



The Sequential Intercept Model and Forensic Assertive Community Treatment (FACT): Implications for Social Work Practice

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In the United States, adults with serious mental illness are overrepresented in the criminal justice system. The sequential intercept model is a novel framework that identifies three major stages where interventions for this population can best be utilized: pretrial diversion, post-plea alternative to incarceration (ATI), and community reentry from jail and prison. This paper begins with a review of the literature that supports the application of Forensic Assertive Community Treatment (FACT) across these three stages. This paper will also draw on the influences of therapeutic jurisprudence, which holds that the courts can be used to both advance public safety and enhance access to mental health services for justice involved people with serious mental illness. The literature has suggested that individuals receiving FACT services have been found to have lower rates of psychiatric hospitalization and criminal justice recidivism in comparison to those who received traditional mental health services. This paper will touch on cutting edge practices to reduce psychiatric hospitalization and criminal justice recidivism rates among people with mental illness that are currently in use. In particular, programs involving law enforcement integration such as ACT-PI teams, co-response teams, and crisis intervention training will be explored. This paper will focus on applications and limitations of FACT across the various stages of the sequential intercept model, with a particular focus of using FACT as a way to reduce racial and gender disparities within the criminal justice system among people with serious mental illness. In light of the broad support the literature highlights for FACT when applied earlier within the criminal justice system, social work practice efforts should accordingly focus on expansion of early access to FACT services. In particular, criminal justice policy efforts should be expanded with respect to utilization of these services at the pretrial diversion and ATI stages, where they are historically underutilized.

Keywords: Forensic Assertive Community Treatment, Sequential Intercept Model, Mental Illness

INTRODUCTION

In the United States, it was recently estimated that over 2.25 million people across the country were incarcerated in the nation's jails and prisons, with another 4.5 million more estimated to be under community supervision, either through probation or parole (Vera Institute of Justice 2017). These numbers, that represent 20% of the world's prisoners, indicate that the United States incarcerates more people than any other nation in the world (Kinner & Young 2018). Moreover, it has previously been estimated that of those in custody or under criminal justice supervision in the United States, 16 to 24 percent met the criteria for having a serious mental illness (Lamb & Weinberger 2005). More recent studies which account for racial and gender disparities put such figures as high as 35 to 71 percent (Bonfine et al., 2020).

This review will explore whether access to community-based mental health treatment for justice-involved people with histories of serious mental illness, including those incarcerated in jails and prisons as well as those under community supervision via probation or parole, decreases their risk of criminal justice recidivism. To do so, the literature on Forensic Assertive Community Treatment (FACT), a collaborative multidisciplinary treatment model widely considered the highest level of care available in the community for justice-involved people with serious mental illness, will first be critically examined. From here, this paper will discuss applications of FACT across the sequential intercept model (SIM), a criminal justice policy framework rooted in the principles of therapeutic jurisprudence (Munitz & Griffin 2006). The SIM holds that there are six distinct points or "intercepts" within the criminal justice system, where individuals with mental illness can benefit from access to community-based services (DeMatteo et al. 2012). In addition, FACT's research base will be critically examined with respect to three key areas across the SIM: pre-trial diversion, alternative to incarceration, and community reentry. This paper will conclude with recommendations for forensic social work practice, particularly with respect to applications of FACT across all stages of the SIM, rather than concentrating these services in the reentry stage.

FACT: Background and Overview

The FACT model of treatment is based on the Assertive Community Treatment (ACT) model. This treatment paradigm emerged in the 1970s in Wisconsin when deinstitutionalization led to the closure of state hospital beds (Davis et al., 2009). At the time, state mental health officials noticed a dramatic increase in the number of psychiatric readmissions of patients discharged from the state hospitals. In turn, multidisciplinary teams consisting of psychiatrists, social workers, and nursing staff responsible for providing community-based mental health treatment emerged. The ACT model was found to significantly reduce rates of psychiatric hospitalization among people with severe mental illness and was subsequently adopted nationwide (Beach et al., 2013).

The ACT model, while effective in reducing hospitalization rates, was not intended nor designed to serve incarcerated people with serious mental illness (Davis et al., 2009). As deinstitutionalization accelerated across the nation, numerous studies have suggested that people with mental illness were actually more likely to be arrested than hospitalized (Cusack et al., 2010; Tamburello & Selhi, 2013).

A point of controversy within ACT literature is what role, if any, ACT teams had on reducing arrests. Although a longitudinal study of arrest data conducted in Chicago by Davis, Fallon, Vogel and Teachout (2009) between 1997 and 2003 suggested that ACT was associated with decreased arrest rates, these findings were inconsistent with two subsequent randomized controlled trials conducted in Rochester (Lamberti et al., 2017) and California (Cusack et al 2010), as well as an additional qualitative study conducted in New York (Beach et al., 2013) that supported these findings.

To address these limitations in the ACT model, the FACT model was created, a model that actively involved partnering with the criminal justice system to allow greater legal leverage. Such legal leverage included collaboration with mental health court staff and community supervision providers such as probation

and parole officers, leading to the rise of the Forensic Assertive Community Treatment or FACT model (Lamberti et al., 2014). Although ACT teams were known to use incarceration as a deterrent for treatment noncompliance, FACT teams marked increased use of legal sanctions such as increased supervision as well as technical violation and reincarceration in the event of treatment noncompliance distinguished them from other more traditional ACT teams (Lamberti et al., 2021).

Both the Rochester (Lamberti et al., 2017) and California (Cusack et al., 2010) studies noted minimal reduction in arrests for ACT team participants in literature reviews, while FACT teams were not only associated with markedly decreased arrest rates but decreased psychiatric hospitalization rates as well. It should be noted however, that at the time the Davis study was conducted, FACT teams were significantly less common than they were at the time the two RCTs discussed above were conducted. The next section will examine the concept of therapeutic jurisprudence, which served as the theoretical basis of the sequential intercept model.

Therapeutic Jurisprudence

It has been estimated that of the 2.25 million jail (pretrial detainees and those convicted of misdemeanors who are sentenced to under one year of imprisonment) and prison inmates (those convicted of felonies sentenced to periods of imprisonment greater than one year), 16-24% are believed to meet diagnostic criteria for a serious mental illness (Lamb & Weinberger, 2005; Wolff 2017; Zgoba et al., 2020). Of note, a disproportionate number of female prisoners had histories of mental illness, with up to 31% of incarcerated women nationwide estimated to meet criteria for serious mental illness in comparison to 16% of male inmates (Cusack et al., 2010). Similar overrepresentation of prisoners with mental illness has been found among people of color, with a New York State sample finding 57% of African American prisoners estimated to meet diagnostic criteria for serious mental illness compared to 20% of white prisoners in the same sample (Swanson et al., 2009).

Beginning in the 1980s and early 1990s, legal and mental health professionals began to take notice of this disproportionately high percentage of people with mental illness that ended up in the criminal justice system. To address the unique concerns that this population faced, the framework of therapeutic jurisprudence emerged. It should be noted that while this framework originated within the legal system, Redlich and Han (2013) emphasize that at its core, therapeutic jurisprudence calls for an interdisciplinary approach that involves not only members of the courts and legal system but other stakeholders, including arrestees and community-based mental health service providers as well.

The first application of therapeutic jurisprudence came in the form of drug treatment courts in Miami-Dade County and Broward County in Florida (Lurigio & Snowden, 2009). These courts, which came into effect as the social impacts and consequences of the War on Drugs were emerging, initially focused on those arrested for misdemeanor drug-related offenses. In lieu of incarceration, offenders would voluntarily enter into substance abuse treatment which was monitored by specialized drug treatment courts that included dedicated prosecutors, judges, and mental health professionals who would monitor their progress. The successes associated with drug treatment courts in Miami later gave rise to mental health courts, which had similar structures and procedures (Boatwright 2019; Han & Redlich, 2016).

At the time of its inception, the therapeutic jurisprudence model and its application in drug treatment and mental health court proceedings was revolutionary. Historically, the courts had embraced a retributive justice model, predicated on the punishment of law breakers and the preservation of law and order (Lurigio & Snowden, 2009). Eventually, drug treatment and mental health courts were established nationwide and their successes have since become widely accepted and celebrated. The next section will critically examine the sequential intercept model and the specific stages where diversion from the criminal justice system can most readily be applied.

The Sequential Intercept Model: Overview and Recent Applications

The sequential intercept model builds on the principles of therapeutic jurisprudence. First described by Munetz and Griffin (2006), this model highlights six distinct points, or “intercepts,” within the criminal justice system in which people with mental illness can access needed assistance: **Intercept 0-** community services (non-forensic mental health treatment providers), **Intercept 1-** law enforcement/emergency services (includes initial encounters with police officers and EMS who routinely respond to individuals in acute psychiatric distress), **Intercept 2-** initial detention and hearings (following arrest but preceding arraignment and pretrial detention), **Intercept 3-** jails and courts (includes pretrial detention as well mental health court and alternative to incarceration dispositions), **Intercept 4- Community Reentry** (includes pre-release discharge planning from state prisons), and **Intercept 5- Community Corrections** (including criminal justice supervision through probation and parole). This model further delineates three specific points for intervention within the intercepts: pretrial diversion, alternative to incarceration programs, and community reentry (Blue-Howells et al., 2013).

Of note, the SIM specifically encourages a focus on early interception and diversion, with significantly reduced recidivism rates noted among individuals diverted from the criminal justice system into community-based treatment at earlier stages (Comartin et al., 2021). Since the adoption of the SIM by the Substance Abuse and Mental Health Services Administration (SAMHSA), this model has been one of the first to inform criminal justice policy with respect to people living with mental illness. Specifically, applications of the SIM model at the earliest stages include Crisis Intervention Training (CIT) and Co-Response Teams (CRT) for law enforcement and other mental health crisis responders (Dempsey et al., 2019; Every-Palmer et al., 2022). Studies of these policy initiatives have noted significant reductions in arrests of people with mental illness as well as use of force incidents by police (Rogers et al., 2019).

LITERATURE REVIEW

Pretrial Diversion & FACT: Crisis-Response Teams & Law Enforcement Integration

The SIM holds that access to high quality mental health services coupled with early diversion from the criminal justice system is associated with decreased rates of incarceration and psychiatric hospitalization among people with serious mental illness (Blue-Howells et al., 2013). The SIM has also been informed by a recent theory known by some as researchers as the *criminalization hypothesis*, which asserts that as a consequence of deinstitutionalization and the lack of appropriate community-based mental health services, the criminal justice system has become the primary tool used to manage disruptive behavior by people with mental illness (Lange et al., 2011). In other words, criminalization describes how jails and prisons have taken the place once held by psychiatric hospitals in institutionalizing those with mental illness.

The criminalization hypothesis also holds that as a consequence of the fragmentation of the community mental health system, people with mental illness tend to receive unequal treatment at every stage of the criminal justice system. With respect to use of force by police for example, within the United States it is estimated that of the 5680 fatal officer-involved shootings between 2015 and 2020, it was estimated that 36-45% of these incidences involved a person who exhibited acute symptoms of mental illness (Rohrer 2021). These numbers are in keeping with studies (Erickson et al., 2009; Pollack & Humphreys, 2020) which assert that despite highly publicized acts of violence committed by those with mental illness, individuals with serious mental illness are far more likely to be the victims of violent crime rather than the perpetrators of it. Moreover, other studies have also found that people with serious mental illness are significantly more likely to be arrested for minor nonviolent offenses and spend considerably longer periods in pretrial detention than the general population following arrest (Pope et al., 2022).

In recent years, researchers have examined the use of FACT teams for individuals with histories of mental illness and incarceration that do not have current criminal justice mandates, such as through probation

or mental health courts (Heilbrun et al., 2012; Skeem et al., 2015). The reasons for doing so stem from exploring FACT as a method to prevent future arrests and involvement in the justice system for this population (Wilson & Draine 2006). In particular, the literature at this intercept focuses most prominently on the relationship between police officers and behavioral health service providers, including FACT teams. A recent survey of 41 police departments nationwide also noted that although less than half of the police departments surveyed had active partnerships with local FACT teams and other behavioral health service providers, but among the police departments that did, rates of arrest and use of force among people with mental illness were markedly less than those that did not (Heilbrun et al., 2012).

Moreover, recent studies conducted in Chicago (Tentner et al., 2019) and Vancouver (Costigan et al., 2021) have examined increased collaboration between outpatient behavioral health providers and police departments, as well as integration of police officers onto non-forensic ACT teams (known as ACT Police Integration or ACT-PI teams). In the Chicago study for example, increased collaboration between police officers, EMS, and outpatient behavioral health service providers was associated with marked decrease in use of force and arrest rates among people with serious mental illness (Tentner et al., 2019). The Vancouver study, which relied on both quantitative data (arrest/hospitalization rates) and qualitative data (self-reports from consumers and providers of ACT-PI teams with police officers incorporated onto their staff), revealed decreased arrest rates and growing trust between mental health consumers, police officers, and service providers. However, this study also highlighted tensions as well, such as consumers' past traumatic experiences with law enforcement, and different professional responsibilities between the police officers and behavioral health service providers assigned to ACT-PI teams (Costigan et al., 2021).

Programs comparable to FACT which foster integration between law enforcement and behavioral health providers at the pretrial stage have also been replicated internationally throughout Canada (Koziański et al., 2021) and New Zealand (Every-Palmer et al., 2022). These studies have consistently reported promising results, including consumer self-reports of increased well-being and improved collaboration between police officers and behavioral health staff when intervention from emergency services was required. However, there have been times where despite these efforts, individuals with mental illness have still been arrested, both for minor offenses as well as serious felony charges. Upon arrest, the SIM stresses the need for early assessment and linkage to alternative to incarceration programs.

FACT and Alternative to Incarceration Programs

For those who are arrested and not granted pretrial diversion, the next major area for intervention on the SIM is at the judicial stage, where diversion into mental health court and alternative to incarceration (ATI) programs can occur (Comartin et al., 2021). As already mentioned, mental health courts are derived from the principles of therapeutic jurisprudence, which promote the use of the court system to improve outcomes for all parties involved, including the community, potential victims, and the defendant (Lurigio & Snowden, 2009). Such highly specialized drug and mental health treatment courts are generally referred to as “problem-solving courts” and are distinguished from the traditional court system by their recovery-focused, non-adversarial approach and operation (Han & Redlich, 2016). In mental health court proceedings, it is common for defendants to agree to a plea bargain in which they receive psychiatric treatment from a designated provider based on the intensity of their service needs.

For patients with serious mental illness who require more intensive clinical services for example, ACT/FACT teams such as the CASES Nathaniel Program in New York City have been utilized as alternative to incarceration programs (Lange et al., 2011). The literature has noted mixed results of individuals receiving FACT services in the context of alternative to incarceration. For example, although consumers receiving FACT services in the community were under more intensive supervision and were at higher risk of arrest for technical violations and noncompliance with the terms of the ATI programs, their rates of psychiatric hospitalization and arrest for crimes directly attributable to untreated symptoms of their mental illness was

significantly lower than individuals who were not receiving FACT services (DeMatteo et al 2012; Heilbrunn et al., 2012; Skeem et al., 2015).

Despite the successes of FACT as an alternative to incarceration program, such interventions are not without their limitations. At this time, the overwhelming majority of FACT teams are not used as alternative to incarceration programs, due to a shortage in available FACT teams within the community (Cuddeback et al., 2020; Cusack et al., 2010). The limited number of FACT teams available instead tend to be used predominantly for those who are reentering the community from state prison or forensic psychiatric hospitals (Lange et al., 2011). In many cases, this is attributable to the expensive nature of FACT services when compared to more traditional outpatient mental health treatment settings (Cusack et al., 2010). Another limitation is that many ATI programs, including those involving the provision of FACT services, require of a guilty plea prior to the defendant's release from custody (Comartin et al., 2021). As a result, defendants are often mandated to mental health treatment, either as a condition of participation in a diversion program or as a requirement of concurrent probation supervision (Han and Redlich, 2016). Such a mandate generally is imposed either in lieu of or in tandem with judicial monitoring by the designated mental health court (Lamberti et al., 2011). This means that should the service recipient become noncompliant with their psychiatric medication regimen or refuse to engage with their treatment providers, they can face technical violation, in which they are rearrested and imprisoned for violating the terms of their parole, even if they do not reoffend (Skeem & Manchak, 2008).

FACT and Community Reentry

The SIM identifies one of the final areas to provide intervention to justice-involved people with mental illness as the reentry stage: those people who are being released into the community from jails and prisons (Comartin et al., 2021). People with serious mental illness who leave prison after serving sentences for felony charges often face significantly greater challenges in community reentry than those leaving jail after serving sentences for misdemeanor charges (Cuddeback et al., 2013). For example, many individuals leaving prison following conviction on felony offenses are less likely to have access to financial benefits such as SSI, supportive housing, and Medicaid, which is needed to access most community-based mental health treatment programs, as such as benefits are often terminated when a person undergoes a lengthy period of incarceration (Baillargeon et al., 2010). Additionally, people with serious mental illness released from prison often face greater discrimination in securing employment and housing in comparison to the general population, making successful community reentry significantly more challenging (Batastini et al., 2017).

Of all the stages of the sequential intercept model, studies have generally found the lowest rates of successful community integration for individuals in the reentry stage. For example, one major quasi-experiment conducted among FACT team participants who were released from state prisons in Illinois showed significantly higher rates of re-arrest and rehospitalization than those that instead began treatment in the pretrial diversion and alternative to incarceration stages (Kelly et al., 2017). This study was unique in that it also examined other variables associated with reincarceration and rehospitalization. It found that in particular, homelessness and ongoing substance use were highly associated with increased rates of both arrest and psychiatric hospitalization. The authors hypothesized that homelessness and substance use were factors that were closely associated with increased contact with law enforcement, which was associated with higher rates of arrest and incarceration. An additional longitudinal study (Beach et al., 2013) and public policy review (Baillargeon et al., 2010) also supported these conclusions, with their findings indicating that people with serious mental illness were at the highest risk of rearrest and recidivism within the first year after their release from prison, particularly among those with histories of comorbid substance use and homelessness.

Despite these bleak statistics, FACT teams often work with consumers who are leaving prison under parole supervision, and are better equipped than traditional community mental health treatment programs to engage with criminal justice supervision partners (DeMatteo et al., 2013). Many researchers have found that the key to successful community reentry for justice-involved people with mental illness is collaboration

between criminal justice supervision and mental health providers (Wilson & Draine, 2006). Mental health and criminology researchers alike have found that FACT teams are the best service available at present in fostering such collaboration, given their dual mandate and effectiveness in reducing both psychiatric hospitalization and criminal justice recidivism (Skeem & Manchak, 2008).

Limitations of FACT and the Sequential Intercept Model

Notwithstanding FACT's success in reducing criminal justice recidivism and psychiatric hospitalization rates among people with serious mental illness, this intervention is not entirely without controversy. Similar to research conducted on inpatient and outpatient civil commitment programs in lieu of incarceration, a major concern among mental health professionals regarding this model is the potentially coercive aspects of using legal leverage, such as probation, parole, and mental health court mandates (Hoge & Bonnie, 2021). This is particularly concerning, since several studies (Lamberti et al., 2014; Swanson et al., 2009) have found that rearrest rates are actually higher among people who reported higher degrees of perceived coercion, particularly when they are no longer subjected to treatment mandates that are imposed by community supervision and mental health court providers.

It is also important to note a drawback of the FACT model, particularly among those teams that incorporate community supervision professionals such as parole and probation officers onto their staff, is the conflicting roles that the various team members have. In other words, different professions often have different objectives and ethical standards (Lamberti et al., 2011). For example, community supervision providers may be significantly more focused on public safety, where mental health professionals would be more concerned with the best interests of the service recipient.

In addition to the ethical concerns that the FACT model faces, there are significant implementation challenges as well, with the most prominent one being treatment fidelity (Lamberti & Weisman, 2021). It should be noted that within the United States, FACT team composition, as well as discharge planning standards for jails and prisons in general, differ markedly across the nation (Kelly et al., 2017) due to a lack of federal standards regarding provision of these services.

Another implementation concern with the FACT model is cost and funding. The California RCT found that the average outpatient costs of FACT team treatment for an individual was \$13,474 per year, versus \$5,115 per year for the treatment as usual group which merely included outpatient treatment and care coordination services. However, this same study also found that FACT significantly reduced the number and associated costs due to psychiatric hospitalizations by approximately \$3400 per day and incarceration by approximately \$2,900. (Cusack et al., 2010).

A final concern regarding the use of FACT in reducing recidivism is the *risk-needs-responsivity (RNR) model*. The RNR model has historically been used by professionals in traditional correctional and community supervision settings to assess recidivism risk for people facing release into the community, including for those with no history of mental illness (Skeem & Manchak, 2008). The RNR model asserts that a person's risk for recidivism is influenced by both criminogenic risk factors such as history of antisocial behavior, and non-criminogenic risk factors, such as history of mental illness, poverty, and lack of access to resources in the community (Rohrer 2021). Lastly, the RNR model also cautions that under the responsivity principle, more intensive and demanding supervision programs such as FACT should generally be reserved for patients whose combination of criminogenic and non-criminogenic risk factors place them at the highest risk of rearrest and rehospitalization, given that such intensive monitoring is associated with increased risk for technical violation of probation and parole leading to rearrest (Skeem et al., 2015). A recent meta-analysis examining the relationship between FACT consumers and associated outcomes on criminal justice recidivism as well as health outcomes (specifically psychiatrically hospitalization) found that although FACT teams decreased incarceration and psychiatric hospitalization rates, it is unclear what role the principles of the RNR

model played on these outcomes (Goulet et al., 2022). The findings of this study as well as others discussed during this paper have considerable implications for the practice of social work in forensic settings.

Implications for Social Work Practice

Despite being a relatively new policy framework, the SIM has broad implications for forensic social work practice, particularly concerning applications of FACT to justice-involved people living with mental illness). In particular, there are specific implications that are relevant to social work practitioners at the pretrial diversion, alternative to incarceration, and community reentry levels, particularly for communities of color who are afflicted by racial disparities in the criminal justice system more acutely than the general population.

At the pretrial diversion stage, one of the major goals for social work practitioners should be to improve collaboration between law enforcement and mental health personnel. The literature has consistently shown that consumers on FACT teams, which by definition incorporate increased legal leverage and collaboration with law enforcement, have lower rates of hospitalization and recidivism (Lamberti et al., 2014). Moreover, recent pretrial diversion studies in Los Angeles have suggested the SIM can and should be used to target systemic racism and promote equity among justice-involved people of color with histories of mental illness (Appel et al., 2020). Specifically, these authors note that it is necessary to improve accessibility to mental health services to black communities, as doing so is associated with a decreased number of individuals in mental health crisis (crises that are often addressed by law enforcement officers). In particular, FACT teams should be encouraged to collaborate with local police departments in establishing joint policies and procedures for responding to individuals in crisis who may require acute inpatient psychiatric treatment. In addition, further research should be conducted on training and social work practice initiatives geared towards mental health crisis response by law enforcement. Such initiatives including ACT-PI teams, CIT training and Co-Response Teams, can improve implementation of these practices (Dempsey et al., 2019; Rogers et al., 2019).

In the later stages of the SIM, social work practice initiatives should call for systematic mental health screening of all arrestees to determine suitability for community-based alternative to incarceration programs. The costs of not adequately assessing mental health service needs for prisoners are often dire. Indeed, a recent study out of California found that the state spends on average over \$11,000 per year for the medical care of a single inmate, with the overwhelming majority of these expenses being attributable to psychiatric treatment of prisoners with mental illness (Heilbrun et al., 2012). To reduce this financial burden, local prosecutor's offices should work with mental health organizations, federal grant agencies (through the Department of Justice and the NIH for example), and public defender offices to establish mental health courts in each county. Cost-benefit analyses of mental health court programs conducted in Pennsylvania (Kaplan 2007) saved taxpayers in that state approximately \$1.75 million dollars per year. A study in California (Cusack et al., 2010) which utilized FACT as an alternative to incarceration program yielded similar results.

For justice-involved people with mental illness at the community reentry stage, researchers have recently studied applications of Critical Time Intervention (CTI) to those leaving state and federal prisons. An empirically-based practice originally designed to reduce homelessness among people with serious mental illness being discharged from psychiatric hospitals, studies on CTI have recently been shown to reduce psychiatric hospitalization and criminal justice recidivism rates among prisoners with mental illness who were recently discharged from prison as well (Angell et al., 2014; Hopkin et al., 2018). The CTI model emphasizes a time-limited approach, where service intensity and engagement with service recipients is highest in the earlier stages of treatment (i.e., shortly after admission into the program) and gradually decreases as the consumer becomes more independent and requires less intensive services (Angell et al., 2014).

Macro level social work initiatives should also include advocating for a federal discharge planning standard, including referral to outpatient psychiatric treatment (including referral to FACT if necessary),

supportive housing, employment, and benefits as appropriate. Having such services in place is associated with decreased rates of criminal justice recidivism following release from prison (Baillargeon et al., 2010; Batastini et al., 2017).

CONCLUSION

In summation, FACT has been shown to decrease recidivism and psychiatric hospitalization rates among justice-involved people with severe mental illness at three stages of the sequential intercept model: pretrial diversion, alternative to incarceration, and community reentry. Since justice-involved individuals with mental illness seem to be at the highest risk of recidivism at the community reentry stage, this review notes that FACT teams are primarily used during the reentry stage, with FACT teams rarely being utilized at earlier stages. Further research as to the efficacy of FACT teams at the pretrial and alternative to incarceration stages would likely prove useful in further reducing recidivism among this vulnerable and underserved population.

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