First-Episode Psychosis and the Criminal Justice System: Using a Sequential Intercept Framework to Highlight Risks and Opportunities

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In first-episode psychosis there is a heightened risk of aggression and subsequent criminal justice involvement. This column reviews the evidence pointing to these heightened risks and highlights opportunities, using a sequential intercept model, for collaboration between mental health services and existing diversionary programs, particularly for patients whose behavior has already brought them to the attention of the criminal justice system. Coordinating efforts in these areas across criminal justice and clinical spheres can decrease the caseload burden on the criminal justice system and optimize clinical and legal outcomes for this population.

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In first-episode psychosis there is a heightened risk of aggression and subsequent criminal justice involvement. Clinical teams are typically experienced in managing imminent risk of violence but may be less aware of opportunities to intervene at the intersection of the mental health and criminal justice systems. Understanding these opportunities can help reduce the risk of further violence or criminal justice entanglement and thereby optimize long-term outcomes. We review evidence pointing to a heightened risk of violence and subsequent criminal justice system involvement in first-episode psychosis and, using a sequential intercept model, highlight opportunities for collaboration between mental health services and existing diversionary programs, particularly for patients whose behavior has already brought them into contact with criminal justice.

Violence Risk and First-Episode Psychosis

A growing body of evidence suggests a heightened risk of violence in first-episode psychosis. A population-based study of 495 cases of first contacts with treatment in the United Kingdom reported that 40% of the individuals had a history of aggression, and of these, approximately half were physically violent (1). A meta-analysis with more widely representative samples reported that about one-third of first-episode psychosis patients had engaged in some form of violence, with 16.6% committing serious violence (specifically, assault causing any degree of injury, any use of a weapon, or a sexual assault) but only .6% committing severe violence (resulting in serious injury that led to hospitalization or to permanent physical harm) (2). Another, prospective study with similarly careful categorization of aggression confirmed a low incidence of serious violence (.6%) but reported that aggression, when defined broadly to include verbal infractions, was present in as many as one in three situations (3). Thus, although available evidence suggests that patients with a first episode of psychosis are unlikely to cause others serious physical harm, consistently measured associations with milder aggression validate the need for preventive efforts.

Several authors have identified potential risk factors for aggression in first-episode psychosis, including male gender, substance use, high levels of criminal behavior, lower education level, reduced behavioral inhibition, history of childhood abuse, anger spurred by a delusion, and persecutory or paranoid delusions. Longer duration of untreated psychosis, a factor known to correlate robustly with poorer outcomes in this population, has also been associated with violence. Early treatment initiation, such as provided in coordinated specialty care clinics, can reduce the risk of violence and incarceration (4,5). Such clinics are becoming more widely available in the United States and provide another platform for clinician engagement with the justice system.

Early Psychosis and the Criminal Justice System

Criminal justice system involvement is common in many early psychosis samples. In one study, 29% of patients in early stages of psychosis had a history of criminal offending prior to treatment engagement (6). Another found that over a four-year period after first hospitalization for psychosis,

9% of patients were incarcerated, with 3.7% incarcerated multiple times (7). Several studies have shown that factors that may increase the risk of incarceration prior to treatment engagement include substance use, fewer years of education and poor academic performance, more paternal criminal convictions, being raised in a larger family, more severe psychosocial problems and psychopathology, and younger age at first use of illicit drugs and at maternal separation.

Interaction with the criminal justice system is associated with worse outcomes. Prior incarceration can become a barrier to engaging in mental health treatment (8) and has been linked to longer duration of untreated psychosis (6). In one study, 37% of patients experiencing their first episode of psychosis were incarcerated at some point during their pathway to clinical care. These patients experienced longer delays to treatment and more severe positive symptoms, and they averaged having more than two episodes of incarceration, mostly for nonviolent, petty crimes (9). Reducing incarceration should thus be a priority for clinical teams.

TABLE 1. Points of interception along the sequential intercept model

Intercept point	Examples
Initial police contact (prebooking diversion)	Mobile crisis clinicians, crisis intervention teams
Postarrest initial detention and hearings	Mental health jail diversion programs
After initial hearings (jails, courts, forensic evaluations)	Specialized courts (mental health courts, drug courts), evaluations for competency to stand trial
Community reentry after incarceration	Mental health "in-reach" programs into correctional settings
Community corrections and support	Specialized mental health probation and parole programs

Criminal Justice System Interception for Clinical Teams

Clinical teams that understand criminal justice procedures and that can collaborate with diversion-oriented services could have a significant impact on overall outcomes in early psychosis. An "interception framework" (10) is used here to organize these myriad opportunities (Table 1) for intervention. Focusing on earlier interception points (preceding reentry services) highlights opportunities for collaboration that may serve to prevent deep and irrevocable involvement in the criminal justice system.

Prebooking Diversion. Police can take disruptive persons to emergency departments or to specialized treatment centers for evaluation in lieu of arrest or "booking," although their latitude to make such decisions varies state by state. Effective prebooking diversion systems require rapid access to various levels of care, including emergency rooms, hospital beds, and outpatient services. Mobile crisis teams, which include clinicians who can quickly respond to behavioral crises in the community, can collaborate with police at the scene to divert patients to locally available mental health services. Crisis intervention teams (CITs) have emerged as the leading prebooking diversion model in the United States over the past 30 years. The CIT model is a prearrest, first-responder program. Police officers, often as a unit within a local police force, are trained in deescalation techniques, mental health assessment, and resource management. An essential feature of the model is partnership with local mental health agencies that assign a CIT liaison clinician to accompany police on calls and help divert persons with mental illness to a range of local mental health services. Some police departments even have "embedded clinicians"—usually social workers—who are hired by the municipality or police department.

Evidence suggests that use of CIT may increase the likelihood of referral or transport to mental health services and may decrease the likelihood of arrest during encounters with individuals thought to have a behavioral health disorder, even when the individual is violent (11). CIT programs can also increase community satisfaction with police as well as police satisfaction and comfort in interactions with persons with mental illness (12). However, there have been no systematic investigations of the CIT model's impact on diversion from arrest.

Jail Diversion Programs. These postarrest programs are designed to divert individuals from the criminal justice system to mental health treatment, with the expectation that successful engagement in treatment may lead to a reduction in or resolution of criminal charges. In contrast to mental health courts (another type of diversionary intervention), mental health diversion is not limited to a special docket (a list of pending cases in the court) for only persons with mental illness; treatment is provided regardless of the plea entered by the defendant (that is, no legal options are prohibited), and treatment is available even when the defense chooses not to link mental health issues to the criminal activity. Treatment focuses on clinical needs, and, consistent with best practices, defendants are assigned to clinical teams that are expected to care for them after the court case is complete.

A few studies have examined the impact of such diversion programs on clinical and criminal justice outcomes. Jail diversion can reduce incarceration time for people with more serious offenses (13) and reduce the number of arrests and hospital days (14), and it is more likely to succeed among individuals with stable housing and an absence of prior criminal behavior (15).

Mental Health Courts. Mental health courts offer judicially supervised transfer of selected individuals with mental illness to specialized dockets with more rehabilitative (as opposed to punitive) disposition options. These options include community mental health treatment, residential placement, and wraparound services aimed at reducing criminal activity and improving access to mental health treatment. Mental

health courts share some common features, but different districts follow various models, and their implementation varies widely. A common approach involves referral to the court by the public defender, district attorney, or judge and an assessment of the defendant's appropriateness for diversion. Almost all programs include collaboration with mental health providers, although many use their own social workers and contract for psychiatric services. The defendant is still under judicial supervision and must appear at court hearings to monitor progress. Mental health courts harness treatment as a tool against recidivism and use the court to encourage ongoing engagement in mental health services. Successful participation in the program may lead to a reduction in or dropping of charges, but individuals who do not comply may be subjected to graded sanctions, from writing a letter to the judge to returning to jail.

Mental health courts have consistently shown improved treatment adherence for participants compared with usual treatment, with most studies reporting fewer jail days for defendants who complete programming, but effects on subsequent recidivism vary significantly (16,17).

Conclusions

As asserted by Munetz and Griffin (10), good clinical care is the ultimate intercept. Thus, clinical teams should focus on providing exemplary clinical care with the goal of alleviating suffering, deceasing violence risk, and enhancing recovery. However, given that aggression and the attendant risk of incarceration are increased in first-episode samples, clinicians who care for patients experiencing their first episode of psychosis should familiarize themselves with local resources available at various intercept points to enhance opportunities for care coordination. Ongoing liaison and collaboration with criminal justice staff by coordinated specialty services for early psychosis is particularly important. In addition, several interventions within the criminal justice system have been proposed (18) and would benefit from clinician involvement, including training local police to better screen newly arrested detainees for psychosis, increasing efforts to improve medication adherence while individuals are incarcerated, and optimizing continuity of care. Thus, increasing efforts to collaborate across criminal justice and clinical spheres present an unfulfilled opportunity to improve clinical and legal outcomes for patients experiencing first-episode psychosis.

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