely, days in the community increased for both groups. FACT participants averaged 224 days in the community during the baseline period. After enrollment in FACT, average days in the community increased to 278 – an increase of over seven weeks. This 24 percent increase is statistically significant (p=.002). The RCG averaged 259 days in the community during the baseline period which increased to 280 the following year. This increase of eight percent is also statistically significant. The RRCG experienced a small non-significant increase in community days. The XRCG experienced a sharp decline in days institutionalized. This is what would be expected if many in the group were no longer in the area.





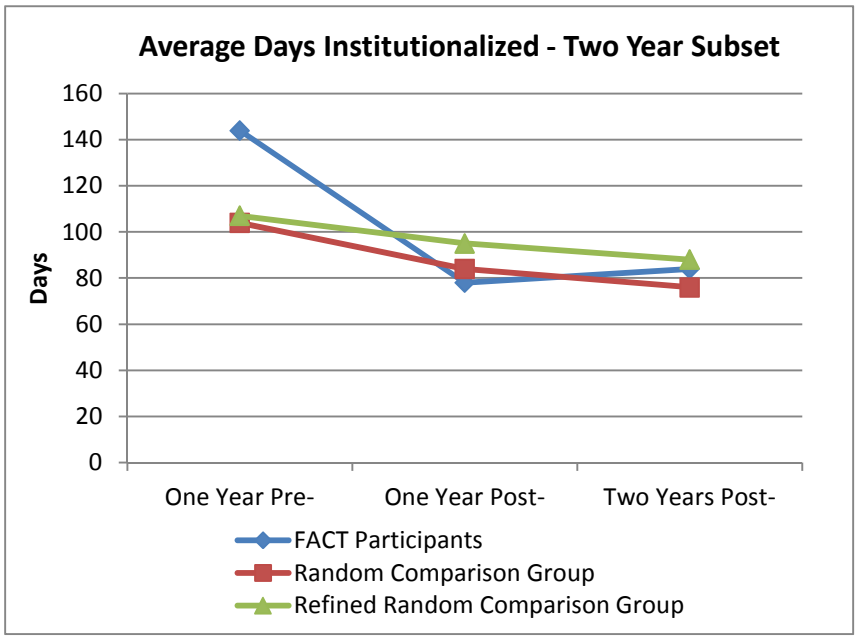
Although the changes in the first post year are statistically significant for both FACT and the RCG, the magnitude of the changes for FACT participants is greater.

The second year subset saw the same pattern for all groups as in year one, a significant decline in institutionalized days and increase in community days from the pre period to the first year post.

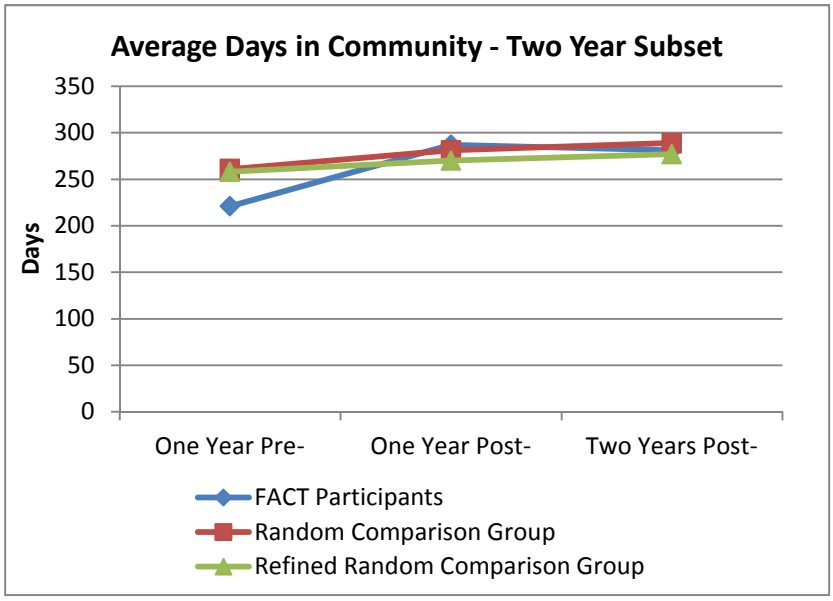
Average Days Institutionalized and in the Community- Two Year Subset							
		Institutionalized			In the Community		
		One Year Pre-	One Year Post-	Two Years Post-	One Year Pre-	One Year Post-	Two Years Post-
FACT (N=37)							
	Average	144	78	84	221	287	281
	Change		-66**	5		66**	-5
	%Change		-46%	8%		30%	-2%
RCG (N=112)							
	Average	104	84	76	261	281	289
	Change		-20*	-8		20*	8
	%Change		-20%	-9%		8%	3%
RRCG (N=92)							
	Average	107	95	88	258	270	277
	Change		-13	-6		12	7
	%Change		-11%	-7%		5%	3%
XRCG (N=20)							
	Average	88	33	19	277	332	346
	Change		-55**	-14		55**	14
	%Change		-63%	-42%		20%	4%

* Statistically significant ($p < .05$)

**Statistically significant ($p < .01$)



In the second post year this subset did not see any significant changes. The FACT group experienced a small increase in days institutionalized while the RCG and the RRCG continued to decline slightly.

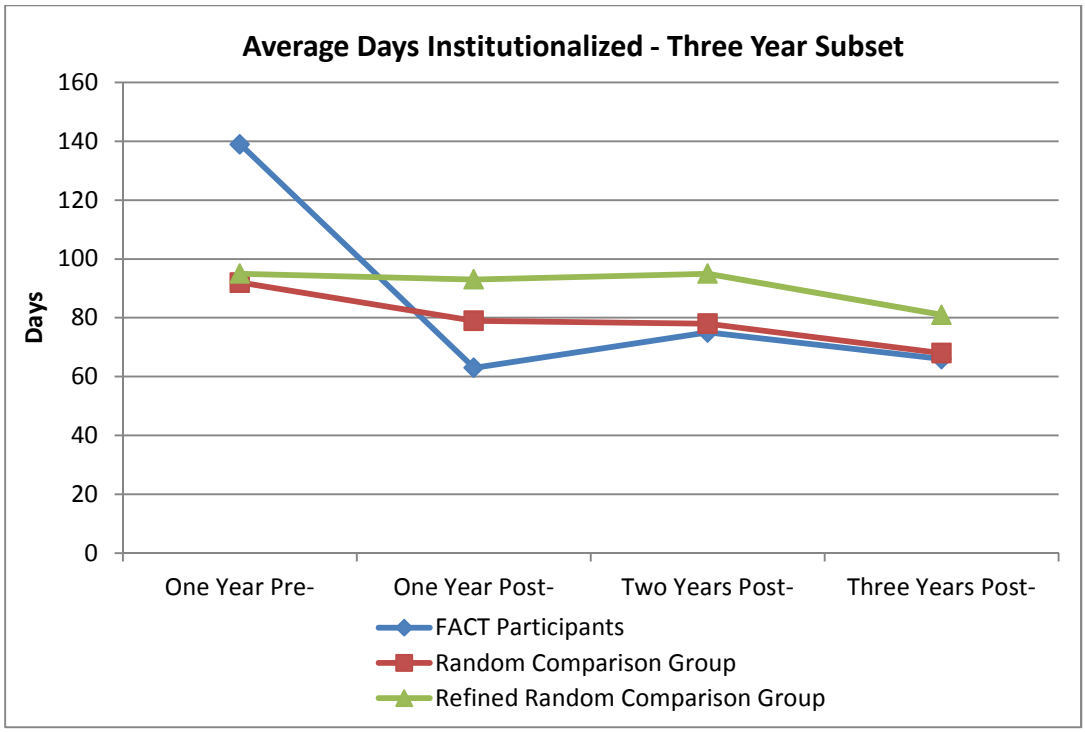


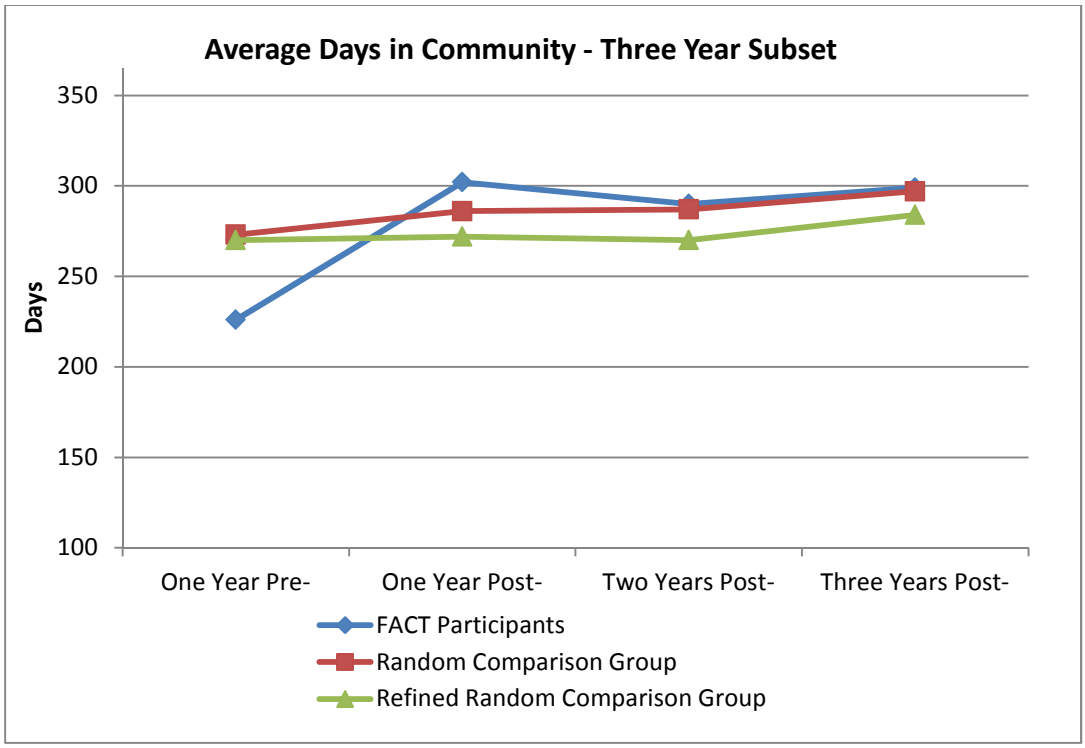
In the first post year FACT participants in this group closed the gap in community days. By the second post year FACT, the RCG, and the RRCG had almost the same average number of days in the community.

The three year FACT subset continues the pattern with FACT seeing significant changes in the first post year. Here the RRCG experiences the same year two non-significant increase in days institutionalized as FACT. Slight declines are seen in the third year for both groups.

Average Days Institutionalized and in the Community - Three Year Subset								
	Institutionalized				In the Community			
	One Year Pre-	One Year Post-	Two Years Post-	Three Years Post-	One Year Pre-	One Year Post-	Two Years Post-	Three Years Post-
FACT (N=10)								
Average	139	63	75	66	226	302	290	299
Change		-76*	12	-9		76*	-12	9
%Change		-55%	19%	-12%		34%	-4%	3%
RCG (N=69)								
Average	92	79	78	68	273	286	287	297
Change		-13	-1	-10		13	1	10
%Change		-14%	-1%	-13%		5%	0%	3%
RRCG (N=53)								
Average	95	93	95	81	270	272	270	284
Change		-2	2	-14		2	-2	14
%Change		-2%	2%	-15%		1%	-1%	5%
XRCG (N=16)								
Average	83	33	20	23	282	332	345	342
Change		-50**	-13	3		50**	13	-3
%Change		-60%	-39%	15%		18%	4%	-1%

* Statistically significant ($p < .05$) **Statistically significant ($p < .01$)





Overall, FACT shows proportionally greater increases in community days than the RCG or the RRCG. The only statistically significant increases occur in the first year for FACT.

Individuals in the comparison groups were able to receive treatment and services as usual. Usual services span the continuum from intensive case management with supported housing to a single brief intervention. High service intensity mental health programs funded or administered by MHCADSD and the individuals in the RCG who were authorized to receive them were identified. Outcomes were examined for those in the high service intensity programs to see if the results were more similar to the high service FACT outcomes.

Note that we do not have information about programs not funded/administered by MHCADSD. For example, the City of Seattle funds a program (Co-Stars) that also targets high users of the criminal justice system and provides intensive case management with supported housing. It is possible that individuals in the RCG could have been enrolled in this program during the study period, but we were not able to obtain this information. The designation of high service intensity is based only on the information available.

Days institutionalized were compared for those in High and Standard/Unknown levels of service programs with those in FACT. In the one year subset those receiving High services were similar to FACT in their average days in the pre period and the decline in the first post year. Small numbers (there were only 12 individuals in a High service program in the first year) may be what makes the decline in the High group non-significant.

Average Institutionalized Days by RCG Levels of Service - One Year Subset

	Total RCG N=124	Standard Services N=112	High Level Services N=12	FACT N=51
Pre Days	106	104	122	141
Post1 Days	85	86	73	87
% Change	-20%*	-18%	-40%	-38%**

* Statistically significant ($p < .05$)

**Statistically significant ($p < .01$)

The two year subset shows a very different picture. Those in the High level service group were not similar to FACT with respect to days institutionalized in the pre period. The High service group does not show any statistical declines/changes. Again there are only eight individuals in this High service group in the two year subset. Significant decreases are seen in the Standard service group.

Average Institutionalized Days by RCG Levels of Service - Two Year Subset

	Total RCG N=112	Standard Services N=104	High Level Services N=8	FACT N=37
Pre Days	104	104	106	144
Post1 Days	84	83	88	78
Post2 Days	76	75	93	84
% Change Pre-Post1	-20%*	-20%*	-17%	-46%**
% Change Post1-Post2	-9%	-10%	5%	7%

* Statistically significant ($p < .05$)

**Statistically significant ($p < .01$)

It does appear that the High service intensity programs are enrolling individuals with higher jail/hospital use. However, the numbers are small and this one indicator is not sufficient to explain the variation within the RCG.

Non-Enrolled Eligibles

The non-enrolled eligibles group (NEG) includes all those in the eligible pool who were not enrolled in FACT. It includes:

- Those engaged by the FACT team but refused services.
- Those engaged and found by the FACT team to not be eligible.
- Those never engaged.

There were 82 individuals in this group. One death very early in the study period brings the total for analysis to 81.

This group has the lowest institutionalization rates of all the groups. An initial ANOVA shows that NEG days in the pre period are significantly lower than the FACT group. It appears that FACT engaged the highest users of service in the eligible pool. We believe that this is a result of the FACT team's approach to locating individuals in the eligibility pool. Many came to the team's attention when they were jailed. One approach the team used to locate individuals involved reviewing a daily list of inmates booked in the previous 24 hours. If someone on the list was in the FACT eligibility pool they could easily locate and reach out to them. Many FACT enrollees entered the program from jail. Using this approach, those who were in jail most frequently had a higher probability of being contacted by the team, resulting in the higher pre period jail utilization of the FACT group.

Average Days Institutionalized - One Year Subset					
	One Year Pre-	One Year Post-	Change	% Change	Sig
FACT (N=51)	141	87	-54	-38%	p=.002
NEG (N=81)	92	72	-20	-22%	p=.041
Refused (N=34)	95	65	-30	-32%	p=.023
Not Eligible (N=25)	126	113	-13	-10%	NS
Never Engaged (N=22)	51	39	-13	-25%	NS

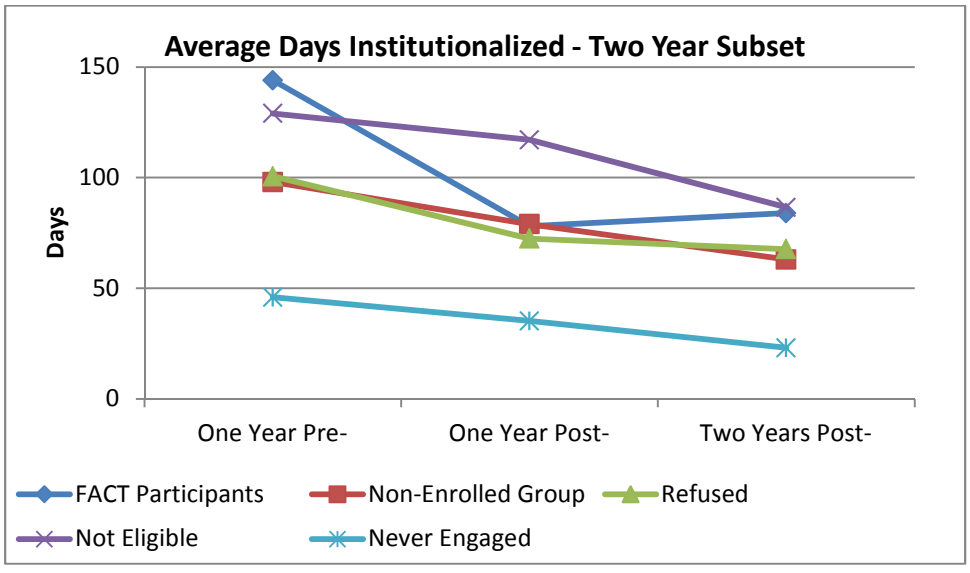
Both FACT and the NEG experienced significant declines in days institutionalized in the first year. FACT started significantly higher than the NEG and had steeper declines. Within the NEG, those who refused had significant declines while the not eligible and never engaged groups had small non-significant declines. Many of those who refused FACT did so because they were already receiving services elsewhere and did not wish to change. This may explain why this group experienced the decrease.

Average Days Institutionalized - Two Year Subset

		One Year Pre-	One Year Post-	Two Years Post-
FACT (N=37)				
	Average	144	78	84
	Change		-66*	5
	%Change		-46%	8%
NEG (N=71)				
	Average	102	82	65
	Change		-20	-17
	%Change		-20%	-21%
Refused (N=30)				
	Average	101	73	68
	Change		-28	-5
	%Change		-28%	-7%
Not Eligible (N=24)				
	Average	129	117	87
	Change		-12	-30*
	%Change		-9%	-26%
Never Engaged (N=17)				
	Average	46	35	23
	Change		-11	-12
	%Change		-23%	-35%

* Statistically significant ($p < .05$)

The two year NEG subset does not have a significant decrease in institutionalized days in the first year as FACT does. However, the not eligible group has a significant decrease in the second year while FACT has a slight increase.



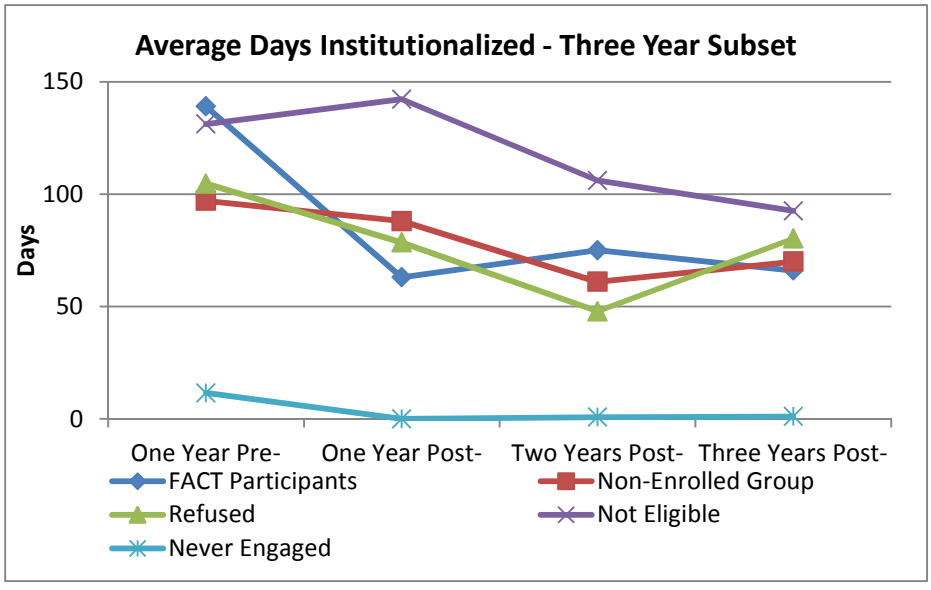
Average Days Institutionalized – Three Year Subset					
		One Year Pre-	One Year Post-	Two Years Post-	Three Years Post-
FACT (N=10)					
	Average	139	63	75	66
	Change		-76*	12	-9
	%Change		-55%	19%	-12%
NEG (N=47)					
	Average	97	88	61	70
	Change		-9	-27*	9
	%Change		-9%	-31%	15%
Refused (N=20)					
	Average	105	79	48	80
	Change		-26	-31	32
	%Change		-25%	-39%	68%
Not Eligible (N=18)					
	Average	131	142	106	93
	Change		11	-36	-14
	%Change		8%	-25%	-13%
Never Engaged (N=9)					
	Average	12	0	0.8	1.1
	Change		-12	0.8	0.3
	%Change		-100%		42%

* Statistically significant ($p < .05$)

The never engaged group in the three year subset contains only nine individuals, demonstrating that almost all of those eligible for the longest period had been engaged at some point by the FACT team. For this group the number of days institutionalized has become very low. Some of this group may have also left the area which would explain why engagement didn't occur.

The significant decline in the second year is now seen for the NEG as a whole, but not for any of the sub-groups.

In this subset the not eligible group has high institutionalized days similar to the levels of FACT. Unlike FACT, the average institutionalized days remains fairly high throughout the study period.

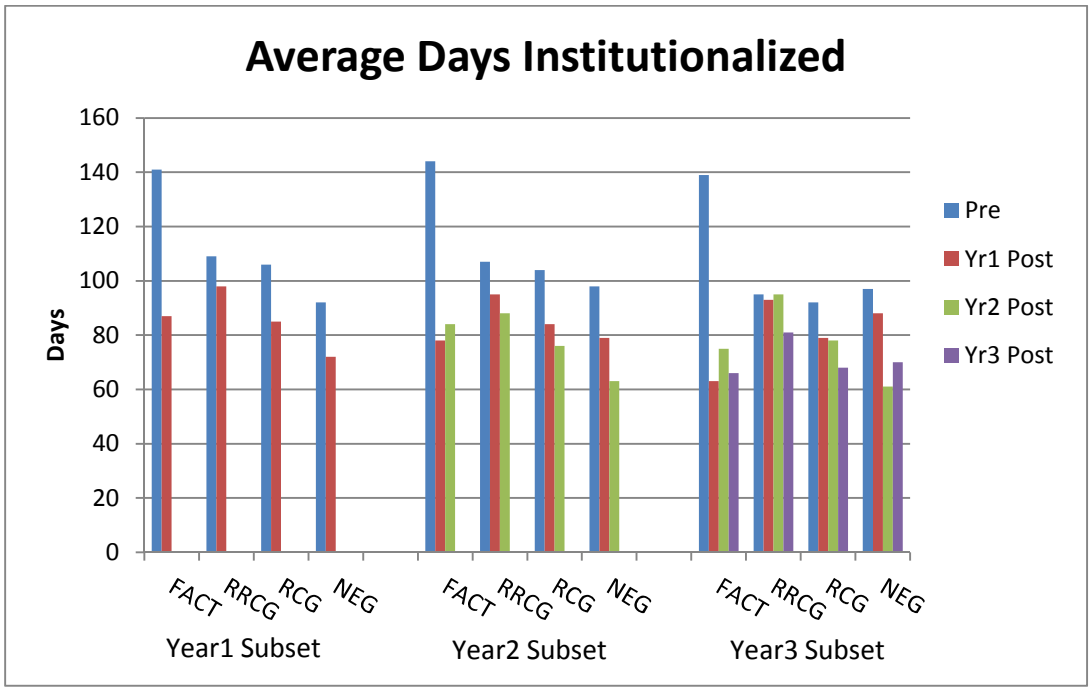


Conclusion

The quantitative evaluation demonstrates that FACT has significantly reduced the combined number of days institutionalized in either jail/prison or psychiatric hospital among its participants. This decrease is driven by large reductions in jail and prison days which are achieved in the first year of program participation. Examining the entire target population from which FACT participants were sampled shows that on average, FACT participants have better, more consistent results.

For all subsets FACT participants have significant reductions in the first year. The RCG shows significant reductions in two of the three subsets. When individuals who left the area or whose diagnosis could not be confirmed were removed from the RCG, these declines were no longer statistically significant.

The NEG shows a significant decline in the first year of the one year subset and in the second year of the three year subset. The magnitudes of these declines are not as large as for FACT.



The chart above clearly shows that FACT enrolled the highest users of these services in the target population and reduced that use substantially. This chart used the most conservative measure of days institutionalized for the RCG and NEG as all individuals are included regardless of whether they have left the area or not. The average days institutionalized would be higher if these individuals were removed.

The reductions in average days institutionalized among FACT participants were sustained throughout the study period. This is a conservative estimate because the few FACT participants who exited the program to serve long jail or prison sentences are included. Some evaluations exclude results for participants once they have exited a program. All participants were included here regardless of how long they were served by the FACT team. The average days institutionalized would be lower if these individuals were removed.

Other Quantitative Outcomes

Outcomes related to other high cost services were measured for FACT participants and the comparison groups. These outcomes are use of mental health crisis services, use of the Dutch Shisler Service Center (a multi-service sobering support center) and use of the Harborview Medical Center Emergency Department.

Data for these outcomes are available through September 31, 2011. The additional data allows the time period for tracking subjects in the evaluation to be extended for three months. This extended time also allows for more subjects to shift into the two year and three year subsets. In fact, all subjects in the comparison groups can now be followed for at least two years so that the one and two year subsets for the comparison groups are identical for this service analysis.

Crisis Services

King County MHCADSD provides 24/7 mental health crisis services and funds additional mental health crisis programs. As part of the service package for program participants, the FACT team assumes this responsibility and responds 24/7 to crisis situations involving FACT participants.

Crisis Services - Average Episodes
One and Two Year Subsets

		One Year Pre-	One Year Post-	Two Years Post-
FACT One Year Subset (N=51)				
	Average	2.84	1.35	
	%Change		-52%**	
FACT Two Year Subset (N=42)				
	Average	2.76	1.52	0.93
	%Change		-45%*	-39%
RCG (N=124)				
	Average	1.66	1.40	1.10
	%Change		-16%	-21%
RRCG (N=100)				
	Average	1.75	1.59	1.33
	%Change		-9%	-16%
XRCG (N=24)				
	Average	1.29	0.63	0.13
	%Change		-51%	-79%
NEG (N=81)				
	Average	1.44	1.06	0.49
	%Change		-26%	-54%

* Statistically significant ($p < .05$)
**Statistically significant ($p < .01$)

In the first year, FACT participants significantly reduced their use of county crisis services by more than half (52%). Reductions seen in comparison groups were not as large and were not statistically significant. Not all FACT participants used crisis services during the study

period. Thirteen of the 51 FACT participants did not use any crisis response services. Of the 38 who used crisis services, 24 reduced use in the first year, seven increased in the first year and seven had no change. When looking at only those who used crisis services, the pre period average was 3.8 episodes which declined to 1.8 episodes in the first year.

The two year subset also saw a significant decline in the first year, followed by a non-significant decline in the second year. Again, reductions in the comparison groups were not statistically significant. The three year subset displayed this same pattern for the first and second years. In the third year the RCG and the RRCG experienced significant declines while the FACT group did not change.

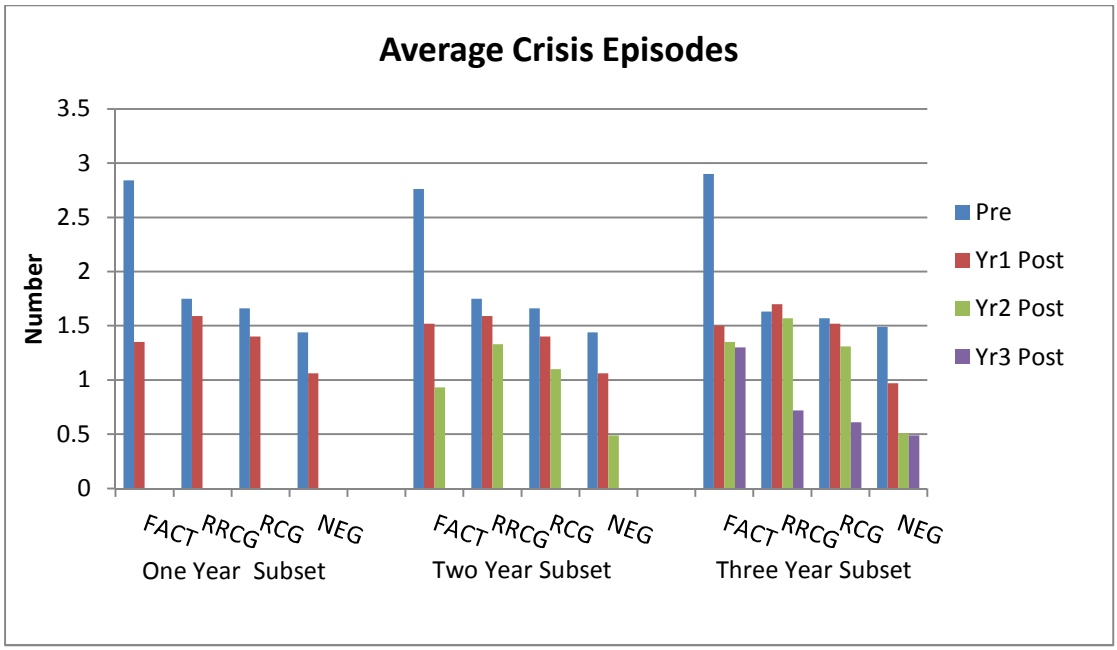
Crisis Services - Average Episodes
Three Year Subset

		One Year Pre-	One Year Post-	Two Years Post-	Three Years Post-
FACT (N=20)					
	Average	2.90	1.50	1.35	1.30
	%Change		-48%*	-10%	-4%
RCG (N=93)					
	Average	1.57	1.52	1.31	0.61
	%Change		-3%	-14%	-53%**
RRCG (N=76)					
	Average	1.63	1.7	1.57	0.72
	%Change		4%	-8%	-54%**
XRCG (N=17)					
	Average	1.29	0.71	0.18	0.12
	%Change		-45%	-75%	-33%
NEG (N=61)					
	Average	1.49	0.97	0.51	0.49
	%Change		-35%	-47%	-4%

* Statistically significant ($p < .05$)

**Statistically significant ($p < .01$)

Note that declines in use of King County crisis services/programs by FACT participants do not necessarily mean that these individuals had fewer crises. It can only be inferred that the cost of these crises have been absorbed by the FACT program and saved by the county.



Dutch Shisler Service Center

The one year FACT subset experienced a small non-significant decline in sobering admissions in the first year. The two year subset experienced a large, though still non-significant, increase in sobering admissions the first year. This difference in outcome results from the utilization by nine individuals. The two year subset did experience a decrease to below pre-FACT level in the second year, but again, this decline is not statistically significant. The RRCG shows a similar pattern, although the first year increase and second year decrease is not as large. The NEG experienced a first year decrease and second year increase. None of these changes in the RRCG and NEG are statistically significant.

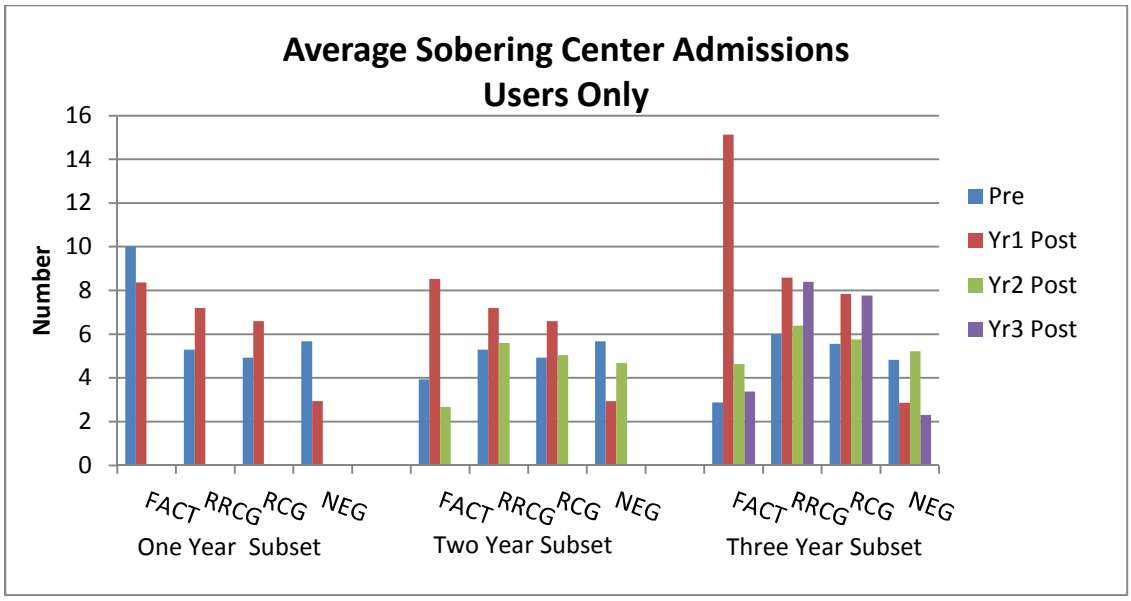
Sobering Center - Average Admissions One and Two Year Subsets			
	One Year Pre-	One Year Post-	Two Years Post-
FACT One Year Subset (N=51)			
Average	3.73	3.12	
%Change		-16%	
FACT Two Year Subset (N=42)			
Average	1.4	3.05	0.95
%Change		118%	-69%
RCG (N=124)			
Average	1.83	2.44	1.87
%Change		33%	-23%
RRCG (N=100)			
Average	2.12	2.88	2.24
%Change		36%	-22%
XRCG (N=24)			
Average	0.62	0.62	0.33
%Change		0%	-47%
NEG (N=81)			
Average	2.17	1.12	1.79
%Change		-48%	60%

As with the two year subset, the three year FACT subset increases sobering utilization in the first year and declines in the second. The third year continues the decline in sobering admissions, but is still higher than the pre-FACT level. All changes are not statistically significant.

The RCG and RRCG experience increases in the first year, declines in the second year, and increases in the third year. The NEG declines the first year, increases the second, and declines again in the third year. Like the FACT group, all changes in the RCG, RRCG, and NEG are not statistically significant.

Sobering Center - Average Admissions Three Year Subset					
		One Year Pre-	One Year Post-	Two Years Post-	Three Years Post-
FACT (N=20)					
	Average	1.15	6.05	1.85	1.35
	%Change		426%	-69%	-27%
RCG (N=93)					
	Average	2.27	3.20	2.35	3.17
	%Change		41%	-27%	35%
RRCG (N=76)					
	Average	2.61	3.72	2.78	3.64
	%Change		43%	-25%	31%
XRCG (N=17)					
	Average	0.76	0.88	0.47	1.06
	%Change		16%	-47%	126%
NEG (N=61)					
	Average	1.82	1.08	1.97	0.87
	%Change		-41%	82%	-56%

The large year to year fluctuations in all groups is driven by sobering center use by relatively few individuals. Among the 51 FACT participants, 19 (37%) used the sobering center at some point during the evaluation period. About the same proportion, 37 percent, of the comparison groups used sobering services during the evaluation period. Results do not change if users only are included in the analysis; only the averages increase.



The three year FACT subset includes only eight individuals who used sobering services. In the first post year only three individuals increased their utilization, one decreased, and four had no change. In this small subset, a very few individuals can cause very large fluctuations in utilization.

It is interesting to note that in other housing programs large declines in use of sobering services are usually seen in the first year. Use of sobering services by the FACT group in the first year post initial housing placement is virtually identical to the results shown here for the first year in the community.

Harborview Medical Center Emergency Department

Use of Harborview Medical Center Emergency Department (HMCED) services was examined before and after FACT participation. Harborview Medical Center (HMC) is located very close to downtown Seattle and is an important provider of services to the population targeted by FACT. It should be noted that HMC is not the only provider of services for this population. Changes in utilization of this facility may or may not reflect an overall pattern of all emergency department (ED) services.

In the year prior to FACT enrollment, participants visited the HMCED 180 times, an average of 3.5 visits per person. Thirteen (7.2%) of these visits resulted in an admission and 80 (44%) visits had a primary diagnosis related to mental illness or substance use. In the first post-FACT year the number of HMCED visits dropped to 66, an average of 1.3 visits per person. This decline was

statistically significant (p=.001). Three of these ED visits (4.5 %) led to an inpatient admission and 29 (43.9%) had a primary diagnosis related to mental illness or substance use.

Average MHCED Visits One and Two Year Subsets		One Year Pre-	One Year Post-	Two Years Post-
FACT One Year Subset (N=51)				
	Average	3.53	1.29	
	%Change		-63%**	
FACT Two Year Subset (N=42)				
	Average	3.19	1.38	1.19
	%Change		-57%**	-14%
RCG (N=124)				
	Average	2.66	2.21	1.40
	%Change		-17%	-37%**
RRCG (N=100)				
	Average	3.00	2.57	1.65
	%Change		-14%	-36%*
XRCG (N=24)				
	Average	1.25	0.71	0.38
	%Change		-43%	-46%
NEG (N=81)				
	Average	3.26	1.60	1.20
	%Change		-51%**	-25%

* Statistically significant (p < .05)

**Statistically significant (p < .01)

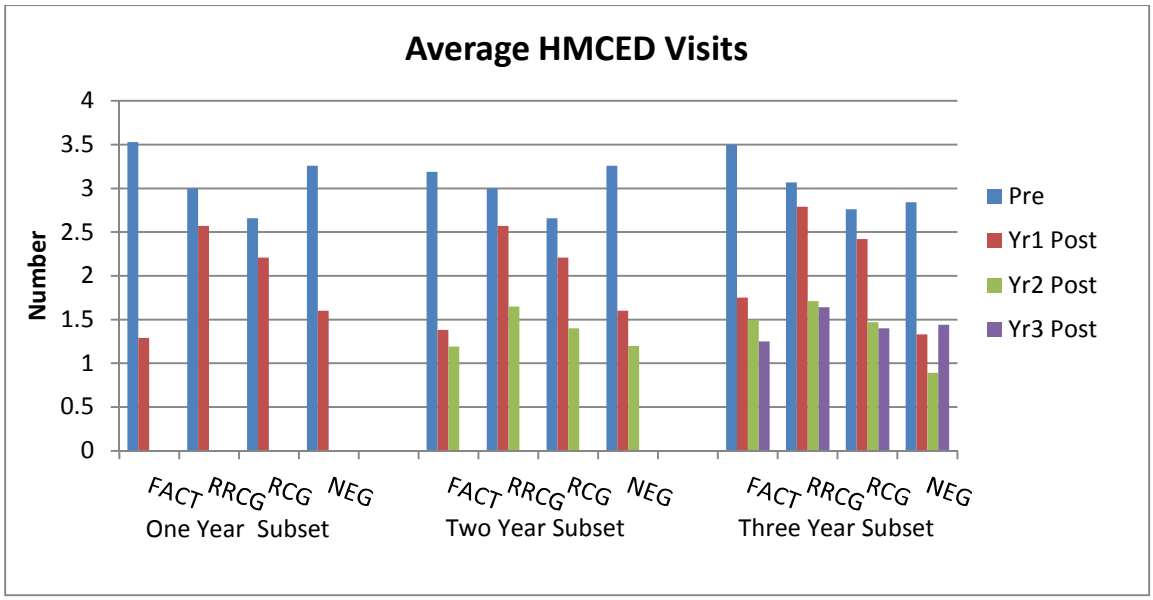
The subset tracked for two years post-FACT (N=42) had 134 HMCED visits in the pre-FACT year, dropping to 58 in the first post year and to 50 in the second. The average in the pre year was 3.2 visits dropping to 1.4 in the first post year and to 1.2 in the second post year. The decline from the pre to first post-FACT year was significant (p=.005) while the small decline in the second post year was not. In the pre year, 55 visits (41%) had a primary diagnosis related to mental illness or substance use dropping to 23 (40%) in post year one and to 12 (24%) in year two.

The three year subset (N=20) had 70 HMCED visits prior to FACT, an average of 3.5 per participant. This dropped to 35 visits in the first post year, 30 in the second and 25 in the third, averages of 1.8, 1.5, and 1.3 respectively. These declines were non-significant for this small

subset. In the pre-FACT year 33 visits (47%) had a primary diagnosis related to mental illness or substance use. In the first post-FACT year 14 (40%) were related to mental illness or substance use and eight in both the second and third post years (27% and 32% respectively).

Average MHCED Visits Three Year Subset		One Year Pre-	One Year Post-	Two Years Post-	Three Years Post-
FACT (N=20)					
	Average	3.50	1.75	1.50	1.25
	%Change		-50%	-14%	-17%
RCG (N=93)					
	Average	2.76	2.42	1.47	1.40
	%Change		-12%	-39%*	-5%
RRCG (N=76)					
	Average	3.07	2.79	1.71	1.64
	%Change		-9%	-39%*	-4%
XRCG (N=17)					
	Average	1.41	0.76	0.41	0.29
	%Change		-46%	-46%	-29%
NEG (N=61)					
	Average	2.84	1.33	0.89	1.44
	%Change		-53%	-33%*	62%

* Statistically significant ($p < .05$)



Summary

FACT participants and others in this target population have crisis services, sobering services, and emergency room services available to them. Participation in FACT is associated with a reduction in use of crisis services and use of Harborview Medical Center Emergency Department (HMCED).

In the first year FACT participants significantly reduced use of county crisis services and sponsored programs. Continued declines in years two and three were not statistically significant. The comparison groups experienced non-significant declines until the third year when the year three subset of the RRCG also experienced a significant decline.

This population did not experience any statistical changes in use of the Dutch Shisler Service Center. Wide fluctuations in use by a relatively few individuals may be preventing the overall picture from emerging.

Use of HMCED declined for all groups at some point during the study period. FACT participants experienced a significant decline in the first year for the one and two year subsets. Others declines were non-significant. The comparison groups also experienced declines. The second and third year subsets of the RRCG declined significantly in year two. The first/second year subset of the NEG declined significantly in year one and the third year subset declined significantly in year two, but then increased (non-significantly) in year three.

Qualitative Evaluation

Qualitative Evaluation Overview

The purpose of the FACT qualitative evaluation is to be able to explain the "how" and the "why" behind the outcomes. Our intent is to identify programmatic and structural factors that contributed to or impeded program success and to identify factors that might be predictive of individual success. We examine how adding a forensic component changes an ACT program, and explore what elements would be critical if someone wanted to replicate the program model.

The qualitative evaluation included interviews with 11 program staff members, 16 stakeholders that included court personnel, jail personnel, probation officers, county staff, and housing providers. Interviews were also conducted with 10 FACT clients, and with three members of the FACT comparison group. FACT clients interviewed had been housed for a range of three months to three and-a-half years. All interviewees provided consent to be interviewed and clients and comparison group members were assessed for competency to consent using the McClelland model. Chart review data, as well as a time study, contributed to information on how much time staff spent on criminal justice activity vs. traditional mental health support.

It is worth noting that the program itself has taken some time to stabilize. Since the program was implemented in 2008, there have been four different team leads and only two original staff members remain. The program has added staffing roles, like a part-time boundary spanner in year four, to work between the criminal justice system and other systems.

Key Qualitative Findings

- Despite differing system cultures and goals, FACT successfully bridges the judicial, detention, and treatment systems. Through provision of 24/7 crisis intervention and support services in client homes, in jail, at the agency, and on the street, FACT increases continuity of care, expands housing options, and reduces client institutionalization.
- Many FACT clients need extensive assistance learning how to appropriately use housing (e.g. toileting hygiene, food/garbage management, safety, neighbor relations, etc.) and often need to be re-housed multiple times before they are successfully stabilized.
- Stable housing contributes to reduced incarceration, improved quality of life, and the ability of clients to begin to focus on recovery. Overall, clients greatly valued housing.

- Clients' ability to engage with staff, take their medications, and avoid drug use predict their ability to be successful.
- Building upon the existing program foundation with better fidelity to the ACT model will likely continue to improve outcomes and quality of life for participants and open up the program to others who need this level of service.

Program Perception

Interviews with clients, staff, and stakeholders demonstrated significant consistency of perceptions. Overall, people felt the program made an important difference, contributing to reductions in re-incarceration and increases in client stabilization. Factors identified by multiple outside stakeholders that contributed to program success included the program's ability to: accompany clients or speak on their behalf at court; provide daily home visits and medication delivery/monitoring; serve as representative payees; provide assistance when needed after hours and weekends; provide housing; provide continuity of care when clients were incarcerated, including provision of medication and holding someone's housing for them; and to build relationships with and engage clients.

"…The program collaborates with the providers in jail so that medication gets continued while they are there; this is the big thing, and they remain a FACT client while they are in jail. When they come out they haven't lost their benefits; they haven't lost their services, they don't have to step back in to see their prescriber and start their medication all again…"

"…To provide services, housing and medication being a huge component. Another that is very important is reporting to court. If they can come and tell the court what the treatment looks like, then everyone in criminal justice will feel better about the placement…"

"A good case manager is number one; someone who is able to engage a person and gain their trust is huge….."

FACT staff reported that program components they felt were essential to success were: having good relationships and good communication with housing providers, the psychiatric hospitals and with the criminal justice system, including the courts, jail, and probation; having sufficient staffing to be able to do outreach to find clients and to visit clients at home; having a nurse on staff; and staff who were committed to serving this population, willing to do the engagement work, and who believed in the possibility of their clients' success.

Nearly all FACT clients interviewed indicated FACT staff valued them and helped them create better lives. The most common way they identified being helped by FACT was through the

provision of housing. Others identified staff as helping with keeping appointments, goal setting, remaining focused, taking medication, stabilization, staying out of jail, becoming a better person, and focusing on recovery.

"…They have changed my life, made me realize that I am worthy. They have helped me nurture my talents…."

"They picked me up when I was in my depression and they helped me stabilize. They put me in housing. They helped me to kind of not die out there, because I was actually dying. They reinstated me when I had made poor decisions; they nourished me. They loved me. They allowed me to come here. They strengthened my independence. They were flexible enough to feed me the food that I really need."

A few FACT clients felt that the program was overly intrusive. A couple of people complained about FACT staff coming to their homes every day to deliver medication; a couple didn't like housing rules and one client complained about being questioned regularly about his alcohol use. FACT clients have case managers serve as rep payees and a few clients did not like that they didn't have control of their money.

"Just don't be bugging me every day and every week. They bring me meds every day and I don't really want their meds. I don't have any problem with alcohol or drugs or anything or mental problem. They called me and asked me if I want them to be my payee and now they have taken control of me. I have been in the system for over a year and I still can't get my money so that I can do what I want, I want to travel out of the country."

Challenges Serving a Recidivist Population Who Struggle with Mental Illness and Chronic Homelessness

External stakeholders and FACT staff both identified continuity of care as a challenge for this population, as incarceration frequently disrupts access to benefits, services, and medical care, including medication. Then they need to start all over again when released. A number of program staff spoke to the inordinate amount of time they sometimes had to spend finding people, particularly after jail release. One stakeholder spoke of this as "*disrupting the momentum of care."* When clients are released from jail without FACT staff being informed ahead of time, it can take significant time for the FACT staff to be able to track the client down again.

"In terms of the frequently incarcerated individuals, the challenges are maintaining their benefits and maintaining their treatment. It is often the case that we have somebody who goes to jail and they are in jail for a length of time. They lose their benefits, and they are exited from treatment. Now, when they come from jail they have no

medication, they have no medical coupon, they cannot get medication until they see a prescriber, which is two months away…"

"..The main problem I see … is just instability. It is hard to develop a therapeutic relationship when they are bouncing from jail, hospital and then into the community… just that, going from place to place, there must be a lot of coordination working with different agencies…"

This disruption can contribute to the clients' mental disorganization, particularly when medications are interrupted. This makes it less likely they will be able to show up for scheduled appointments, be they with medical providers, probation or the court. Their behavior may not be predictable. Initially, many are not especially interested in receiving services.

"When someone has a chronic mental illness they frequently are not predictable and regular in their behaviors …… for example, if they don't show up to report to me one day is that a willful violation or is that just somebody who is disorganized and doesn't realize it's Tuesday or whatever day they are supposed to report…… I don't want to punish somebody for being mentally ill. If the reason for the trouble we are having is their mental illness, then I would like not to punish them for that, rather to come up with other ways to address their behavior…"

Missed court or probation appointments are one of the main reasons clients are violated and returned to jail.

"…Clients have pretty poor memories; it is difficult for them to remember time and places, hence getting to court can be most difficult…"

The second most common reason is drug use, followed by other misdemeanor types of activities. When asked about what was going on at the time of their last arrest, seven of the 10 clients interviewed indicated that they had been using drugs and/or alcohol at the time. Four specifically mentioned being on the streets and dealing with the stresses of homelessness. Four clients identified drugs or drunkenness as a factor that made it difficult to stay out of jail.

"I was using drugs, I was homeless, I was getting into fights with people, and I was getting drunk."

Housing

Finding appropriate housing for this population can also be a challenge. When asked about the greatest difficulties serving this population, one staff person said:

"…finding appropriate housing for individuals with no income and long criminal history and poor rental history and poor behavior habits like eviction notice…"

Criminal convictions close off many housing options for individuals. Add the stigma of mental illness, multiple prior evictions, poor tenant skills, and poor social skills, and it is easy to see how housing options would be limited. Another problem is that people sometimes burn through the limited options that do exist, through repeated rule violations, drug use, poor care of their apartments, or assaultive behavior. Even when housing can be found, there may be additional barriers to overcome, such as the person not having a valid photo ID. This is a more complex problem than one might think. Multiple staff spoke to the difficulties of helping individuals who didn't have ID and the complexities of documenting who they are under current Homeland Security rules.

Another difficulty is finding housing that is appropriate. As individuals enrolled in FACT generally have little to no income, coupled with poor tenancy and criminal histories, it is not surprising that much of the housing available to them is in neighborhoods where drug use, prostitution, and other crime is common. Being in these environments create hurdles for individuals who are trying to turn their lives around.

"…They wanted me to move back downtown….. in my drug using block and my crime using block ….. I thought it was unsound mental health to move me back to my drug zone and my crime zone."

One issue that the program has had to grapple with is "housing readiness," which is essentially an amalgam of the individual's desire to live in housing, combined with their understanding of and ability to follow through on basic skills most individuals take for granted, such as keeping an apartment sanitary.

"Some people don't want to be housed and sometimes some people don't know what to do when housed. They literally don't know that when you leave food, open containers of cooked food, things will happen to it. There will be molds that are going to be attracted to it, roaches, and it needs to be thrown away. Sometimes we think that once we get them in the apartment things will be fine on some level, but the tiny micro steps of education has to take place. That education is a constant thing; it's not just that you tell somebody once, but a chain of every single day for a year on how to manage a living space…"

"Sometimes we're pulling the residential managers over and saying this person is not yelling at you because they don't like you; they are yelling at you because they got a lot whole of voices in their head. They are much louder than yours, and (the person is) just trying to communicate with you."

"You see she has an image of home in her mind that she is ready to create. Not everybody has that. It seems, if somebody has that and then they get housing, even if they have been homeless for a long time, there is a sense like I can relax, I can rest, I can recuperate. I can sleep in a safe environment and now I am ready to go out and make appointments that I need to make, take showers on a daily basis and I can kind of attack

the world rather than the world attacking me. So I think definitely having a safe harbor prepares our clients for the day."

While a number of staff stated that, *"any client who is homeless"* is ready for housing, others identified those were, *"tired of living on the streets," "tired and just ready to relax," or "old and tired,"* as those who were most ready for housing. Most felt it was hard to predict who would do well, but that a willingness to engage with staff was usually a positive sign.

"There is an assumption that the people in our program, that they don't want to be homeless; they don't want to be in jail; they don't want to be in the hospital. But at times our clients look at those situations and say, you know what? Actually, I know how to manage being homeless better than I know how to be in an apartment, or I know how to feel safe in jail better than in the community."

The amount of engagement necessary to get some clients interested in housing and willing to stay in an apartment was surprising to some at the outset. This is by and large a distrustful population. The capacity to build that trust over time is one of the strengths of the program.

"One of the most difficult challenges is trying to engage them, making them understand that you are here to help them that they can trust you. You are here to develop a relationship with them and you will be there when they need help."

"It is a population that is not used to trusting people. They are very suspicious of people in places of authority and it is hard to engage them at the very basic level. It is because of their mental illness and their trauma histories. They have been rejected by their families. They have been abused by their fellow drug dealers in communities. They have a lot of paranoia. They have been let down by social services. They have spent most of their time on the streets. They have been stolen from. They have been treated as criminals. Hence, it is very hard for them to believe there is something you can do for them."

In order to tease out how FACT clients felt about different living options we offered client interviewees a series of forced choice options between two alternatives for spending the night. Seven out of the ten would prefer an apartment over all other options. One individual preferred the Sobering (sleep off) Center, one preferred a motel and the third preferred jail to an apartment. All found an apartment preferable to being outside or in a shelter. All found a motel preferable to a shelter or being outside and all preferred the Sobering Center over jail. A couple of individuals preferred jail to being in a shelter or outside. They were pretty evenly mixed between preferring the Sobering Center to being outside or vice versa.

Housing Benefits

Despite the difficulties of initially engaging individuals around housing, finding appropriate housing options, and teaching people without home maintenance skills how to live independently, housing was perceived as making an extraordinary difference for participants by everyone we spoke with.

Stakeholders spoke to noticing reduced incarcerations, the ability to address other issues, increased motivation to stay out of jail, and improved treatment compliance when participants were housed. Staff spoke to stability, increased medication compliance, ease of finding clients and helping them to meet their obligations and appointments, reductions in jail time, and improved physical and emotional health when clients were housed. Participants spoke to peace of mind, privacy, freedom, safety, and self-worth. All clients and comparison group members interviewed unanimously endorsed having their own place as very important to them.

"Ooh, no. There is nothing bad like the streets, bro'. I have been through it for real. It is better to be inside than to be on the streets. When you are out there on the streets you do what the streets requires, and the streets requires drinking, drugs, stealing and a whole lot of different things. There is nothing that will make me want to leave (sober housing). You leave in the morning and come back in the evening."

"When they are housed, at least for us, it seems like the amount of time they spend in jail is less. So, more opportunities to focus on long term solutions. When not in housing their focus is on their immediate needs- where am I going to sleep, what am I going to eat? With housing, it takes away this anxiety; it allows treatment to take place."

"They are much more likely to comply with treatment and court orders. They are much more likely to comply with medication."

"…Then they can start relaxing. They don't have to worry about their safety as much and you can see that. And then they do start engaging more and that is a great way for us to keep them engaged…... It makes everything easier if we find them a house, because if they are homeless they have to come here for medications. We can't go to find them and we know where they are and we know where they should be. A lot of them are so much happier to have a house which makes a big difference to working with us."

"You are guaranteed enough sleep, rest every night. It is better than being outside worrying about someone flipping."

"I have a place that is secure for me and my children, for my grandchildren to come by. I have a place that I can put my money on my dresser without worrying about my money being gone. I can have serenity by having peace so I can pray to my God without offending anyone or anyone interrupting me. I can take a shower or walk around naked

or I can have my girlfriend come over and walk around naked. I can know my food will be in the refrigerator if I put it in the refrigerator and come back home to eat."

"…the sense that I am not a homeless person anymore. I am in a place with an apartment or a house, and that somehow gives me greater value in society than when I was marginalized as a homeless person."

Housing Difficulties

A number of staff and stakeholders identified two general trajectories for people once housed. Some, once they are housed, are able to work toward stabilization. Others use their homes as safe places to increase their drinking and drug use. As FACT uses a harm reduction model, participants do not have to be sober, in treatment, or accessing other services to live in FACT supported housing.

In either case, staff frequently have to intervene and spend a lot of time helping residents learn how to live appropriately within their apartments, get along with neighbors, and follow rules. Some clients show little capacity for being able to do this, and as previously mentioned, burn through the limited housing options that do exist. A number of staff expressed a desire for more time to assist clients with developing basic skills, such as shopping at the grocery store.

Some clients, once housed, resist engagement and attempt to avoid FACT staff and refuse to open their doors. Four of the 10 clients interviewed indicated that they did not like the restrictiveness of some of the housing rules and wanted more privacy and independence. Four others indicated there was nothing hard about staying in housing. One identified his own drug use in the apartment as putting his housing at risk. Four identified challenges with keeping their apartments clean or taking care of basic necessities and four identified paying rent or money management as being difficult. Two identified their case managers as helpful to them in keeping their housing.

"There are some people in FACT you get into housing and they start working on their mental health symptoms. They take medication. They want to go to treatment. They want to do therapy and they go to their groups and they want to address their chemical dependence issues. I am thinking of one person who is staying clean and sober, he went to a local community college and then he ended up moving into his own apartment through one of our vouchers… and he is just doing very well. We have other people who get into housing and they don't want to talk to us. I have housing. I don't need meds. I don't need to talk to you. I don't need your services. Go away. And then we have other people we get into housing and they lose it. We get them some new housing and they lose it. We get some new housing and they lose it."

"Usually those guys or girls (unsuccessful in housing), usually they go back to drugs and alcohol. Usually they break some of the house rules, and usually they go from one tier of housing to another to another and they don't see that they're going downhill with each one. So there's a little bit of just not comprehending that the behaviors are gonna get them moved to a place that's not so nice. Along the lines of not understanding that they are slipping, there's in addition to drugs and alcohol, the honesty factor kind of gets thrown out the window and they begin to not trust being able to tell us that they want to use more than they are using. I guess not understanding the need for the program to have them stop using or to use less or to manage it, and then having them, at that point, not continuing to be honest with us about what they really want."

"You can't have overnight visitors. You can't have women visit. Your children can't visit and even if someone wants to visit, they have to check up with the case managers. I have been losing women because of these rules."

"And they want to check and see if you are drinking alcohol…., and they have a problem. They are always asking if you are drinking. I am retired from…… and I am old enough I can drink beer when I want once in a while. I am not in a program where alcohol is forbidden. It irritates a person if they keep coming and ask everyday if you are drinking beer or not. It is irritating. It is none of their business. I have a room and I should have privacy to be able to do what I want to do in my apartment. And they tell you you have to answer the door if they come by or anything. But they keep asking you if you are drinking or not. There is no reason I shouldn't get beer when I want. I don't get drunk or anything."

"When you have some place to live, because they can have some more things, oftentimes they begin to care more about going to jail. I have also seen some people get into housing and then they have a nice warm comfortable place to drink and smoke crack. I have seen both."

Recidivism

A large number of individuals interviewed, including staff, stakeholders, and clients indicated that just being off the streets reduces the likelihood of being arrested. Many staff and stakeholders identified mental illness symptoms, lack of cognitive ability to understand the connection between their actions and the results, poor impulse control, anger, drug use, housing instability and a refusal to engage as primary factors contributing to these individuals winding up arrested and incarcerated. When asked to describe individuals who had difficulty staying out of jail, one key informant said:

Someone whose mental health has decompensated; they are responding maybe to internal stimuli, voices, auditory hallucinations, that maybe are creating paranoia for them. They feel they need to go out and protect themselves. Someone who is actively using- chemical dependency. When you are intoxicated, you are more likely to go out there and do something stupid. Someone who is homeless. They are out on the streets. They are hungry. They want to get their needs met so they go and steal something from a store, whether it is to sell it to go to get money to buy food or it is food or they are doing that to support their addiction that they're engaging in to cope with being on the streets.. I think those are the main three things that really make it more likely for them to stay in jail. Because they are visible; if you are on the corner and you are homeless, you look dirty. You are using drugs so you have behaviors when intoxicated and you have increased mental illness. Police are gonna see you, so if you're doing stuff you aren't supposed to be doing, even if you are just in a parking lot and you're not supposed to be there, you will be arrested for trespass.

One client identified the lack of having a place to get mail while homeless as contributing to incarceration, simply because he couldn't receive communications informing him when he was expected to appear where. As previously indicated, missed appointments, seen as non-compliance with court orders, are one of the most common reasons individuals are violated and re-incarcerated.

"The biggest problem people have with the judge system is that they don't have a mailing address, so when they put out a warrant for your arrest, you have no way of knowing about it. They need to offer people that are homeless a mailing address so that you can receive information from the court system. People that are homeless don't have mail so they don't know anything until they are stopped for their ID and they find themselves back in jail."

A few stakeholders indicated that they thought some clients preferred jail to the streets or to being responsible for themselves. Some lamented that circumstances were such that jail was a better alternative for some individuals. While most clients had never deliberately been arrested, two interviewees had, one of them on multiple occasions. The first tried to get himself incarcerated because it was "freezing to dead" outside. While four client interviewees said there was nothing good about jail, other interviewees identified jail as a place they could reflect and regroup, meet God, learn lessons, and relax after being on the streets.

"You get a chance to regain your mind. You think about certain things. You try to maintain your own stability. You got to really focus yourself again and reconstruct some of what you did. You got to evolve again. You got to catch up with your morality."

"I was looking for housing, rest and sleep."

"For some clients, jail is surprisingly a comfortable place for them. They see jail as a safe place to be. They have some structure. There are people they will feel comfortable with."

"Some folks do not have anything in the community, so they find their greatest stability when they are incarcerated. That is just not right. We shouldn't have people doing better in jail than they are doing out in the community, but unfortunately that is the case sometimes."

Philosophical Culture Clash Between FACT and Criminal Justice Systems

While those we spoke with in the criminal justice system lauded the benefits of FACT and other programs geared towards helping offenders with mental illness, there are striking differences in culture and expectations that can make it difficult to harmonize the two systems. FACT applies a harm reduction model, which includes acceptance of where an individual is now, and continual attempts to engage the individual and reinforce small steps toward recovery. It is a therapeutic approach. The criminal justice system has rules. From their vantage point, you have either obeyed the rules, e.g. shown up for court or probation, not engaged in an illegal activity, or you have not obeyed the rules. For the most part, it is a punitive system where you get punished for rule violations. Overall, FACT staff wished that the courts would see imperfect progress as good, and display more flexibility. Some criminal justice stakeholders lamented that the FACT harm reduction model does not reinforce zero tolerance for use, which is their standard. Staff and stakeholders noted that this culture clash created challenges for them as system reinforcers, and for clients.

"…because the FACT program is client centered and I think its goal and its sort of philosophy is it meets the clients where they are at. But the court has expectations, and the expectations of a client who is extremely alcoholic, he is going to be put in a fairly structured chemical dependency treatment program. But the FACT program approaches it from the angle, well, the client is willing to do this and this is what we will do for the client. Those two philosophies are definitely different, so I don't know the resolution for that. I tried to ask the FACT program to amend the treatment plan for this client but they just made recommendations of what they thought was appropriate and I just don't agree with that. At the same time, the client likes being in the program. He feels well supported; he feels well connected to his counselors there and so that is a good thing. From a clinical perspective, they are doing good work. It's only the way they interface with the criminal justice- I think there are problems there because I don't think they are doing what the court expects them to do."

"I think the court just needs to be aware about meeting people where they are and realizing that success is not going to be perfect compliance from day one, but that instead, small steps. Like if someone has not been taking medications, or is taking them

three days a week, recognizing that and encouraging that as success, rather than looking at that as non-compliant and a failure."

"The FACT clients need probably patience and understanding from the court, because the court is used to, if you are non-compliant there must be a punishment."

"My understanding is that the FACT program is harm reduction; it is challenging to the probation officers. We work in line with the court promoting no use."

"My interaction with the FACT team has been very positive. I think it should be a zero use program. On the probation stand point."

"I think that we come from the IDDT model where we say we will meet somebody where they are at in terms of their desire to reduce the substance use, but courts do not look at it that way. They say you must be abstinent now, today, but when you use again you will go to jail. But that is like saying that I will take away all the coping skills you have learned in order to manage trauma symptoms, to manage being homeless, and to live on the streets and I will not give you anything to replace that. That is why abstinence, to me, doesn't work. Another one is commit no future violations. I don't think that our clients commit criminal violations because they have no regard for law. I think they have behavioral problems that are tied to their mental health symptoms.

This philosophical divergence is apparently not unusual[1] . The standard ACT model supports the King County FACT team's approach. However, the cited review of FACT programs suggests that applying legal leverage may be useful in achieving treatment compliance. It also suggests that this difference in philosophy be approached in a collaborative problem solving manner rather than punitively.

FACT in King County is reducing criminal justice system involvement for its participants, and therapeutic limit setting in the form of legal leverage is being used to some degree. It may be useful to examine where and how consistently legal leverage is currently used, how effective it is, and identify situations where it may be used more strongly. Unfortunately, robust evaluations of FACT programs applying legal leverage are not available. Without this information, it is impossible to estimate how much more reductions in criminal justice system use could be expected or what the potential negative consequences might occur if legal leverage were emphasized.

[1] Reentry Planning for Offenders with Mental Disorders: Policy and Practice; Dlugacz, Henry A., M.S.W, J.D., editor; Chapter 7: Forensic Assertive Community Treatment: Origins, Current Practice, and Future Directions; Lamberti, J. Steven, M.D., and Weisman, Robert L., D.O.; Civic Research Institute, Kingston, NJ, 2010

FACT vs. ACT

What differentiates FACT from ACT is the forensic focus. The primary aim of the FACT program is to reduce jail use, as opposed to a traditional ACT program where the focus is more likely to be on reducing psychiatric hospitalizations. While ACT is geared primarily toward Axis I disorders, it appears that many individuals in FACT have co-occurring substance use disorders, and some have co-occurring Axis II disorders as well. The need for substance abuse intervention appeared greater than you would see in a non-forensic ACT program. We were unable to obtain detailed diagnostic information that would have allowed us to identify and control for anyone who may, subsequent to admission, have been identified with a primary diagnosis of chemical dependency or Axis II, to see how outcomes may have been affected.

Specific forensic program components that have been added over time to the model include introduction of Moral Reconation Therapy (MRT), an evidence-based program geared toward reducing recidivism; a Boundary Spanner to act as a bridge between the criminal justice and the mental health systems and who acts as a liaison to the courts; strong coordination with probation; and a focus on chemical dependency. The forensic component requires that staff be knowledgeable about the criminal justice system as well as about providing mental health services. They need to develop relationships with court, probation, and law enforcement staff and negotiate a culture that is philosophically different from the treatment philosophy employed by FACT. The staff does their best to take responsibility for assuring that clients are aware of their obligations to report to court, probation, or elsewhere, and to assist them with showing up. Staff often accompany individuals to court and frequently incorporate forensic-related work into their daily interactions. They also visit clients in jail, which can also be a time-consuming process.

"Jail and court is extremely time-consuming. One of our case managers can go to court and they can sit there all day long. That's definitely a time sink and a challenge. When you're sitting in court you're not engaging with patients; you're not taking care of patients. So, just the sheer amount of time that some of the case managers have to sit around in court is a problem….Certainly, the forensic piece is huge. That extra time that it requires to go to court, to engage with the parole officer, the probation officer, engage with public defenders, to keep track of their court requirements, definitely makes it a step harder than a typical ACT team.

We have to be more mindful of safety, quite frankly. And we have to be more mindful of keeping the community safe, too. We always have to have that in the back of our heads as our client base presents a threat to the community. Are we safe when we visit our clients? It adds a level of complication, definitely."

Evaluation staff conducted a random moment time study to try to estimate the amount of time the team spent doing forensic related activities. This time study estimated that forensic tasks occupied approximately 14 percent of staffs' time. The amount of time observed varied among staff selected for observation. One staff spent only four percent of their time on forensic tasks while another spent 20 percent. The variation is probably wider than what was observed since staff have been known to spend most of a day in court. Also, it is likely that staff spend more time on forensic related activities for new participants who are entering the program through the justice system, than for individuals who are well established within the program.

In order to maximize staff safety, staff always go out in pairs to do outreach or home visits. This has budgetary and staffing implications and affects how much time workers have to attend to their clients' needs. Indeed, not having enough time to get their work done was the most frequently cited challenge identified by staff.

While staff saw the program structure as contributing to their ability to advocate within the criminal justice system, a few staff noted that the criminal justice component of the program impacts the therapeutic relationship.

"One of the barriers is when you approach someone who starts out in jail, it is hard to gain their trust; they are not sure if you are out to help them or you are going to be just another parole or probation officer- if you're just going to be someone who is going to be reporting on them and putting requirements on them. One of the things we need to do when we engage clients in jail is to convince them that really we are a treatment team- that we are there for them. This is a chance for them to get their needs met. This is not something else they need to do to stay out of jail. This is something we need to be mindful of."

"Sometimes our clients have a hard time being honest with us about their continued drug use even though we tell them we are a harm reduction program and you can still be in our program if you use drugs. But they are afraid to be honest with us because they know that the courts, we work together. So we might say, if they tell me… oh yes, I used cocaine last night, they might be afraid maybe the courts, the probation officer, or DOC might find out because they told me, so they're not as maybe honest with our team as they would be."

Success Factors

There are specific program components that contribute to its overall success. There are also individual motivational and behavioral factors that appear to be indicative of a client headed either toward success or a downward spiral.

Key FACT program elements identified by external stakeholders as essential include:

- Seeing people in jail and providing continuity of care
- Delivering medications to jail
- Assistance transitioning between jail and the community
- Providing housing
- Holding an individual's housing for them while incarcerated
- Staff ability to serve as a go-between with the legal system
- Reliability coming to court
- Daily client contact
- Daily delivery and observation of medications
- Case managers serving as representative payees for their clients
- 24/7 availability for crisis intervention
- Having consumers on the team

"What is great about FACT is that they meet people where they are at the level they are, which is very often at a point where they are unable to get themselves into treatment. When FACT gets involved it's nice because usually the case manager will show up in court and we have got a boundary spanner that we can communicate with, so that increases our ability to communicate with our clients. And it also gives the court some comfort in knowing that a person is being closely followed and closely monitored and having their needs met. And that allows us to get more people out of custody and put more people on probation who may not be as high functioning as other probationers. And all that leads to more successful outcomes."

Key FACT program elements identified by staff include:

- Forging good partnerships with the courts, jail, housing, probation, and hospitals
- Staff who want to work with the population and who believe in their possibility of hope and change
- Integrated Dual Disorders Treatment model (IDDT), evidence-based treatment for co-occurring mental illness and chemical dependency
- Ability to do *on-going* outreach and engagement work with clients and establish trust
- Outreach to courts and jails
- Adequately staffed housing
- Ability to guarantee landlords the program will cover any damages created by clients
- 24/7 availability for crises and significant problems
- Working in pairs and other safety protocols
- Medical personnel (nurse, part-time psychiatrist) on team
- Small caseloads

" … Again, the ACT manual strongly encourages you to transport people alone, to go into homes alone. We do not do that. We are in teams. We have added that a lot of

outreach takes place in the jail; a lot of outreach takes place in the courts. The FACT team has done wonders. We have developed partnerships with the jails, with the courts, with probation officers, with CCOs, which is necessary in order to do this. We have these partnerships, so especially if someone is on probation with the court or with the Department of Corrections, they don't just go out and arrest them. They talk to us first. We set up a plan together. We enact it together, so we can keep them out of jail. While this might be something that ACT teams do every once in a while, this is something we do every day….. In addition, I would say with housing, I feel like we have to work a little bit harder to find people who are willing to rent to us. So that developing these relationships, giving these extra assurances that we will be there if something goes wrong, that we will be there to support the manager- that we will intervene. I feel like we have to do a little bit more because of the criminal histories."

"What contributes to a client's ability to engage and remain engaged in treatment, I think, is trusting our team- feeling that we are on their side. We are here to help them succeed. Our purpose is not to help the courts. Our purpose is to help them. It takes some time. Sometimes it takes a long time. We have clients who have been in the program for a year, and maybe we may just see them a couple of times, but then we keep showing up every time they get arrested. And so they kind of get used to us and realize that we are trying to help them. We're not just here; we keep showing up, even though they don't show up for us. When they go back to jail, the case managers go to the jail and visit them. They can see that even though they're not changing their behavior, we keep trying to engage them."

"Having a nurse available everyday is huge. We love it and every other program is jealous of this."

Staff generally endorsed that it was very difficult to predict who would ultimately do well in the program, as engagement is often a very long process and change is often in slow baby steps. Yet, after a long time, some people do turn around. For many clients, the housing is the primary hook of the program and they are not at all interested in treatment. Staff have reported that some clients are still "pre-contemplative" about change even after being in the program for four years.

Despite lack of long-term predictability, there were indicators that were consistently identified by both staff and stakeholders of individuals who were on a path to success and those were likely on a path to return to homelessness or jail. External stakeholders nearly universally identified drug and alcohol use as the primary driver of client failure to succeed, followed by refusing medications and living on the street as the next most likely drivers of failure. Conversely, not using drugs or alcohol and a willingness and ability to develop relationships with program staff were the most commonly cited characteristics of someone who would experience success. FACT staff were most likely to cite client stability, as evidenced by the ability to maintain their housing and daily adherence to medication, followed by having a goal and being

willing to change, as indicators someone would be able to successfully stay out of jail. Willingness to trust and being honest were also cited by staff as indicators that a client would continue to do well. The most common indicator mentioned by staff that someone was likely to be headed back to jail was drug use. This was followed about equally with being off medications, being unwilling to engage, and having unstable or no housing. Clients themselves, when asked, "What makes it difficult to stay out of jail," most frequently identified drinking and drugs. Other difficulties they cited included their tempers (fighting), being around the wrong people, poor decision-making, lifestyle associated with not having a home (including no mailing address), and probation requirements.

Positive Client Indicators	Negative Client Indicators
• Staying sober/limited drug use • Relationships with team members • Trust/Honesty • Tired of streets or jail • Motivated to make changes in their lives • Not living in a high drug area • Housing stability • Taking care of apartment- keeping it clean • Paying rent • Asking for help • Taking prescribed medications • Compliant with treatment plan • Reduced criminal activity • Able to identify goals • Fewer incarcerations	• Increased use of drugs/alcohol • On street/Stealing to meet survival needs • Refusing prescribed medications • Decompensating/Mentally disorganized • Distrustful/Unwilling to engage • Discount later consequence of jail for experience in the moment • Poor impulse control • Engaging in criminal activities • Inability to follow rules • Dislike authority • Isolating/Unwilling to engage • Aggressive/Getting into fights • Frequent ER use • Poor comprehension of consequences of their actions • Spending large quantities of time institutionalized

"When we get to develop a rapport with the client as an equal exchange where we are honest with them about their assessments, where they are at and what they need to do, and they can be honest with us about how much their chemical dependence is affecting them and where they are at with that, I think that honesty, that level of exchange is a good predictor that a client would do well."

Program Challenges

The combination of extensive paperwork requirements, time spent in court, time spent in jail, time tracking clients down, time traveling to client residences scattered throughout the county, and the need to work in pairs, all contribute to constraints on time that staff would like to have available to devote to other things. Time was the most frequently cited challenge by FACT staff, with half of them speaking to time management or time pressure challenges. Things they would like to have more time for included taking clients shopping (cited by half), engaging clients in fun or recreational activities, assisting clients with benefit applications, taking clients to medical appointments, and engaging clients who are more on the periphery. A few staff noted that if the housing options were less spread out it would increase efficiency as they could spend less time travelling *between* clients and spend more time *with t*hem.

"I would like to see them housed closer together. We spend a lot of time travelling, going to where the clients are: Burien, Tukwila, their housing is located in different locations within King County. The clients need to be centrally located so that we can have more time with them."

External stakeholders expressed a desire for more communication, for example, case conferences between Mental Health Court and FACT, more meaningful activities for FACT clients to participate in during the day if they weren't in treatment, and more chemical dependency treatment. Staff turnover was also cited as a complicating issue. A few lamented that the program wasn't open to more people, as they wanted to see more individuals benefit from FACT.

"I'm really happy to know there is a program of such caliber out there that wants to engage clients coming from all sorts of places. I know that it is difficult to get my clients into the FACT program. That's one of the challenges. I feel like there are too many requirements and that makes it challenging, because there are so many clients that can benefit from such service. Part of my thinking is, 'why do we have to wait for repeated offenders or repeat hospital visits before we can give them some service?' Why not try to engage them early on, so we can avoid such intense repetition? And, what it does to my clients, they get institutionalized, to know that jail and hospitals are the way to live, instead of saying, no, there are other ways that we can work in the community so you feel more normal and not get institutionalized in hospitals or jails."

Program Recommendations

FACT has achieved several positive outcomes and has earned the respect of their criminal justice and human service partners. It is important, however, to continue to improve on outcomes and provide a structured and supportive environment so the participants can reach their recovery goals.

➢ Improve Fidelity to the ACT Model

Many of the recommendations for improving the FACT program based on these evaluation findings can be summarized under **improve fidelity to the ACT model**. This shouldn't be surprising given that ACT has been demonstrated repeatedly to improve the functioning and community tenure of individuals with serious mental illness who are homeless. The forensic ACT that has been implemented in the King County FACT program is effective in reducing use of the criminal justice system within a year of participating in the program. Further criminal justice reductions and progress toward independent living have been elusive.

Several of the areas for improvement identified in the fidelity reviews correspond to issues identified in the evaluation.

> Chemical Dependency Treatment – The fidelity review team recommended that IDDT be expanded to more FACT participants and that the Chemical Dependency (CD) Specialist increase time spent providing CD specialist services. Drug use was identified as a significant issue throughout the qualitative evaluation. Drug and alcohol use is a factor for FACT participants in recidivism, non-compliance with court requirements, and inability stay housed. Drug and alcohol use is believed to be extensive in FACT. The evaluator attempted to measure drug and alcohol use among FACT participants by collecting data from the required periodic screenings. However this request for data was refused. FACT administrators should direct their attention to this issue and collect data necessary to monitor progress in this area. It is unfortunate that the CD Specialist position has experienced significant turnover and stabilizing this role should be a priority.
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> Person-Centered Individual Treatment Plan - FACT is a program that serves outliers – persons on the extreme edges of jail utilization and community stability. Although similar in forensic background, the FACT population varies dramatically among themselves. Cultural and social differences, varying diagnoses and co-occurring disorders, and differences in life experiences combine so that everyone enters the program in a different place. Many have a history of trauma, but each experience is

unique. Each individual has their own personal goals and vision of where FACT might take them. In many ways, the FACT program is a collective of fifty unique programs. The ACT model handles this diversity via the Person-Centered Individual Treatment Plan. The fidelity review noted that FACT needed improvement in several areas related to these plans. Recommended improvements include using Peer Specialists to bring the voice of recovery to the planning process, center the plan on the client's personal goals, base the client's weekly schedule on the plan, and have the plans drive the team's daily schedule.

Rehabilitative Services – The review team recommended that the Person-Centered Individual Treatment Plans be used to identify which FACT clients needed rehabilitative services. ACT defines rehabilitative services to include functional skills training to enhance independent living, such as activities of daily living (ADL), safety planning, and money management. If FACT were to achieve full fidelity in providing these services, some of the issues identified in the qualitative evaluation would be mitigated. Lack of ADL skills was frequently cited as a problem when housing FACT participants. This problem contributed to safety concerns for all residents of buildings housing FACT clients. Inability to manage rent payments was identified as a factor in housing loss. FACT participants often need to learn budgeting and money management so that rents are paid and food can be bought throughout the month. The FACT team spends significant time performing tasks related to paying client bills and distributing checks. Whenever possible, FACT participants should be transitioned to financial self sufficiency.

Vocational Services – The fidelity review team recommended that the Vocational Specialist increase the proportion of time spent providing vocational services. The Vocational Specialist should conduct vocational assessments for more clients, work on job/training/education development and placement, and follow progress with coaching and support. These activities should be part of the treatment plans and be scheduled on the client's monthly schedule.

Graduation and Exit Strategy – The fidelity review team and the evaluation both found that FACT staff did not know of a process to graduate or exit participants from the program. This was puzzling since a strategy has been in place since 2010. FACT should implement the existing strategy or identify the barriers to its implementation so it can be revised. Appropriate exits will allow new participants access to FACT services.

- **Continue to Work Closely with the Criminal Justice System**

The FACT team collaborates with the courts, jails, prison, and law enforcement to reduce use of the criminal justice system among participants. The evaluation showed that despite some philosophical differences, this collaboration is working well and FACT is viewed as a positive addition to the system. Still, improving this relationship would increase the benefits. All parties should explore the pros and cons of therapeutic limit setting in the form of legal leverage for

appropriate FACT participants. Consider bringing the FACT team to court or bringing court staff to the team for treatment planning meetings about shared clients.

A part-time Boundary Spanner has recently been added to the FACT staff. This person is located in the Seattle Municipal Court House and provides support to FACT clients and coordination between the FACT team and the courts. As this is a relatively new position; it is not yet clear how this role is integrated with the rest of the FACT team. FACT should consider the Boundary Spanner to be an extension of the team into the criminal justice system rather than the liaison to a court. The Boundary Spanner should be more involved with day to day FACT team activities such as team meetings and individual treatment planning. The Boundary Spanner should enhance the flow of information between FACT and the criminal justice system, which would be particularly useful when using legal leverage.

- **Design a Step-Down Strategy**

As FACT participants become more stable and independent in the community their need for the full range of FACT services declines. A strategy should be developed that respects this growing independence, yet has the capacity to provide a safety net should the need arise. Providing step-down support services for FACT participants who may not need FACT level services, but are not yet ready for standard outpatient mental health services alone, may help the transition to self-determination as well as free up capacity in FACT for others who need this intensive level of treatment.

The step-down strategy could also include participants who step away from the program for several months as a result of incarceration or hospitalization. Currently these clients have minimal contact with the FACT team until the time of reentry. Some never return to FACT but are exited after many months of inactive enrollment. The strategy should have standards for FACT outreach during the time away from the program and criteria for returning to the program at reentry from institutionalization.

- **Review FACT Staffing**

FACT staffing meets full fidelity for a 50 consumer ACT team. Given the safety concerns related to this population and the additional criminal justice related tasks that the team must support, this staffing configuration should be examined to see if it is appropriate for a forensic ACT. This review should take place after fidelity has improved. ACT is designed to make most efficient use of staff time. Once FACT is functioning as a high fidelity ACT model, an assessment of what needs are not met and what activities are not able to occur will clearly identify necessary changes to the staff configuration. It is possible that the service needs of this very criminal justice system involved population are not met with a standard ACT staffing model. To ensure

staff safety, the FACT team goes into the community in pairs. The impact of this should be assessed. FACT should determine whether it is always necessary for two staff to attend to a single client whenever they are in the community. There may be opportunities to use existing supports in the community such as housing staff in some situations. The need for safety is real. The challenge is to maximize the services provided while keeping staff safe. This issue could be impacting fidelity. The fidelity review team found that FACT is providing fewer in vivo services than desired.

FACT staff noted the amount of time needed to travel between housing and service locations was impacting time spent with clients. King County is large geographically and traffic can be slow. FACT is already working toward consolidating housing near the Seattle core to mitigate this issue. This solution does restrict where FACT participants live in King County. One of the FACT program funders requires the program to serve clients throughout the county. A balance between serving clients throughout the county and maximizing time directly serving clients should be agreed upon.

- **Access to FACT Services**

FACT capacity is small; only 50 can be served by the program at any time, and the program is limited to those meeting explicit forensic and diagnostic criteria. During the evaluation many expressed frustration at their inability to refer clients to the program. When asked about improving FACT, many suggested changing eligibility criteria to make the program easier to get into.

At this time, MHCADSD is committed to enrolling the highest utilizers of jail with a serious mental illness in this most intensive service. This target population far exceeds the current capacity of FACT. Relaxing eligibility criteria is not recommended.

The process of identifying the target population for FACT disclosed that almost half of the highest users of King County's jails do not meet diagnostic criteria for an ACT model program. The diagnostic criteria for ACT exclude individuals whose primary diagnosis is related to substance abuse or an Axis II personality disorder. These individuals should be assessed to determine what other services, particularly trauma-informed services, would best meet their needs.

- **Housing Broker Role**

The Housing Broker has been very successful in working with landlords and the housing community to overcome barriers to housing this challenging population. While this position is no longer funded by FACT, the agency has continued this role and expanded it to other forensic and difficult to house populations. Perhaps this type of position could overcome barriers in

other areas. The FACT Vocational Specialist could use the housing broker model to improve training and employment opportunities for those with serious mental illness and criminal histories.

- **Staff Retention**

Staff turnover has been considerable and impacts both program and clients. The agency should explore primary factors contributing to turnover and address those that are within their control.

Conclusion

The FACT program has made substantial progress toward its primary objectives of stabilizing participants in the community, promoting recovery, and reducing use of the criminal justice system. Building upon this existing foundation will continue to improve outcomes and quality of life for participants and open up the program to others who need this level of service.

"I think that it's been an amazing program and I hope it gets bigger and more well funded. I know that they've gained the trust of prosecution, defense, the court, and it is huge to have a program that everyone knows works and believes in and trusts in because that makes it a lot easier to get our clients out of jail into those programs. I am very thankful of FACT."