



INFORMATION BRIEF

# First-Episode Psychosis: Considerations for the Criminal Justice System



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## INTRODUCTION

Criminal justice professionals frequently interact with individuals with mental illnesses. Between 7 and 31 percent of all police calls in the United States involve a person with a mental illness, and it is well-documented that individuals with a mental illness are overrepresented in jails and prisons, with estimates that up to 14.5 percent of men and 31 percent of women in U.S. jails have a serious mental illness (Shapiro et al., 2015; Steadman et al., 2009). Although they comprise only a small subset of individuals with a mental illness who interact with the criminal justice system, young people experiencing a **first episode of psychosis (FEP)**—that is, their first experiences of psychotic symptoms—represent an important group for early intervention. This is due to both the likelihood that they will experience poorer long-term outcomes and be more costly to treat if overlooked, and the fact that early intervention programs for psychosis have been demonstrated to be effective at improving functional and clinical outcomes for this group.

The National Institute for Mental Health (NIMH) uses the term **Coordinated Specialty Care (CSC)** to refer to a recovery-oriented, team-based, multi-component treatment model for persons experiencing FEP. The recent expansion in the United States of CSC-type programs is an important development for criminal justice professionals to know about as they seek to reduce justice involvement among individuals with a mental illness. CSC providers can also benefit from increased knowledge of the criminal justice system and potential opportunities within the system for early detection. Early intervention for people without easy access to psychiatric care in the community may have significant downstream impacts on health and criminal justice involvement.



### THE PURPOSE OF THIS BRIEF IS THREEFOLD:

1. To educate criminal justice professionals about FEP and the importance of early intervention;
2. To inform criminal justice professionals about the availability of CSC models in the community; and
3. To highlight key opportunities for detection, diversion, and intervention in the criminal justice system.

## BACKGROUND ON FIRST EPISODE PSYCHOSIS

Experienced by roughly 100,000 people annually in the U.S., FEP is defined as an individual's first presentation of psychotic symptoms (calculated from McGrath et al., 2008). The peak age of onset is consistent across populations globally, around 15-25 years of age (Heinssen, Goldstein & Azrin, 2014). While the hallmarks of psychosis are hallucinations (seeing or hearing things that others do not) and delusions (fixed, false beliefs), young people often manifest earlier warning signs such as social withdrawal,

uncharacteristic declines in work or school performance, and suspicion of others (NAMI, 2016). Psychotic symptoms can result from physical illness or exposure to trauma or substance use, as well as a number of mental illnesses (bipolar disorder, schizoaffective disorder, schizophreniform disorder), but FEP is most frequently described as being associated with schizophrenia.

In addition to the fear, unease, and confusion that such symptoms stoke in young people and those close to them, psychotic disorders such as schizophrenia can have a profound negative impact on a young person's academic, social, and professional development, and on their physical health. The U.S. economic burden of schizophrenia in 2013 was \$155.7 billion due to costs associated with

unemployment, loss of productivity due to caregiving, and healthcare (Cloutier et al., 2016). Furthermore, individuals with psychotic disorders have life expectancies 10-25 years shorter than those of their peers (Breitborde, 2017).

However, mounting evidence suggests that reducing the **duration of untreated psychosis (DUP)**—the length of time between onset of psychotic illness and initiation of treatment—has positive implications for prognosis (Heinssen, Goldstein & Azrin, 2014). Early intervention after a first episode can lead to remission of symptoms such as hallucinations and delusions and increase adaptive functioning, thus preventing the vocational and social fallout typically associated with psychotic disorders (Heinssen, Goldstein & Azrin, 2014; Norman & Malla, 2001). Those who experience prolonged DUP (a study of patients presenting to 34 community-based treatment centers reported median DUP of 74 weeks) suffer poorer long- and short-term outcomes with regard to symptoms, quality of life, and social functioning (Addington et al., 2015; Brunet & Birchwood 2010; Penttilä et al., 2014).

In order to minimize DUP, researchers have examined pathways to care—the help-seeking efforts pursued by people in distress or those close to them, as well as “non-sought” routes to care (Rogler & Cortes 1993; Singh, 2005). These pathways are varied and diverse, are often mediated by a host of social, cultural, and health services factors, and are in no



way limited to the healthcare settings in which early intervention efforts have traditionally been located. Notably, many pathways may involve involuntary hospitalization, contacts with faith-based organizations and relatives, and often, in instances of prolonged DUP, interaction with the criminal justice system (Singh, 2005; Singh, 2015).

Pathways to care often involve delays or bottlenecks due to barriers such as social withdrawal and loss of social support, which are common sequelae of psychosis. Additionally, many demographic factors such as unemployment, residence in public housing, and ethnic minority status are heavily associated with long DUP. Most notably for this audience, however, it is known that exhibiting psychotic symptoms can lead to justice system involvement and that a history of incarceration, childhood mistreatment, and neighborhood disorder are predictors of delays in accessing care and thus longer DUP (Broussard, et al., 2013; Sale & Blajeski, 2015). Given these findings, the criminal justice system represents a critical arena in which capacity for detection of a FEP and referral to appropriate services, including the CSC models described in the following section, must be deployed and scaled up.

#### Symptoms Can Include:

- Hearing, seeing, tasting or believing things that others don't
- Unusual thoughts or beliefs
- Strong and inappropriate emotions or no emotions at all
- Social withdrawal
- Decline in hygiene, self-care

Source: <https://www.nami.org/earlypsychosis>

## Advances in Early Identification and Treatment of Psychosis

The past decade has seen a groundswell of research whose findings support early intervention measures for psychosis. The National Institute of Mental Health's 2008 Recovery After an Initial Schizophrenia Episode (RAISE) study added to a growing body of evidence from the U.K., Australia, Canada, and Scandinavia supporting the development of CSC as an early intervention strategy. By implementing and testing CSC models in settings throughout the U.S., RAISE demonstrated that individuals who initiated treatment in these programs within 1.5 years of onset of symptoms remained in treatment longer, showed improvement in quality of life and work and school functioning, and had reduced use of hospital services compared to those receiving standard care (Gonzalez, Goplerud & Shern, 2016).



CSC models vary widely but are broadly defined as interdisciplinary, team-based, multi-component approaches to supporting clients' recovery goals and individual needs during and after a FEP. Engaging clients and their relatives as members of the treatment team, CSC programs offer a menu of evidence-based services such as case management, individual or group psychotherapies, employment and education support, family education and support, and pharmacotherapy and primary care coordination (Gonzalez, Goplerud &



Shern, 2016; Heinssen, Goldstein & Azrin, 2014). Programs are usually targeted toward individuals between 12 and 35 years of age who have had psychotic symptoms for no more than 2 years prior to program entry, and are intended to serve clients for 2-3 years until they can step down to less intensive treatment or transition into standard care in the community (NASMHPD & NRI, 2015; Heinssen, Goldstein & Azrin, 2014). CSC programs are often flexible in nature and may provide services across clinic, community, and home settings. In turn, these programs lower barriers to entry into person-centered care, can provide more assertive care during psychiatric crises, and offer a unique opportunity for the development of referral pathways reflective of population needs (e.g., emergency departments, inpatient settings, and the criminal justice system) (Heinssen, Goldstein & Azrin,

2014). Currently there are over 200 CSC programs operating across the country, and that number continues to grow. Expansion is expected to 48 states by 2018 (Dixon, 2017; Gonzalez, Goplerud & Shern, 2016).

#### Selected Resources on Coordinated Specialty Care Programs

- [Program Directory of Early Intervention Psychosis Programs \(pdf\)](#)
- [On-Line Map of Early Intervention Psychosis Programs](#)
- [Coordinated Specialty Care—First Episode Psychosis Programs: Why specialty early intervention programs are a smart investment](#)
- [Fact Sheet: Building Upon Existing Programs and Services to Meet the Needs of Persons Experiencing a First Episode of Psychosis](#)
- [NASMHPD Early Intervention in Psychosis Virtual Resource Center](#)
- [NIMH Recovery After an Initial Schizophrenia Episode \(RAISE\) webpage](#)
- [Prodrome and Early Psychosis Program Network \(PEPPNET\)](#)

## Psychotic Disorders and First-Episode Psychosis in the Criminal Justice System

The poor outcomes associated with a prolonged DUP and the findings connecting incarceration history with a longer DUP suggest that early intervention to reduce DUP must target key figures and institutions in the criminal justice system. Available data suggest that there is higher likelihood of encountering someone with FEP in the justice system than in the community and that there are a significant number of people for whom criminal justice contact represents the first chance for treatment (Ford, 2015). The Bureau of Justice Statistics 2002 survey of 6000 people incarcerated in jail found that 24 percent reported symptoms of a psychotic disorder within the past year (compared to 1.4% in the general population) (James & Glaze, 2006; Cohen & Marino, 2013). And, although 60

percent of jail inmates reported experiencing symptoms of a mental disorder, only 21 percent had received a clinical diagnosis or treatment by a mental health professional in the previous 12 months, suggesting that 39% of those who entered jail having experienced symptoms of mental illness had received no formal treatment (James & Glaze, 2006).

The fact that many people experiencing first-episode psychosis may enter the criminal justice system before the health care system is further evidenced by a study of 191 first-episode psychosis hospital admissions, which found that most individuals had been arrested (70 percent) and the majority had been incarcerated (59 percent) prior to their first hospitalization (Ramsay Wan et al., 2014). Compared with patients who had no previous incarcerations, the median treatment delay for this group was much longer (approximately 2 years versus 3 months). Such data offer further evidence that the criminal justice system is a prime

location for identifying FEP and diverting or referring people into CSC programs. Although early intervention efforts to date have largely targeted settings such as healthcare, behavioral health, and education, expanding the focus to criminal justice settings is critical for a population that is likely to not be employed or in school and not receiving primary care health services, and is therefore unlikely to traverse traditional pathways to care (Ramsay Wan et al., 2014).

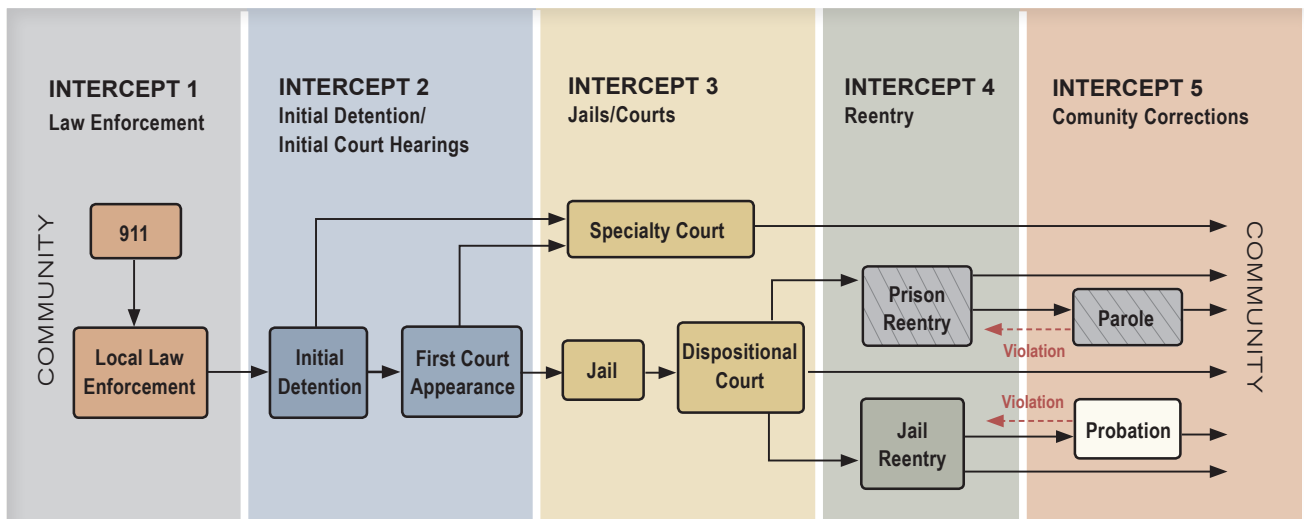
**This brief focuses on points of contact with the criminal justice up through jail rather than prison because of this critical time period of intervention for first-episode psychosis; people in jail may be held in detention upon arrest, while awaiting disposition of a criminal case, or when sentenced to less than a year.**



## Opportunities for Early Detection in the Criminal Justice System

The sequential intercept model is a widely-used conceptual framework that addresses the interface between the criminal justice and mental health systems (Munetz & Griffin, 2006; SAMHSA GAINS Center, 2013). The model describes a series of opportunities for intervention that can prevent individuals with a mental illness from becoming enmeshed in the criminal justice system. Such opportunities are located along various points of a continuum, from community-based services that focus on crisis response systems and pre-arrest models adopted by law enforcement; to pre-arrest and/or jail-based behavioral health screening, assessment and intervention; to services offered at reentry or located within community corrections<sup>1</sup>. Using the sequential intercept model as a guide, this section reviews the locations in the criminal justice system where opportunities exist for integrating early detection services for FEP.

**Figure 1.** The Sequential Intercept Model



Source: SAMHSA GAINS Center. (2013). Developing a comprehensive plan for behavioral health and justice collaboration: The Sequential Intercept Model. <https://www.prainc.com/wp-content/uploads/2016/04/SIMBrochure.pdf>

<sup>1</sup> For another useful visual of Sequential Intercept Model with the addition of “Intercept 0 – community services,” see <https://www.prainc.com/wp-content/uploads/2017/02/PRA-SIM-Intercept-0-nologo.pngx>

## INTERCEPT 1

### LAW ENFORCEMENT

Law enforcement officers can serve as a key resource for identifying early signs of psychosis and diverting people to appropriate care. Law enforcement officials are increasingly adopting specialized responses to people with mental illnesses. These responses include the Crisis Intervention Team (CIT) model and mental health co-responder models, in which police officers are trained to recognize the signs of mental illnesses and manage encounters with individuals with mental illnesses, or they are accompanied by trained mental health staff (Broner et al., 2004; Steadman & Naples, 2005). CIT programs are considered a national best practice due to their positive effect on officers' attitudes, knowledge, and beliefs about individuals with a mental illness, as well as their ability to connect individuals with a mental illness to appropriate psychiatric services (Compton et al., 2008, 2014a). CIT-trained officers are much more likely to refer individuals to services or transport them to a treatment facility than they are to make an arrest and demonstrate increased self-efficacy around interacting with people with psychosis (Compton et al., 2014a; 2014b). This fact is especially important given that many individuals who have experienced a first episode of psychosis credit first responders such as police officers as being the first people to recognize their symptoms and intervene (NAMI, 2011).



#### SETTING UP A CRISIS INTERVENTION TEAM

The original CIT program was created in 1988 in Memphis, TN following the fatal shooting of a man with a history of mental illness and substance abuse by a Memphis police officer. Known internationally as the “Memphis Model,” CIT began as a local effort to bring together law enforcement personnel, mental health professionals, and advocates, and has since expanded nationally as an innovative first-responder model of police-based crisis intervention that aims to improve officer and consumer safety and redirect individuals with mental illnesses from the criminal justice system to the health care system. The centerpiece of the model is 40 hours of specialized training for a select group of officers that volunteer to become CIT officers. There are currently 2,632 local CIT programs across the United States. To find existing CIT programs or to learn more about creating a successful CIT program in your jurisdiction, visit the National CIT Center at the University of Memphis’s website: [www.cit.memphis.edu](http://www.cit.memphis.edu)



## INTERCEPT 2

### INITIAL DETENTION AND PRELIMINARY COURT HEARINGS

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Not all individuals experiencing a first episode of psychosis who have police contact will be identified as such or be diverted to services as an alternative to arrest. For this reason, it is important that opportunities for diversion to CSC also exist when a person is first detained post-arrest. A short window of opportunity exists for early detection and screening in the time between when a person is initially detained and when they make their first court appearance. Nonetheless, depending on the jurisdiction, a variety of professionals may have the opportunity to conduct brief mental health screens to flag early psychosis and use that information while developing pretrial release and detention recommendations.

The Enhanced Pre-Arrest Screening Unit (EPASU) in New York City's Manhattan Criminal Court is one example of an innovative effort to support early identification of medical, mental health, and substance use issues and can support a path for diversion for those with serious behavioral health conditions (see Text Box: *Manhattan*

*Enhanced Pre-Arrest Screening Unit*). Settings that already have the capacity to conduct pre-arrest screening could use this intervention point as a location for detecting a first episode of psychosis and working with advocates, including defense attorneys and family members, to present enrollment in CSC programs at arraignment as an alternative to incarceration. In turn, enrollment in appropriate, evidence-based care is likely to increase stability in the community and the likelihood of the individual's return for any future court hearings.



### Manhattan Enhanced Pre-Arrest Screening Unit

The Enhanced Pre-Arrest Screening Unit (EPASU) pilot launched in Manhattan Criminal Court in May 2015 after a 12-month planning process led by the NYC Health + Hospitals' Division of Correctional Health Services and the Vera Institute of Justice. The EPASU was designed to accomplish three goals:

1. Increase Manhattan's capacity to deliver medical care to people moving through the arrest-to-arrest process;
2. Improve coordination of health services between correctional and community healthcare providers; and
3. Bolster diversion efforts for people with behavioral health conditions.

The EPASU now operates 24 hours a day, 7 days a week in Manhattan. It is staffed by a patient care associate (PCA) and a nurse practitioner (NP) who use an electronic screening tool to detect physical and behavioral health needs and treat a range of common medical conditions that previously required transfer to a hospital. A licensed social worker (known as the "diversion liaison") is also on staff to identify people with behavioral health problems by searching existing electronic health databases and, with the individual's consent, share relevant information with defense counsel prior to arraignment. In consultation with their clients, defenders have the discretion to use the information in the clinical summary to advocate for the client at arraignments or at a later stage in the case. Health information gained during the screening is also shared with correctional health providers in jail in order to improve continuity of care for people who do enter into the custody of the New York City Department of Correction. Findings from a process evaluation of the EPASU pilot are forthcoming.

## INTERCEPT 3

### JAILS AND SPECIALTY COURTS

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#### JAILS

Individuals whose cases are not disposed at arraignment or who do not qualify for diversion will often spend at least some time in jail, and thus it is vitally important that jails build their capacity to detect early psychosis and provide initial treatment that is in-line with evidence-based standards of care. Most jails conduct at least basic mental health screening at intake and refer people for further evaluation and/or mental health services if necessary.<sup>2</sup> And, although identification of a mental illness does not always lead a person to engage in treatment, it does enable clinicians to begin working on the engagement process and treatment planning (Ford, 2015). The holistic approach promoted by CSC programs and described above may be impossible in a jail setting due to organizational factors (budgetary constraints, concerns about the use of medication as a commodity, etc.) but experts argue that other elements such as family involvement and interagency communication are feasible in a jail setting (Ford, 2015). Indeed, any efforts at care during a period of jail incarceration can potentially improve prognosis for an individual suffering from a first episode of psychosis. Sharing information across justice and health agencies can also improve continuity in the provision of services as people move between settings (see [Justice and Health Connect](#) for additional resources on interagency information sharing).

#### SPECIALTY COURTS

It is also possible that a mental health court could offer treatment as an alternative to incarceration for a person experiencing a first episode of psychosis. Mental health courts vary widely on a number of factors, including the types of charges and mental illness diagnoses accepted, as well as the plea and treatment requirements (Almquist & Dodd, 2009). Although no mental health courts exist that specifically target individuals experiencing their first episode of psychosis, some have argued that they may be particularly well-suited for first-episode patients, “who may struggle more than their chronic counterparts with issues of insight and engagement” (Ford, 2015). Even so, the issue of net-widening should be kept in mind, since the intensive supervision of people enrolled in mental health court can lead to deeper criminal justice involvement than might have occurred if a person was adjudicated in traditional court and linked to community-based treatment.

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<sup>2</sup> Two widely used jail intake screens are the Brief Jail Mental Health Screen (BJMHS) and the Correctional Mental Health Screen (CMHS-F/CMHS-M). Both of these are available in the public domain. See <https://www.prainc.com/wp-content/uploads/2015/10/bjmhsform.pdf> and <https://www.ncjrs.gov/pdffiles1/nij/216152.pdf>

## INTERCEPT 4

### REENTRY

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Best practices indicate that planning for reentry into the community should begin at jail booking and that periodic screening and assessment during a person's incarceration can help inform the services and supports that are appropriate for them to receive upon release (SAMHSA, 2015). Indeed, since the average jail stay is fewer than 7 days, jail transition planners are a key resource for linking people with FEP directly to CSC programs upon release. Most people are released from jail pretrial with little or no prior warning but communication around transitions is especially important for people who are newly psychotic since every day they spend post-release without outpatient services puts them at increased risk for recidivism and hospitalization, and also may decrease their motivation to engage in treatment (Ford, 2015). Transition planning and preparing for a warm hand-off from the jail—including by inviting behavioral health providers to reach into the jail—can be a key way to improve engagement with treatment following release.





## INTERCEPT 5

### COMMUNITY CORRECTIONS – PROBATION<sup>3</sup>

Finally, since the majority of people under correctional supervision are on probation, collaboration between probation agencies and CSC programs is an especially fruitful area for further development. New probationers can be screened at booking and officers can take advantage of information on treatment needs that has been gathered at earlier intercepts to connect their clients to appropriate community-based treatment. Furthermore, probation officers are key figures to target for early detection education campaigns give the frequency of contact they have with the young people under their supervision. Examples of instances where CSC programs have collaborated with probation officers and expanded the focus of early detection efforts will be described in more depth below.

#### CHALLENGES WITH DETECTION & INTERVENTION IN CRIMINAL JUSTICE SETTINGS

Although it is clear that proper screening and assessment provides the foundation for the detection of FEP and triage and/or referral to appropriate treatment interventions, it is also true that the criminal justice system presents unique challenges to detection and intervention. Early detection of psychosis is difficult even in community-based settings and the duration of untreated psychosis can be influenced by the way symptoms manifest, as well as by patient, family, and health-system factors (Broussard et al., 2013). Criminal justice settings present additional obstacles. Barriers to detection efforts include the highly stressful nature of the environment, in which a person is dislocated from their community and may distrust the people in charge of their care; the rapid turnover of individuals, which might hamper adequate assessment processes; the lack of staff trained to detect serious mental illnesses; and the limited resources present (Trestman et al., 2007). Further challenges arise in custody due to the lack of collateral information that staff might have otherwise obtained from family or community providers as well as the fact that there may be motivation for individuals in custody to either exaggerate or minimize symptoms for specific reasons (e.g., to influence housing placement or avoid victimization) (Ford, 2015).

Even with the additional barriers presented by criminal justice settings, the fact that they may be among some of the few institutions that come into contact with people with undiagnosed psychosis means that there remains an obligation to develop effective means of early detection and engagement. Collaborations between criminal justice professionals and CSC providers can improve the likelihood that criminal justice settings serve as resources for early detection of psychotic disorders and reducing treatment delay.

<https://www.prainc.com/wp-content/uploads/2015/10/bjmhsform.pdf> and

<https://www.ncjrs.gov/pdffiles1/nij/216152.pdf>

<sup>3</sup> Community corrections also includes parole but since people on parole are on conditional release in the community following a prison term, and this brief focuses on jail, parole is not included in this section.

## Collaboration between Criminal Justice Professionals and Coordinated Specialty Care Models

Many CSC programs are already working with people who have current or past criminal justice involvement and further outreach to and engagement with this population is possible. The following recommendations can guide CSC providers and criminal justice professionals who are interested in collaborating.

### CONSIDER EARLY DETECTION INFORMATION CAMPAIGNS

A variety of public education campaigns have been launched to expand awareness about FEP and encourage early detection and intervention. The public education campaign launched in southern Connecticut by the STEP program, for example, combines professional outreach with a social media and advertising campaign to promote awareness and shorten the duration of untreated psychosis (Srihari et al., 2015). The campaign targets a variety of stakeholders who can influence a person's pathways to care, including justice system professionals. Communities would benefit from the launch of such campaigns more widely.

Police officers, probation officers, and defense attorneys might benefit especially from these campaigns given their frequent interactions with young people and their ability to serve as figures who could rapidly direct appropriate people to CSC programs.



### ESTABLISH PARTNERSHIPS BETWEEN CSC PROGRAMS AND CRIMINAL JUSTICE AGENCIES

Criminal justice system professionals should identify CSC programs in their communities and reach out to providers that are offering interventions that are most appropriate for their client's needs. The philosophy of CSC programs—that they work with whatever problems a client brings to the table—means they are willing to help clients who are navigating the criminal justice system (see Text Box: Robert's Story). CSC

providers consulted for this brief spoke of having visited clients in jail, advocating for them in court, and collaborating with probation officers. As one clinician commented when reflecting on working with people who have criminal justice system involvement, "The criminal justice system isn't aware that we're willing to do it. That we'll be there. That we'll do what it takes." The fact that CSC providers are often faced with clients who don't believe they have a need for treatment (outside of any legal mechanism), means they may be especially skilled at engaging people who initially connect with treatment because of criminal justice involvement. But their orientation to long-term recovery also means that CSC providers will stick with clients for extended periods of time to ensure they have a full range of supports needed for success; many programs offer approximately two years of treatment based on client needs and preferences.

## ROBERT'S STORY:

### A YOUNG MAN'S EXPERIENCE WITH PSYCHOSIS, CRIMINAL JUSTICE INVOLVEMENT, AND COORDINATED SPECIALTY CARE



Robert is a 28-year-old who is currently studying for his doctorate. During his senior year in college in Oregon, he began experiencing symptoms of psychosis that caused him to drop out of school and detach from his family and friends. “I basically started wandering around, finding in my psychosis, in my own mind, the meaning of life... I thought the whole world revolved around my perceptions – that people could witness what I was experiencing through my senses.”

Although his friends noticed changes in his behavior and reached out to his family to share their concerns, connection to psychiatric care lagged and Robert's symptoms led to an incident where he was found in a stranger's home. Robert was arrested and charged with burglary. After a period of a few months cycling between a psychiatric hospital and jail while standing trial, he was found guilty except for insanity—Oregon's version of the insanity plea<sup>a</sup>. Robert was sentenced to 20 years of supervision under the Psychiatric Security Review Board (PSRB) but granted conditional release to live in the community because his crime was not violent and because the Early Assessment and Support Alliance (EASA) program was available to work with him. EASA is a statewide network of programs in Oregon that uses a CSC approach to early psychosis intervention. Programs work with young people ages 12 to 25 who have had a first episode of psychosis within the last 12 months with the goal of providing the education, treatment, and resources the person needs to be successful in the long-term.

Robert credits EASA with providing him with the “compass” he needed to refocus his life and avoid future disability: “Not only were they helpful in reformulating my reality, but they were helpful in forgiving me. And I felt like EASA was not there to punish me. They were there to teach me. Teach me the ways of how the world actually works.” With their support and connection to employment opportunities, Robert was able to obtain a job as a peer research assistant. He also joined the EASA Young Adult Leadership Council, a group of young people with lived experience

<sup>a</sup> Per Oregon statute 161.295, “a person is guilty except for insanity if, as a result of mental disease or defect at the time of engaging in criminal conduct, the person lacks substantial capacity either to appreciate the criminality of the conduct or to conform the conduct to the requirements of law.”

## ROBERT'S STORY: (Continued)

of psychosis who offer peer support, build community awareness, and advocate for policy changes to support early psychosis intervention programs at the national level. This group has been a source of consistent support for Robert over the last six years.

Robert acknowledges how the fact that he was mandated to treatment and that EASA was required to send monthly reports to the PSRB initially changed his relationship with his care team. He recalls, "You potentially have to be on the defense of not revealing certain things about you that could possibly get you in trouble." Even so, he was able to build a relationship of mutual trust over time, particularly as he reconnected with school and work opportunities and rebuilt relationships with his friends.

After two years with EASA, Robert transitioned to another community behavioral healthcare provider where he now meets with a case manager weekly and sees a psychiatrist every two months. He has had no subsequent criminal justice involvement and has only minimal supervision from the PSRB. He continues to work on his doctorate and has been able to reformulate his experience as a source of strength: "Having my experience worth something [is important]. I used to think that all the work I did in college was worthless and that my future was going to be broken and hopeless because people don't like criminals. I have that stigma. Part of being in school is using my tragedy and using my darkness and cultivating a comfort for others to sort of reveal their own struggles in class. **I found out that all of us have struggles and that if we can reveal it, we can hold strong as a community... No one can do it alone. You need good social support and that includes EASA. If I didn't have a social network... it would have been a different road."**





## COMMUNICATE ABOUT ELIGIBILITY CRITERIA AND MANDATED TREATMENT

CSC providers have eligibility criteria related to a person's age, the presence of psychotic symptoms, the duration of symptoms, and the presence or absence of other diagnostic criteria. This means that not all people who might seem appropriate for a CSC program will be eligible upon more careful screening and assessment. Even if a CSC program is not a good match, however, the CSC provider may be able to suggest alternative treatment options for the client.

With regards to specific criminal justice criteria—and the question of whether CSC programs are able to serve as mandated treatment providers for people under court order—existing programs have different approaches. Some programs are willing to serve as mandated treatment providers and report back to appropriate entities (e.g., judge, probation officer) as required by the terms of the court order. The principle of shared decision-making that undergirds CSC programs can be challenging to uphold in cases where a young person is required to attend treatment (and may face legal consequences for not doing so). In these cases, being transparent with clients about working together toward a future without mandated treatment is a key strategy. This transparency is echoed in literature about providers who have dual roles of care and control, suggesting that effective relationships with clients in such situations involve caring, but also trust and a firm but fair style (Skeem et al., 2007).

Other CSC programs do not consider themselves to be programs that allow mandated treatment enrollment because it conflicts with the core value of voluntary engagement.

Such programs will not, for example, report a client to his or her probation officer if the client fails to attend treatment sessions, although they may be willing to report on the client's progress more generally; in any case, they are clear with the relevant criminal justice professionals up front about the voluntary nature of their program.

Finally, CSC providers consulted also spoke of instances in which they provide voluntary treatment services to justice-involved clients above and beyond whatever treatment is mandated. This type of service layering—in which a client completes mandated treatment with one provider but also enrolls in a CSC program because they have chosen to do something additional—may be particularly effective for people who have minimal treatment requirements from the court but can benefit from a more holistic approach to care that works with people on their unique needs and recovery goals. Such an arrangement might not be appropriate for all people. Indeed, there are individuals with treatment mandates who will desire a more structured program to satisfy the terms laid out by the court. But for others, the comprehensive supports provided by CSC programs may be appealing, and voluntary enrollment will help ensure longer-term support beyond the period of court-mandated treatment.



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## Conclusion

CSC programs have shown great potential to positively impact the trajectory of young people who have experienced a first episode of psychosis and can be a valuable resource for criminal justice professionals. Although research has established that a high number of people who experience a first episode of psychosis have had previous criminal justice involvement and that such justice involvement lengthens the amount of time during which they receive no treatment, the criminal justice system has largely been overlooked as an opportunity to direct this population into appropriate, community-based treatment. Further attention to the various intercepts at which psychosis could be detected by criminal justice professionals and to the practical ways that criminal justice professionals and coordinated specialty care providers can collaborate around care is a necessary next step. At a time when there continues to be concern about the high rates of mental illnesses found in criminal justice settings, opportunities to divert people from jail altogether or to use jail as a critical gateway to care should be pursued vigorously.

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