FORENSIC ASSERTIVE COMMUNITY TREATMENT (FACT)
EXPERIENCES IN BELGIUM AND THE NETHERLANDS

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OVERVIEW:

1. Why Forensic?
   - What about Community-based Psychiatric care in forensics ?
   - What about ACT and FACT?
   - Who fits a Forensic Population?
     - Problem vs. Status
     - Diversion
     - Ethics
     - Criteria
2. Forensic Community - Based care and FACT in Be/Nl: a comparisson
3. Conclusions and recommendations

WHY FORENSIC?

General Psychiatric care **does not work** for Forensic patients or forensic outcome

Structured Risk Assessment

Transfert of forensic to general psychiatry is a challenge (Germany, Netherlands,…)

Histories of failed regular psychiatric treatment (90%)

Patient characteristics

- Antisocial personality
- Violent crimes
- Substance Use Disorders (crime-related)

Staff characteristics (van Dam et al. 2021)

COMMUNITY-BASED PSYCHIATRIC CARE IN FORENSICS?

- Recidivism – recidivism – recidivism…

- Forensic Rehabilitation theories:
  - Risk-Need-Respositivity (RNR) Ward & Maruna
    - Criminogenic needs oreinted approach
    - Strong evidence-base
  - Good Lives Model (GLM) Andrews & Bonta
    - Adds non-criminogenic needs

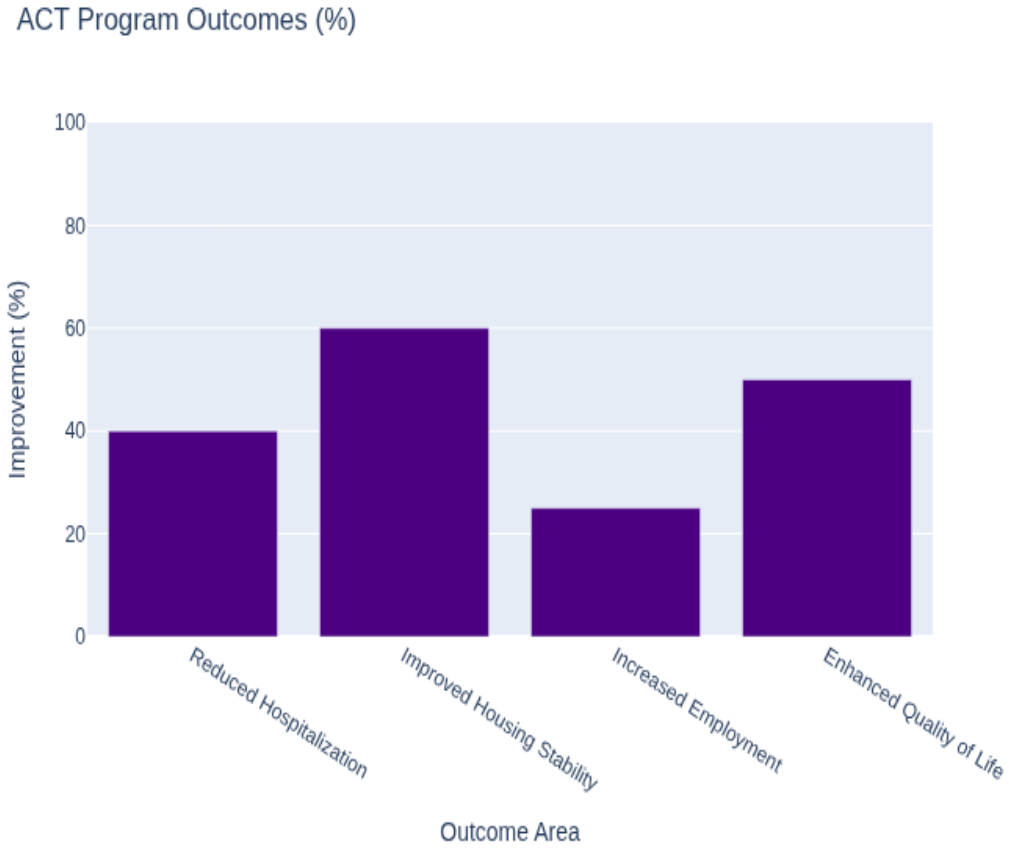
- What WORKS? (*Hayes et al 2014*)

  - 4,8 – 53% general recidivism
  - 10 – 20% violent recidivism
  - 11 – 80% Hospital admissions

EXAMPLE: ACT AND FACT

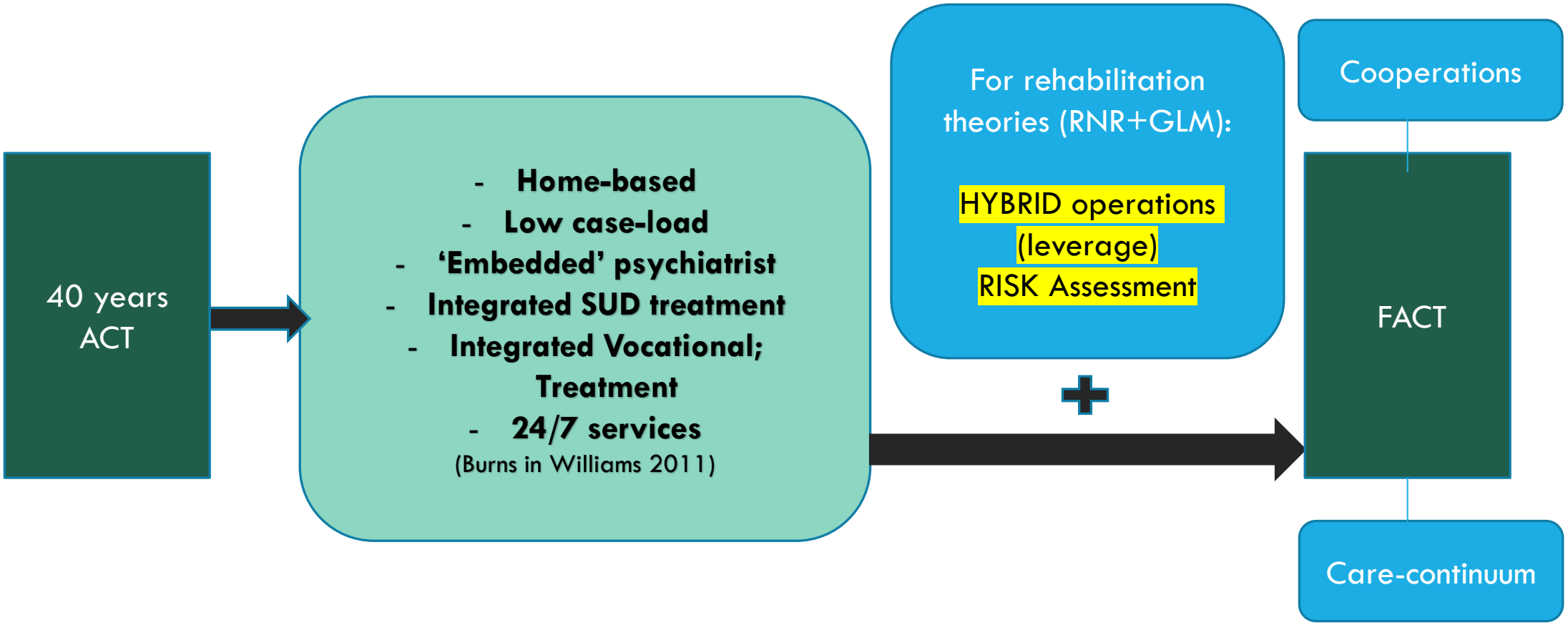
ASSERTIVE COMMUNITY TREATMENT (STEIN 1980)

CATEGORY	DETAILS
Key Features	•Multidisciplinary Team •Home-based treatment •24/7 Availability •Individualized Care •Integrated Services (SUD) •Long-Term Support
Target Population	•Severe mental illness •Frequent hospitalizations •Difficulty with traditional services •Co-occurring substance use disorders

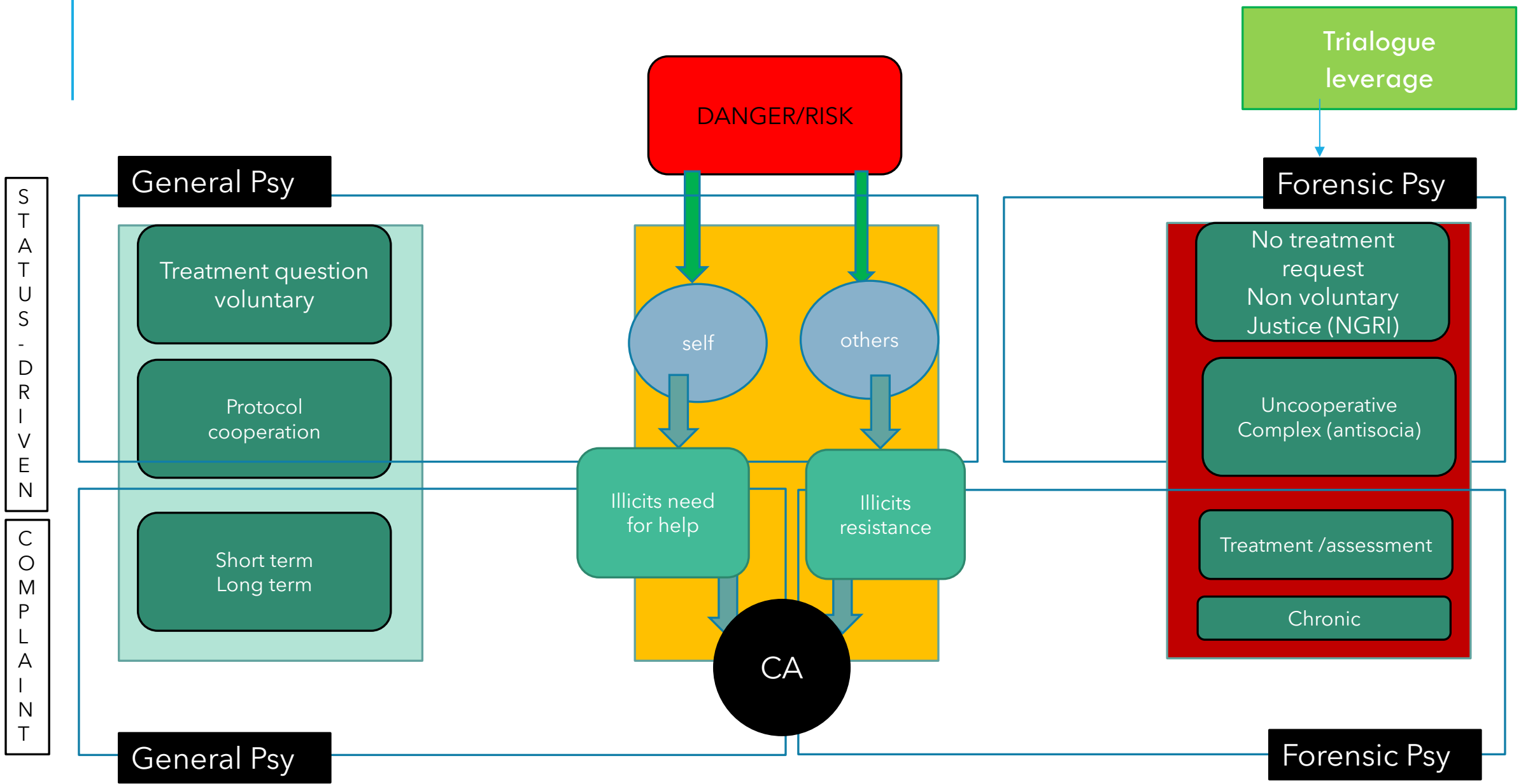


Threats: Model Fidelity demands / quid Europe?

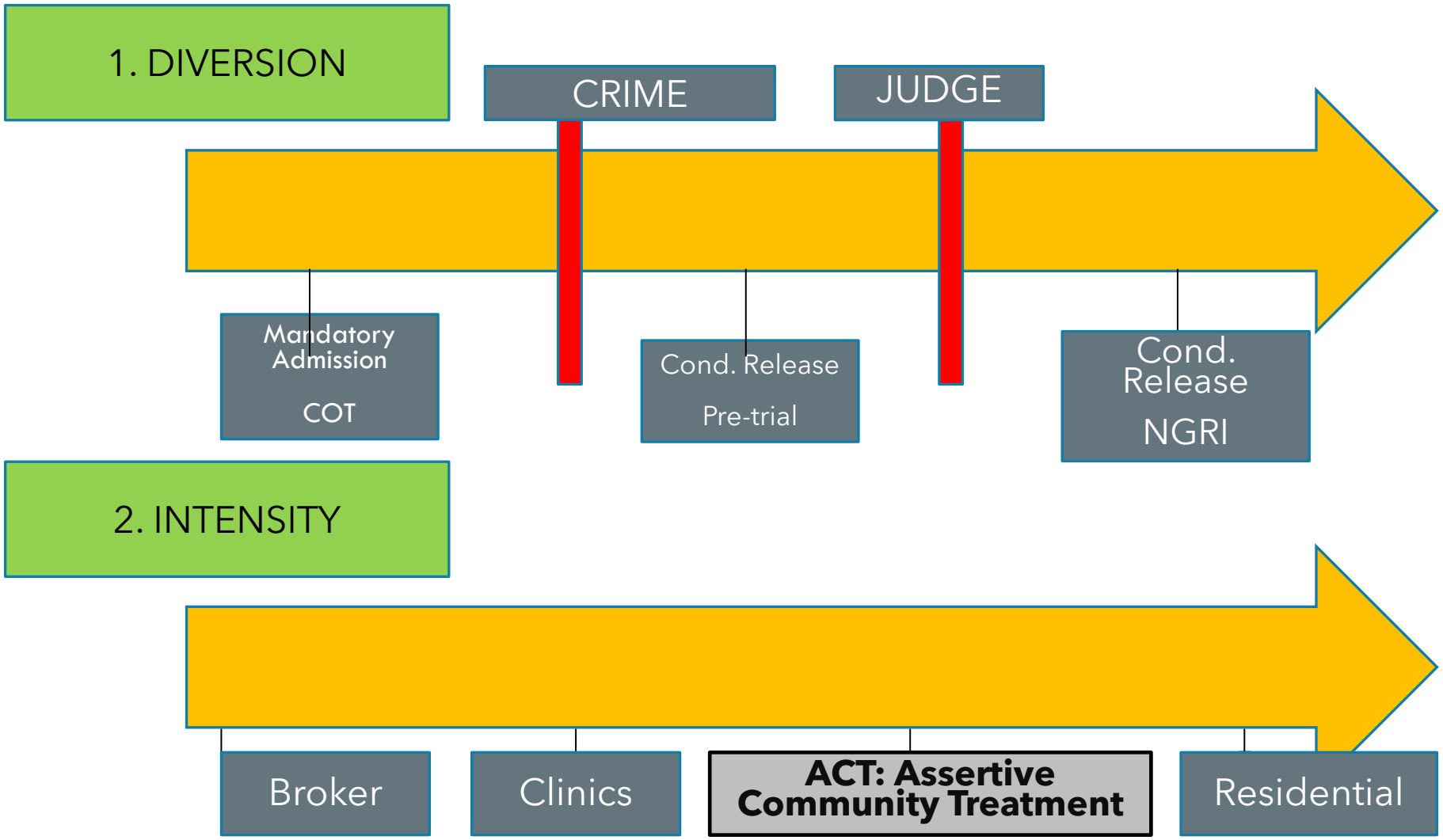
FACT BASIC ELEMENTS (MARQUANT ET AL. 2016)



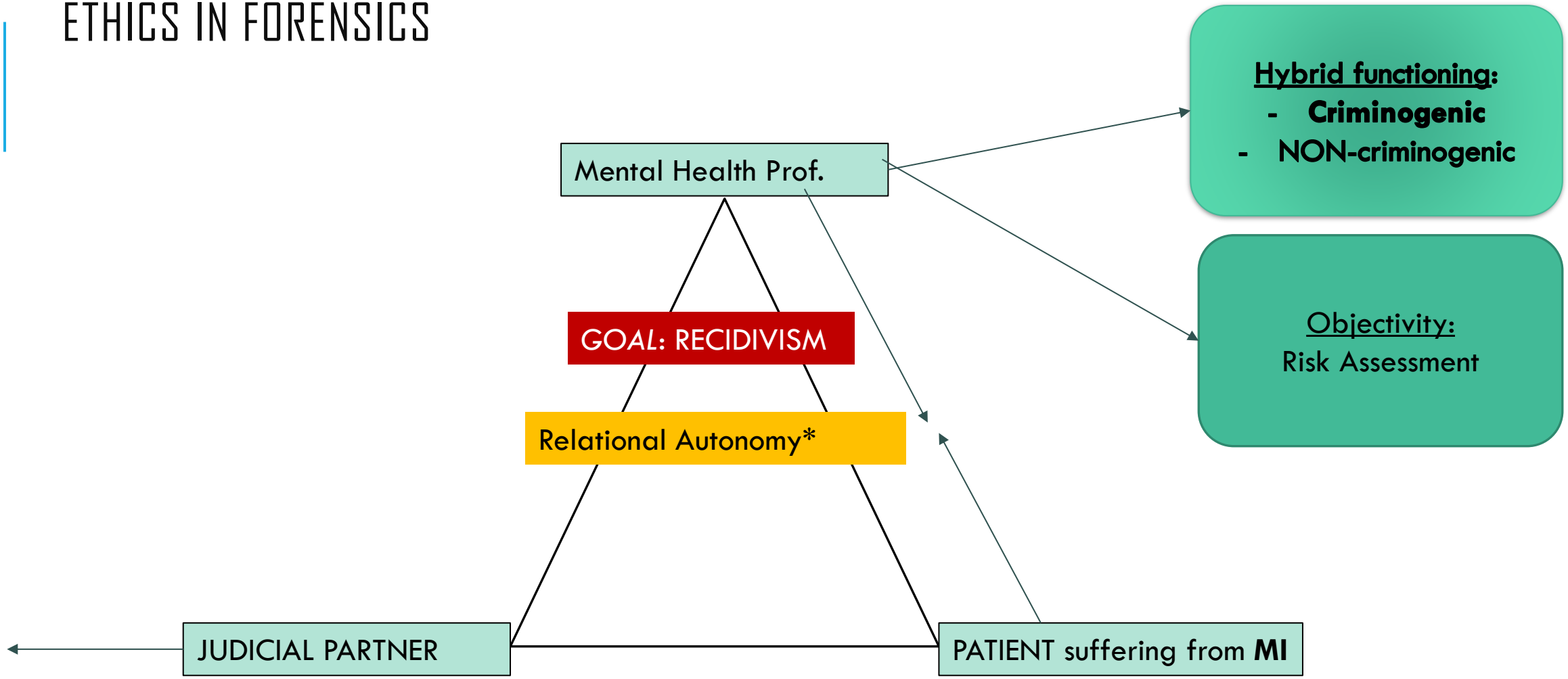
FORENSIC OR REGULAR PSYCHIATRY: POPULATION?



DIVERSION


1. DIVERSION
CRIME
JUDGE
Mandatory Admission
COT
Cond. Release
Pre-trial
Cond. Release
NGRI
2. INTENSITY
Broker
Clinics
ACT: Assertive Community Treatment
Residential

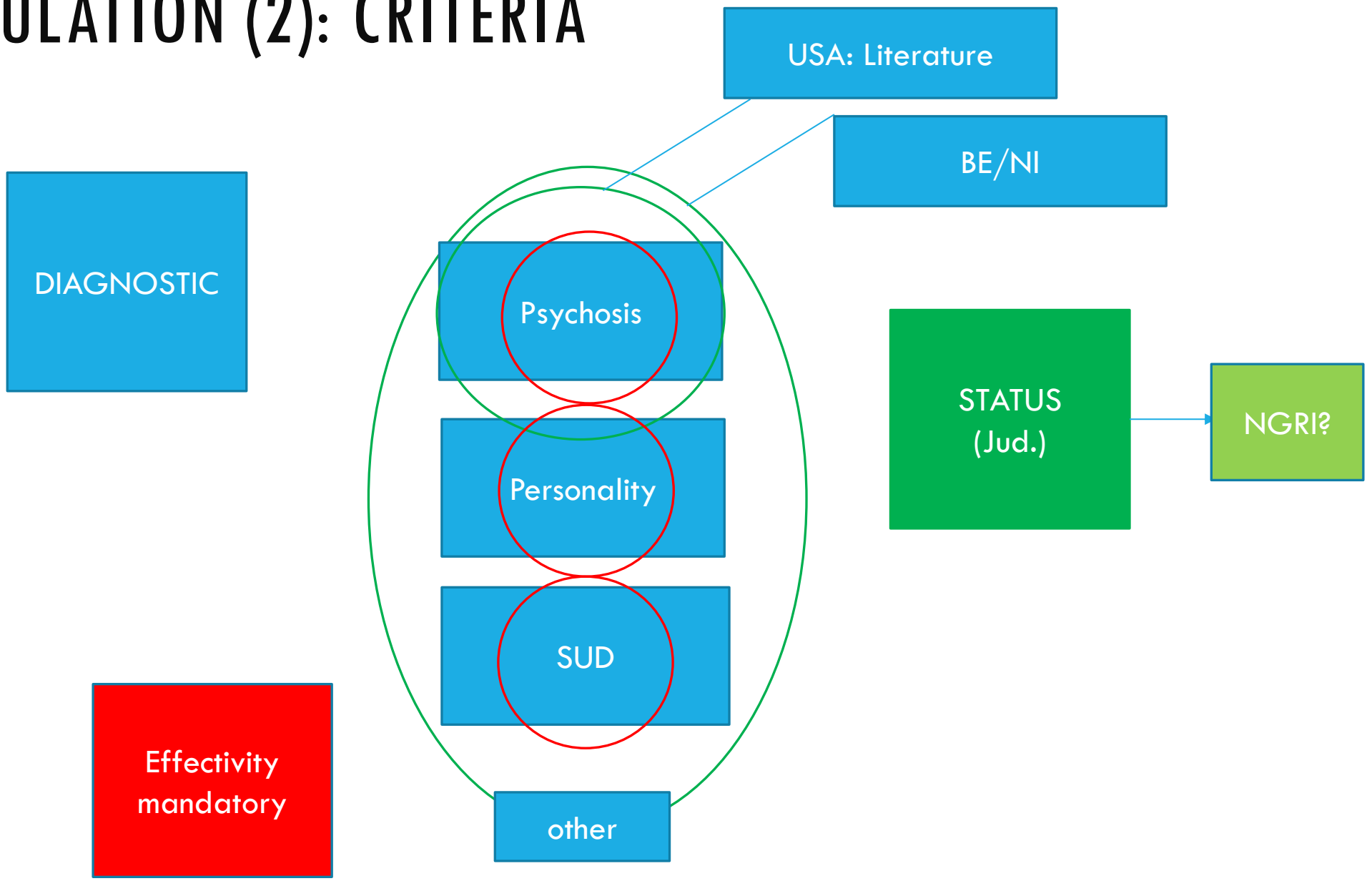
ETHICS IN FORENSICS



*Vollm & Nedopil 2016

*Molodynski 2016

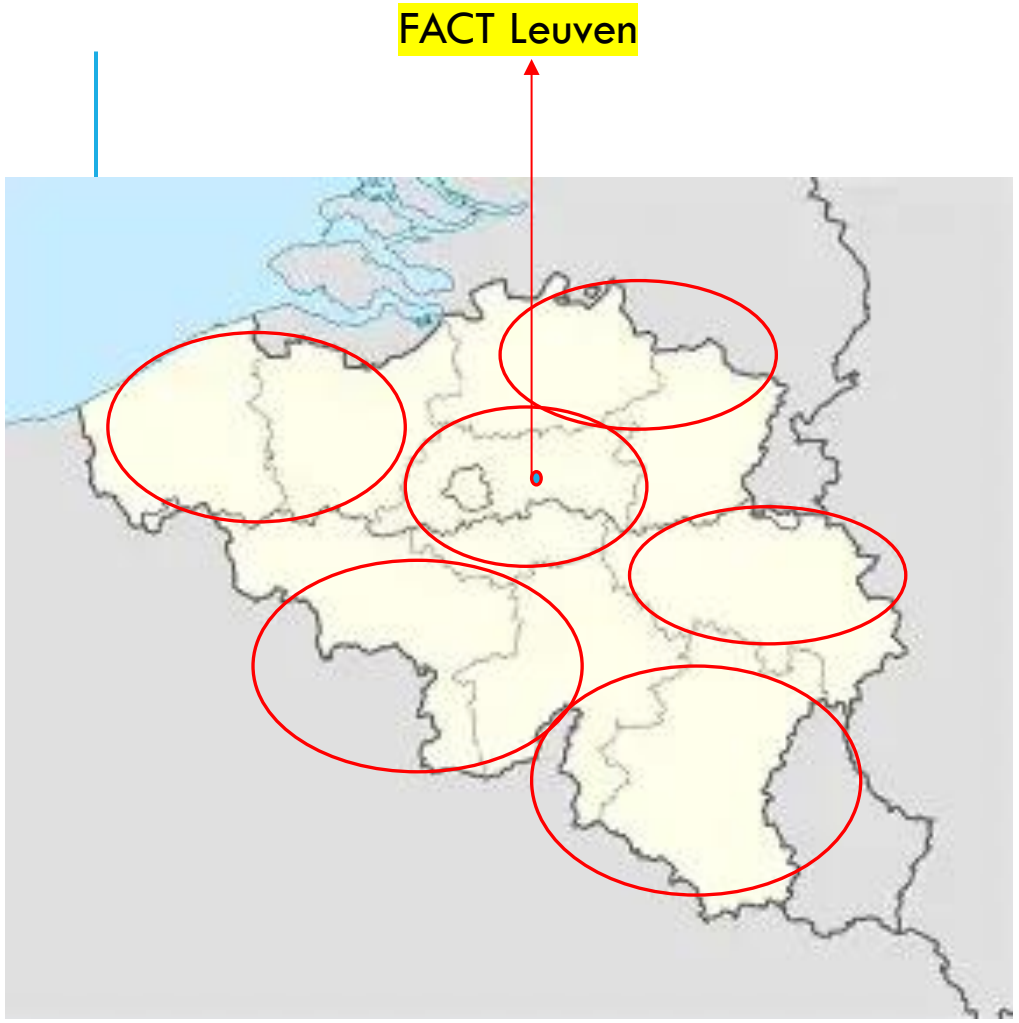
POPULATION (2): CRITERIA



BE VS. NL

Comparisson Be/NL

	BELGIUM	NETHERLANDS
Pop	11,8 million	18 million
GDP	665 Billion	812 Billion
GDP/C	44.837 (7)	63,000 (4)
Mental health care	Residential Focus (119/100k)(1)	Community focus
Forensic care	Present / high quality	Present/ high quality
	Mostly Residential (1142/1939) (18/100k)(2)	Mostly Residential (4016) (23/100k)(1)
	Strictly NGRI	NGRI, justic involved, **voluntary**



Situation Belgium:

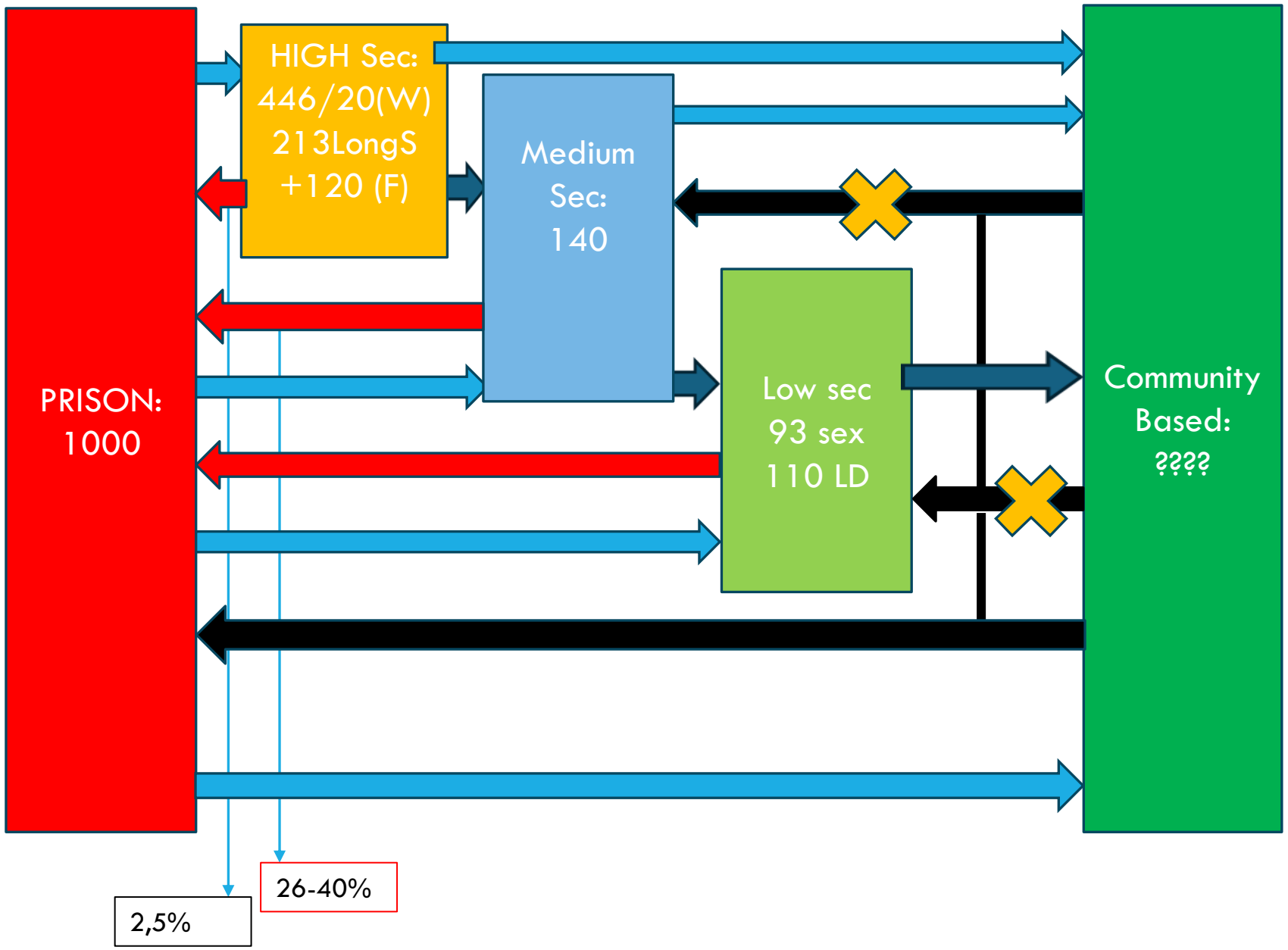
Forensic community-based care linked to **Appeal courts**

Strengths:

Strong residential network (forensic)
Forensic care continuum
Limited to **NGRI**

Weaknesses:

-Community-based services are underdeveloped and underused.
-1 FACT team
-Mostly clinic-based
-Mostly integrated into regular psychiatric services
-Disparrate and broker model based
-long waiting lists in prisons



Issues:
Spread-out services
Integrated into regular psychiatry (training?)

Broker Model

1 FACT team
Leuven (100,000p)

Outcomes?

Marquant et al. 2018: FACT in a care-continuum

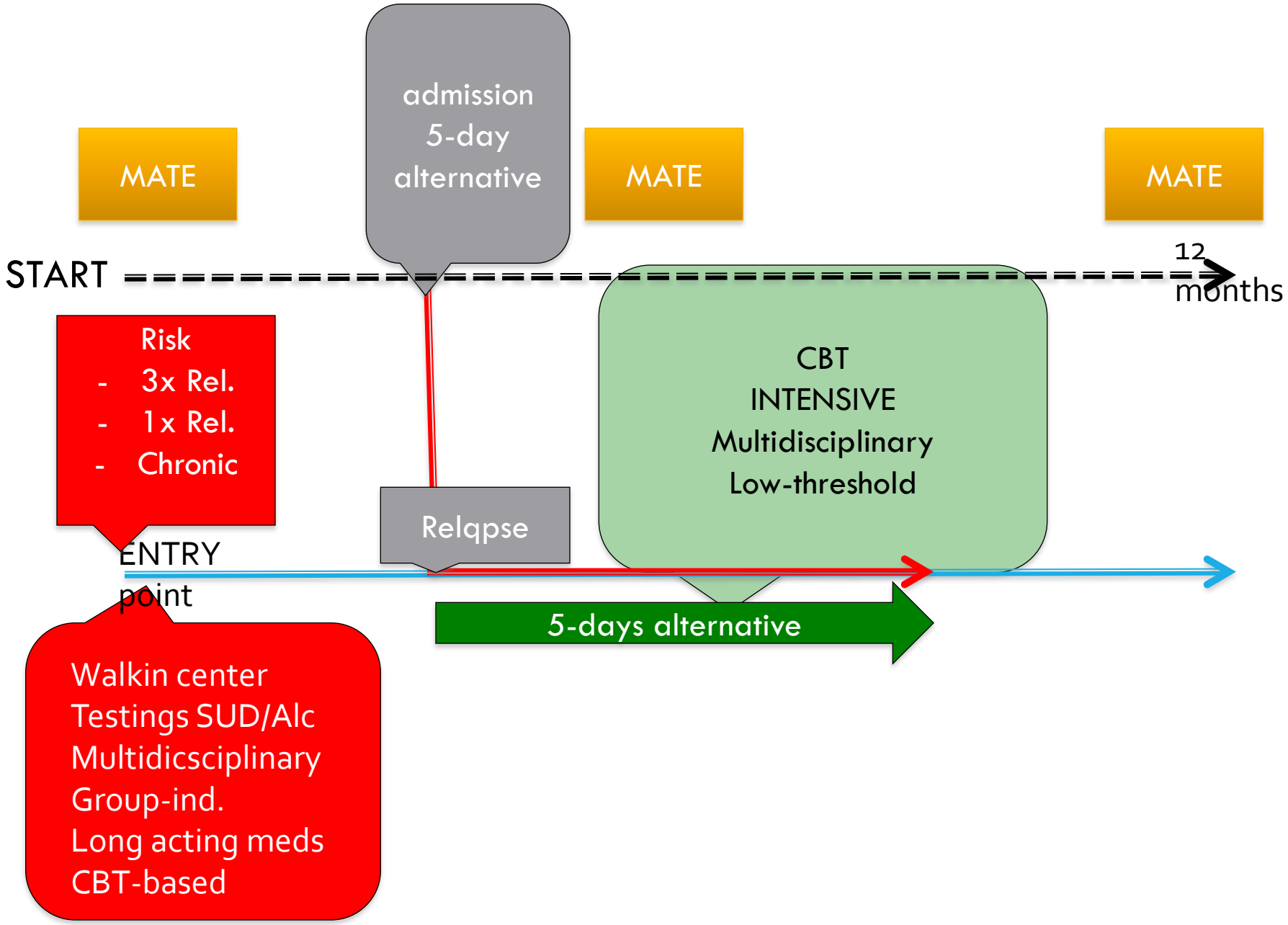
N=70
Control=56
33 months
Corrected for:
- Antisocial traits
- Violent index offence
- SUD

Patients post hospital release !
Admission was standard for SUD

Forensic outcome: recidivism	OR	p
Group (FACT versus TAU)	**6.29**	.029
Forensic outcome: new incarcerations		
Group (FACT versus TAU)	**13.96**	.001
Non-forensic outcome: admissions		
Group (FACT versus TAU)	**21.32**	.03

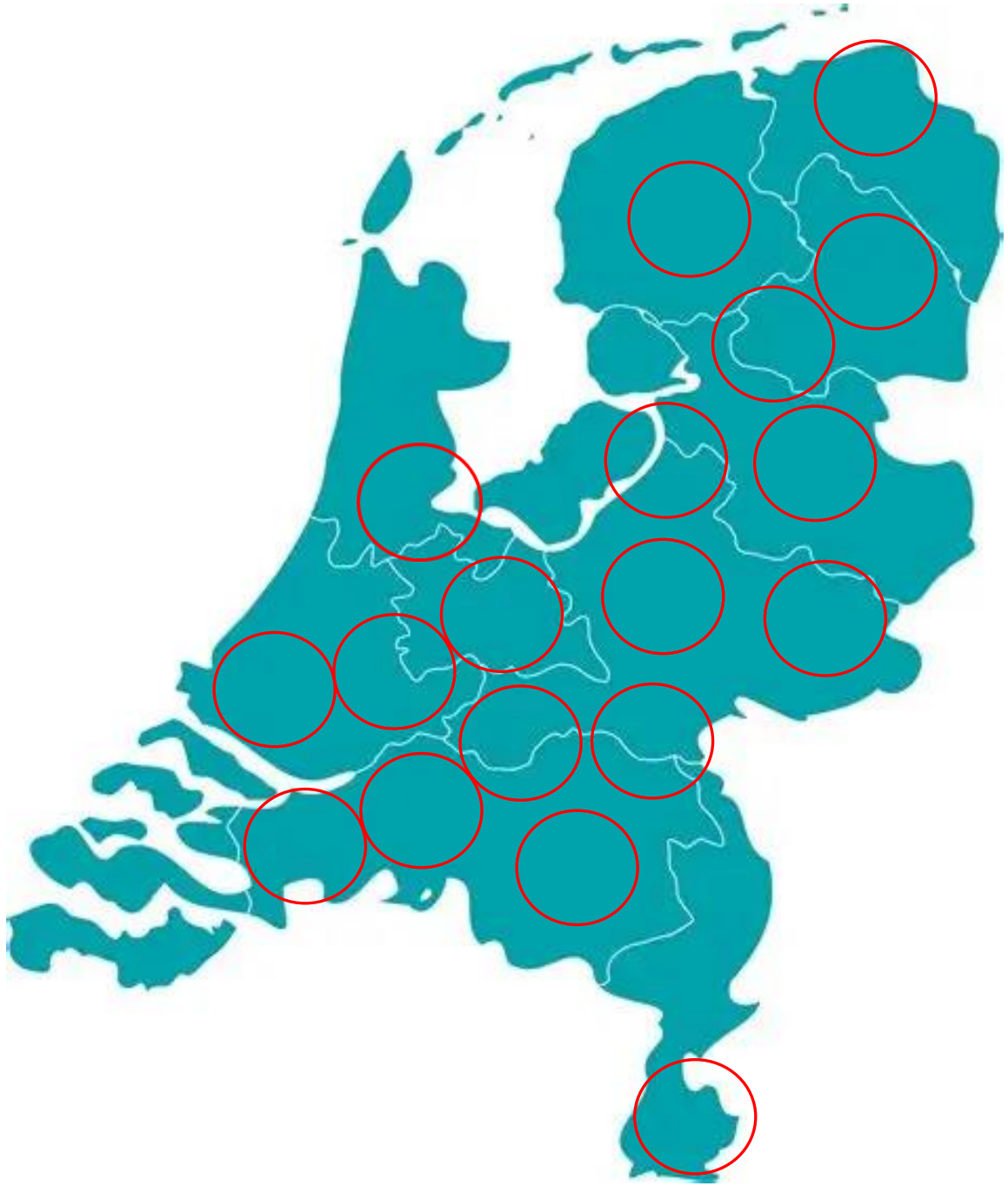
	FACT	Control
Community Tenure (%)	**79,7**	64,1

Admissions: profile	
Number	103 (0-11)
LOS median	12 (7)
SUD in admissions	70%
24%	68%


admission
5-day
alternative
MATE
MATE
MATE
START
12
months
Risk
- 3x Rel.
- 1x Rel.
- Chronic
CBT
INTENSIVE
Multidisciplinary
Low-threshold
Relqpse
ENTRY
point
5-days alternative
Walkin center
Testings SUD/Alc
Multidicsciplinary
Group-ind.
Long acting meds
CBT-based

RESULTS: N=24/ FOLLOW-UP: 12 M

			N	%
Total relapses		77	77	
	5-day alternative offered	total	53	69
		succesful	46	87/ 60 of total
		admitted	7	13
	Immediate admission		22	29
	Refusal cooperation		2	
For outcome	arrest		6	25
	detention		3	12.5
Time to admission (Kaplan Maier)	In favor of 5-day admission			



Situation the Netherlands

Strengths:

-ACT teams cover the country

-FACT teams cover most of the country (cities) **(20)**

(Flex-ACT is a variant of FACT)

-Strong focus on cooperation with judicial and social services

-strong legislation regarding coercive measures

Weaknesses:

-Not limited to NGRI! Also non-forensic and even voluntary admissions (effective?)

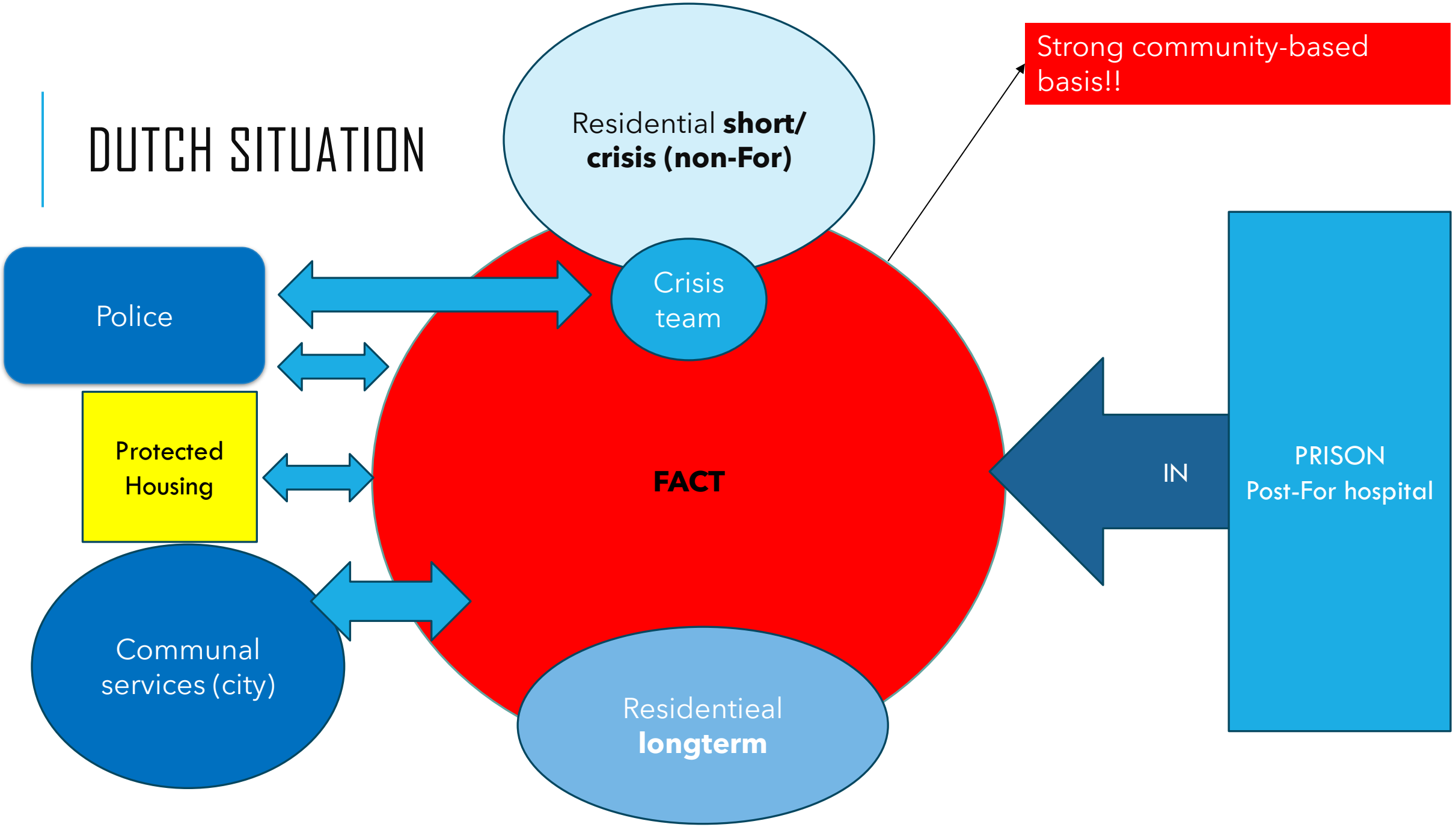
Kusters et al (2018) : 46% is voluntary

-Scarce residential places general psychiatry:

only short and crisis admission (bias psychosis).

-no forensic back-up (excpet for NGRI)

DUTCH SITUATION



OUTCOMES?

(NEIJMEIJER ET AL. 2017)

N= 321 / 12M/ (8) (A)*

KUSTERS ET AL. (2018)

N=76 / 15M/(1) (B)

*after 15M in care

No description of fACT

	T1	T2	significance
% patients in Detention	34.1	22.7	yes
Risk assessment (HKT-R)	1.8	1.6	yes
LOS detention	27.8	18.2	yes
% patients with police contacts	57.1 (A) 34,2 (B) 67 (B)	41.2	Yes Uncontrolled uncontrolled
% patients admitted regularly	13.9	15.8	no
% patients admitted Forensically	18	14.9	no
LOS (both)	5.3 27.1	12.1 20.2	no no

NL-BE COMPARED

	Be	NI
Community vs Residential	Residential ++++	Community +++
Pivital point	prison	community
Residential back-up	available	Very limited
SUD	integrated	Semi-intagrated
Care continuum	forensic	Mixed for/regular
outcomes	controlled	uncontrolled
legislation	limited	extensive
Included people	NGRI only	Problem oriented
funding	Dept. Justice + Health	NGRI: Dept Justice Rest: Health insurance
Cooperatiom police services	poor	Strong but waining

CONCLUSIONS:

1. COMMUNITY-BASED FORENSIC PSYCHIATRIC CARE

There is a **need** for community-based forensic services

The **forensic patient** is a patient with a judicial partner

FACT is the **best candidate** for this task

These services need to have **specific elements** (Rochester scale R-FACT)

Importance of **Social care** (housing,…)

Threats to its effectiveness are:

- Budget costs (initial/ongoing/dilution to regulqr))
- Lack of (forensic) residential back-up
- Lack of model fidelity
- Lack of training of staff
- Lack of good legislation for internal and external position of patients
- Incidents in the community

ESSENTIAL ELEMENTS OF FACT(LAMBERTI & WEISMAN 2021)

Rochester FACT (R-FACT) scale:

Item	item
ACT fidelity TMACT	Community supervision
Dual admission criteria	Combined team meetings
Justice-involved clients	Progress monitoring
Written participation agreement Information-sharing authorization	Shared problem solving
Information-sharing authorization	Evidence based mental health and SUD interventions
Risk/Need assessment	Evidence based community correctional interventions
Assessment-informed treatment planning	Shared training
Criminal justice collaboration	Transition procedures

ADMISSION CRITERIA:

Care-continuum:
SUD !!

Admission location		
Directly from prison	- Exclusion HIGH risk - Third strikers - No violence - SUD seriousness low	4 studies RCT Lamberti et al. 2017 Solomon et al. 1995 Cusack 2010
Post-admission forensic hospital	- Less exclusion criteria - SUD seriousness unspec. - Includes violence	4 studies Simpson et al. 2006 Marquant et al. 2018 Smith et al. 2010 Parker et al. 2004

CONCLUSIONS (2):

2. LESSONS Belgium – Netherlands:

Too much (NL) or too little (Be) Community is detrimental.

Operate in a **forensic care-continuum**

Substance Use Disorders are crucial to manage

Crisis management with **SUD** as a **crisis inducer**

Network with judicial partners (prof. Secrecy)

Legislation makes a difference

Exit strategy