



CONTINUITY OF CARE FOR PRISONERS WITH SERIOUS MENTAL ILLNESS: SUMMARY OF A SYSTEMATIC REVIEW

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Introduction

Continuity of care (CofC) for prisoners with serious mental illness (SMI) represents a persistent global challenge at the intersection of mental health and criminal justice systems. In a recent systematic review (Brooker and Sirdifield, 2025), we explored the international evidence on the extent to which continuity of mental health care is maintained after release from custody, and the extent to which interventions aiming to improve continuity of mental health care impact on mental health and criminal justice outcomes for people with SMI. Our review built on earlier conceptualisations of CofC as a multidimensional construct encompassing managed transitions, experience and relationships, regularity, meeting needs, coordinated care, consolidation, and supported living (Burns et al., 2009). Across the 16 reviewed studies, one consistent pattern emerged: despite evidence that timely mental health support reduces relapse and may reduce reincarceration (Trofimovs et al., 2023), ex-prisoners with SMI face fragmented and inadequate care pathways and often do not engage with care post-release with serious implications for both individual wellbeing and public safety.

1. The Scale and Nature of the Problem

Epidemiological evidence consistently demonstrates that SMI prevalence in custodial settings far exceeds that of the general population (Fazel & Seewald, 2012). This disparity is further compounded by high rates of comorbidity, substance dependence, and trauma among incarcerated populations (Bebbington et al., 2021). This pattern extends beyond prison walls: people on probation also experience high rates of psychiatric disorder (Brooker et al., 2012). Yet despite this well-documented burden, services often fail to ensure continuity between institutional and community care.

We found empirical evidence that suggests that post-release engagement with community mental health services remains strikingly low (Kubiak et al., 2011; Lennox et al., 2012; Lovell et al., 2002) and one study showed that over 90% of those that did access community

mental health treatment post-release received less than 10 hours of service per month (Lovell et al., 2002).

2. The Impact of Comorbidity and Complexity

Baillargeon et al. (2010) showed that co-occurrence of SMI and substance misuse elevates risk of re-incarceration beyond that associated with being diagnosed with either SMI or a substance misuse disorder alone. Subsequent evidence from Snow et al. (2022) showed that individuals with dual diagnoses incur healthcare costs over three times those of the general population and are almost three times more likely to be re-incarcerated. Butler et al. (2020) similarly found that ‘frequent attenders’ at emergency departments were disproportionately those with co-occurring disorders—highlighting the need to ensure that people can access effective support early to reduce high use of expensive crisis care.

Arguably the persistence of fragmented provision reflects structural inadequacies: prison mental health services often lack resources to plan post-release care effectively, while community teams may lack forensic or dual-diagnosis expertise. The absence of dedicated pathways for those with complex needs leads to cyclical patterns of crisis intervention, emergency service use, and re-entry into the criminal justice system. These findings reinforce the need for service models explicitly designed to address comorbidity, highlighting that continuity of care cannot be achieved without continuity of responsibility across sectors.

3. Expedited Health Insurance and Systemic Barriers

A notable cluster of studies included in our review focused on expedited Medicaid enrolment in the United States, which aimed to bridge gaps in healthcare access immediately post-release (Cuddeback et al., 2016; Morrissey et al., 2016). These interventions typically initiated Medicaid applications while individuals were still incarcerated, thus ensuring insurance coverage upon release. Consistent evidence indicated that such programmes improved enrolment and facilitated greater use of outpatient and prescription services. However, there were not significant impacts on use of psychiatric services and inpatient care, and the impacts on criminal justice outcomes were inconsistent. In some studies, expedited Medicaid recipients demonstrated higher rates of re-incarceration, although this may be largely due to violations rather than new charges (Domino et al., 2019). These findings suggest that while financial access is a necessary precondition for continuity, it is not sufficient in itself to prevent relapse or recidivism. Our review thus underlined the importance of integrating structural reforms (such as insurance coverage) with relational and therapeutic continuity—components identified by Burns et al. (2009) as fundamental to effective mental health care.

4. Intervention Models: What Works?

We included six studies of other types of intervention in our review. Here, Forensic Assertive Community Treatment (FACT) models demonstrated some success in reducing

hospitalisation days and jail admissions (Cusack et al., 2010). These resource-intensive teams combine psychiatric treatment, substance use support, housing, and vocational assistance. The meta-analytic evidence (Goulet et al., 2022) supports their effect on reducing criminal justice contact, though gains in mental health outcomes appear modest. The strength of FACT models lies in their proactive engagement and shared accountability between criminal justice and health providers—a rare but crucial feature of effective continuity.

Jarrett et al. (2012) piloted Critical Time Intervention (CTI) in UK prisons, which they describe as ‘a holistic model of case management which focuses on linking patients up with community services to ensure care is delivered’ (Jarrett et al., 2012: 188). Here support includes providing personal links and links to community-based services, and practical and emotional support. They found improved medication adherence and general practitioner registration among participants, though small sample size and high attrition severely limited the conclusions that could be drawn. However, positive conclusions were drawn regarding increased service access in a later study (Shaw et al., 2017). The intervention’s relational focus—sustained personal contact during the ‘critical time’ after release—aligns closely with the concept of continuity as consistent and predictable interpersonal connection.

Among the most robustly evaluated interventions, Chandler and Spicer’s (2006) randomised controlled trial demonstrated that integrated dual disorders treatment significantly improved engagement with outpatient services. This model exemplifies how addressing comorbidity within a single, coherent framework can enhance service continuity.

Other naturalistic and quasi-experimental studies (McKenna et al., 2015; Green et al., 2016) further supported the value of pre-release coordination. Interventions combining in-reach planning with post-release follow-up yielded measurable improvements in contact with community mental health services and reduced risk of re-imprisonment, especially when the duration of post-release support exceeded two months. These findings converge on the conclusion that intensive, multi-component, and prison-linked programmes are most effective, albeit costly and susceptible to attrition.

5. Service User Perspectives and Structural Deficits

We sought quantitative studies in our review and (perhaps partially as a consequence of this) found a significant absence of lived experience research. Service-user studies such as Ali et al. (2018) provide crucial context: among individuals with SMI who had previous criminal justice involvement, 28% reported unmet mental health needs, compared to 20% among those without such histories. Stigma, fear, and affordability were cited as barriers. This underlines that continuity of care is not purely logistical but relational and perceptual—reliant on trust, cultural competence, and user-centred practice.

However, systemic fragmentation remains a recurring obstacle. Data linkage between prisons, health services, and probation agencies is limited, even in high-income jurisdictions (Hard, Gipson and Whitfield, 2025). Administrative boundaries, confidentiality regulations, lack of integration between information technology systems, and inconsistent assessment frameworks impede the smooth routine transfer of information. The absence of integrated

governance structures sustains a cycle of neglect: responsibility for post-release mental health care falls between institutions rather than being shared across them.

6. Policy and Practice Implications

Our review underscored the need for coordinated policy frameworks that recognise re-entry from prison as a critical juncture in the care continuum. Effective CofC requires not only inter-agency collaboration but also investment in workforce capacity, data integration, and person-centred service design. From a policy perspective, we believe that our review suggests several priorities:

1. **Embedding pre-release planning within correctional mental health services**, ensuring that discharge arrangements are clinically led and begin well before release.
2. **Expanding community-based dual-diagnosis and forensic outreach capacity**, integrating substance misuse and psychiatric care.
3. **Incorporating service-user feedback into programme design**, ensuring interventions address needs; conducting research to explore the reasons for disengagement with services with a view to continuous quality improvement to enable provision of acceptable and accessible care; and measuring the impact of accessing interventions on outcomes such as quality of life rather than assuming that service access equates to benefit.

As Applegarth et al. (2024) argue, improving re-entry outcomes requires moving beyond ‘one-size-fits-all’ models towards genuinely person-centred processes that amplify the voices of those with lived experience.

7. Conclusions

Across the sixteen studies included in our review, the evidence paints a consistent picture: continuity of care for prisoners with SMI remains limited, fragmented, and insufficiently prioritised. Expedited Medicaid initiatives improve access to services in the US but do not reliably reduce reoffending. In contrast, we can tentatively conclude that research conducted in several different countries suggests that intensive and multi-component interventions—particularly those initiated before release and continuing into the community—have shown the most promise for improving both mental health engagement and criminal justice outcomes.

Thematically, our review identified three key determinants of successful continuity: (1) investment into early and proactive transition planning; (2) integrated responses to dual diagnosis; and (3) sustained relational contact across the custody-community divide. Yet persistent barriers—bureaucratic, financial, and cultural—continue to undermine these aims. Future research should focus on incorporating lived experience perspectives into intervention design, evaluating cost-effectiveness, and developing effective models that are both scalable and sustainable.

Ultimately, continuity of care for this population is not only a clinical or operational challenge but a moral and societal one. Ensuring that people with serious mental illness do

not fall through the cracks of fragmented systems is essential to reducing reoffending, promoting recovery, and upholding the ethical integrity of both mental health and criminal justice institutions.

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