involvement. The authors then proclaim that “a new approach” is needed that addresses these factors, including criminogenic risk factors, and that utilizes cross-system collaboration. They further suggest that the sequential intercept model could help achieve such outcomes.

In discussing current services, the authors refer to forensic assertive community treatment (FACT) as a “first-generation” intervention (i.e., one that seeks to prevent criminal justice involvement among people with mental illness by treating their mental illness). This characterization is inconsistent with the work our research group and others have published on FACT over the past 20 years.

The first national survey of FACT programs was published in 2004, and it characterized these early programs as “developing integrated mental health and criminal justice service systems” (2). Our prototype model in Rochester, New York, featured multipoint service integration involving health care, criminal justice, and social service systems (3). We subsequently incorporated strategies for addressing criminogenic risk factors, an idea published in *Psychiatric Services* in 2007 as part of a conceptual framework to guide model development (4). These principles of addressing criminogenic needs and cross-system collaboration eventually received validation in 2017 through a randomized controlled trial funded by the National Institute of Mental Health. In that study, FACT was associated with significant reductions in criminal convictions and time spent in jails and hospitals, along with significantly improved engagement in community-based care (5). These principles have since been adopted nationally by the Substance Abuse and Mental Health Services Administration (SAMHSA) as cornerstones of FACT (6).

Some people continue to view FACT as simply diverting justice-involved individuals into standard assertive community treatment teams. One could likewise view diversion into standard mental health services as the essence of the sequential intercept model, which has emphasized “intercepting” patients from the criminal justice system. However, such characterizations reflect a basic lack of understanding of these strategies. The prevailing view of FACT is evident in SAMHSA’s position paper, which was developed through a national consensus process, and highlights addressing criminogenic needs and cross-system collaboration as core elements of this approach (6).

It is our hope that those who choose to use “first-generation” terminology in the future will be more mindful of the current state of play regarding services for justice-involved people with severe mental illness in community settings.

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Meeting the Needs of Justice-Involved People With Serious Mental Illness: In Reply

IN REPLY: As admirers of their work, we thank Drs. Lamberti and Weisman for their comments on our article (1). We agree that the evolution of forensic assertive community treatment (FACT) they describe is exactly the type of community-based, multipronged, comprehensive service approach needed to address the high rates of justice involvement among people with serious mental illness. We also agree that the FACT service delivery model as described by the Substance Abuse and Mental Health Services Administration (SAMHSA) is one example of how our proposed vision can be put into action.

The evidence for the effectiveness of the FACT model that Drs. Lamberti and Weisman have developed is promising. That said, we have a couple points of clarification. Neither our critique of the criminalization hypothesis nor our discussion of the research that has consistently shown that mental illness is not a strong predictor of criminal justice involvement is new (2, 3). With the recent adaptations that have been made to standardize FACT, the authors appear to agree with us on the basic premise of our article, which is that we need to expand existing community-based mental health services to include new approaches to addressing involvement of forensically involved people with serious mental illness. For us, that is the call to action.

To that end, we note that while the emerging research on FACT is promising, there is much yet to be learned about how FACT works best, for whom, and under what circumstances (4). It could well be that much of the mixed findings of prior research is related to the high degree of variability found in the structure and operating procedures of FACT teams across the country (4, 5). The recent SAMHSA guidelines mentioned by Drs. Lamberti and Weisman offer programs sound direction on how to standardize FACT programs. However, more research is needed before the evidence for this standardized FACT model’s impact on recidivism is clear (6). We also have far to go to ensure the dissemination and uptake of this standardized version of

FACT. As it stands now, FACT programs are an expensive resource with limited availability, and local demand for such specialized services can outpace the community's ability to provide them (5).

FACT is a program that straddles the border of specialized forensic services and what we hope will be mainstream criminogenically informed community mental health services. On the basis of the available evidence, we consider the standardized FACT program to be one key component of the continuum of community-based services that is needed to create the "intercept 0" we describe in the article. But, like most of the services on this continuum, there are many questions that remain about how best to use FACT to intervene as early as possible in the trajectory of criminal justice system involvement for people with serious mental illness. We are heartened by the commitment that Drs. Lamberti and Weisman demonstrate toward our shared goal and look forward to working with them and others to find the answers.

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Submissions Invited for Social Determinants of Mental Health Column

A new column in *Psychiatric Services,* Social Determinants of Mental Health, edited by Ruth S. Shim, M.D., M.P.H., and Michael T. Compton, M.D., M.P.H., aims to focus on clinical and policy issues as they relate to social justice in psychiatry and the social determinants of mental health, with a specific focus on mental health disparities and evidence-based strategies to improve mental health equity across population groups. Initiatives taking place in hospitals, clinics, health systems, and insurance plans will be emphasized. Ways in which clinicians and mental health services can address (screen for, evaluate, and ameliorate) social determinants of mental health will be highlighted. Manuscripts that emphasize specific social determinants of mental health, including discrimination, adverse early life experiences, poverty, social exclusion, low employment status, and low educational attainment, to name a few—and particularly how these determinants connect to mental health outcomes and can be addressed by mental health services—are particularly welcome. Papers, limited to 2,400 words, may be submitted online to the Social Determinants column via ScholarOne Manuscripts at mc.manuscriptcentral.com/appi-ps.