Comparing Two Systematic Reviews of Continuity of Care and Community Reintegration for People with Serious Mental Illness Released from Custody

Introduction

The transition from prison or jail into the community is a particularly vulnerable period for people with serious or severe mental illness (SMI). Individuals may leave custody with complex and overlapping needs relating to psychiatric treatment, medication, substance use, physical health, housing, employment, finances and social support. At the same time, responsibility for care commonly shifts between prison healthcare, community mental health services, primary care, probation and voluntary-sector organisations. Weaknesses in communication or delays in establishing community support may consequently lead to discontinuity of treatment, deterioration in mental health, homelessness, crisis-service use and further contact with the criminal justice system.

The two systematic reviews considered here address this broad problem from related but distinct perspectives. Simpson et al.'s *Reintegration programmes for people with severe mental illnesses released from correctional institutions: systematic review* examines the effectiveness of specialised reintegration programmes for people with SMI moving from correctional institutions into the community. It includes 26 studies and considers a broad range of interventions and outcomes, including community support, mental healthcare, health insurance, social functioning and recidivism.

The second paper, *The extent and consequences of continuity of care for people released from prison or jail with serious mental illness: a systematic review with a narrative synthesis*, has a more specific focus. It examines both the extent to which people with SMI access mental healthcare following release and the effects of interventions intended to improve continuity of care. Sixteen studies are included and organised into three categories: descriptive studies of post-release service use, evaluations of expedited Medicaid programmes and evaluations of other continuity-of-care interventions.

Although there is considerable overlap between the two reviews, they are not duplicates. They differ in their conceptual starting points, research questions, inclusion criteria, search methods, organisation of evidence and interpretation of outcomes. Nevertheless, they arrive at strikingly similar conclusions: continuity of care remains inadequate for many people with SMI leaving custody; interventions are generally more successful in improving access to services than in reducing recidivism; and effective transitional support is likely to require intensive, sustained and multicomponent provision beginning before release.

Differences in conceptual focus

The most important distinction concerns the conceptual framework adopted by each review. Simpson et al. frame the issue primarily as one of **community reintegration**. Reintegration is treated as a multidimensional process involving mental health

treatment alongside housing, employment, financial security, social support and access to addiction services. The paper therefore views successful transition as extending beyond connection with community mental health services. Reintegration is influenced by interacting personal, interpersonal, institutional and community factors, and successful programmes must respond across several of these domains.

The continuity-of-care review adopts a narrower but more conceptually developed mental healthcare perspective. Its central concern is whether care received in custody is continued effectively following release. Continuity is explicitly informed by the framework developed by Burns et al., incorporating experience and therapeutic relationships, regularity of care, meeting individual needs, consolidation of treatment, managed transitions, care coordination and supported living. This provides a clearer theoretical definition of continuity than is evident in Simpson et al.'s broader concept of reintegration.

These perspectives are complementary. Reintegration may be regarded as the broader outcome, whereas continuity of mental healthcare is one of the principal mechanisms through which successful reintegration may be achieved. However, continuity of care alone may be insufficient. A person may attend psychiatric appointments and receive medication while continuing to experience homelessness, unemployment, poverty or social isolation. Conversely, practical assistance with housing and finances may improve stability but fail to address untreated psychosis or disrupted medication. Both papers ultimately recognise this interdependence, although they approach it from different starting points.

The terminology used also differs slightly. Simpson et al. refer primarily to "severe mental illness", whereas the continuity review uses "serious mental illness". In practice, both concentrate largely on schizophrenia, psychosis, schizoaffective disorder, bipolar disorder and major depression. Both identify inconsistency in the operational definition of SMI across primary studies. Simpson et al. draw particular attention to variation in definitions of both SMI and recidivism, noting that some studies define recidivism as any reincarceration, including technical violations, whereas others restrict it to new offences. Such variation complicates comparison and may partly explain apparently contradictory findings.

Research questions and scope

The reviews differ substantially in the breadth of their objectives. Simpson et al. ask broadly whether reintegration programmes designed specifically for people with SMI are effective. Their review encompasses interventions including peer mentoring, day reporting centres, Critical Time Intervention, intensive case management, therapeutic communities, community mental health teams and expedited Medicaid enrolment. Outcomes include mental health symptoms, treatment engagement, service use, social functioning and criminal justice involvement.

The continuity review is structured around two more precise questions:

1. To what extent do people with SMI continue to access mental healthcare following release from prison or jail?
2. What effects do interventions designed to improve continuity of care have on mental health and criminal justice outcomes?

This distinction is important because the first question permits the inclusion of descriptive or naturalistic studies that do not evaluate an intervention. These studies provide evidence about the scale and nature of discontinuity after release. For example, the review reports that only four of 53 people released from prison in one UK study had documented contact with a Community Mental Health Team at one-month follow-up. In another study, 23% of jail episodes involved no mental health contact either in custody or in the community, while in 44% of episodes the next mental health contact occurred only following reincarceration.

This descriptive evidence is a particular strength of the continuity review. Before asking whether an intervention works, it establishes the nature of the underlying problem. Its findings suggest that the issue is not merely whether services produce improved outcomes, but whether people leaving custody obtain timely and meaningful access to services at all.

Simpson et al. include a wider range of programme models and therefore provide a more comprehensive account of the broader reintegration literature. Their 26 included studies represent a larger evidence base than the 16 studies included in the continuity review. However, the wider scope also creates greater heterogeneity. Programmes with substantially different aims and mechanisms are considered together under the broad heading of reintegration. The continuity review sacrifices some breadth in exchange for a more focused analysis of mental healthcare transitions.

Search methods and methodological rigour

Both papers use systematic review methods and narrative synthesis because substantial heterogeneity prevents meaningful statistical meta-analysis. However, Simpson et al. employ the more extensive and formally structured search process.

Simpson et al. searched seven major databases: MEDLINE, PsycINFO, EMBASE, CINAHL, ASSIA, Criminal Justice Abstracts and Cochrane CENTRAL. The search extended from database inception to November 2025 and was updated to January 2026. The review was developed with support from a medical librarian, followed PRISMA guidance and was prospectively registered with PROSPERO. It also considered grey literature, including dissertations, conference abstracts and material from relevant government agencies. Of 6,929 records initially identified, 26 studies were included.

By comparison, the continuity review searched PsycINFO, SocINDEX, ASSIA and MEDLINE. It also incorporated studies identified through prior knowledge of the literature and one additional paper identified during preparation of the review. A total of 2,136 database records were identified, from which 16 studies were ultimately included.

Simpson et al.'s search is therefore broader and likely to have greater sensitivity. The inclusion of EMBASE, CINAHL, Criminal Justice Abstracts and CENTRAL increases coverage across medical, nursing, criminological and intervention research. PROSPERO registration also provides greater transparency by documenting the intended methods in advance and reducing the risk of post hoc methodological changes.

Both reviews used independent screening by two reviewers and processes for resolving disagreements. Simpson et al. provide greater detail concerning duplicate data extraction, senior-reviewer oversight and quality assurance. The paper also uses design-specific risk-of-bias instruments: RoB 2 for randomised controlled trials and ROBINS-I for non-randomised intervention studies. The continuity review uses the Mixed Methods Appraisal Tool across all included studies and does not exclude studies on the basis of quality.

There are advantages to both approaches. RoB 2 and ROBINS-I permit a detailed assessment of particular sources of bias and may be more appropriate for evaluating intervention effectiveness. The Mixed Methods Appraisal Tool provides a consistent framework across diverse methodologies and is relatively accessible to readers. However, the risk-of-bias analysis in Simpson et al. more clearly demonstrates that much of the apparent evidence of effectiveness comes from studies with serious or critical methodological limitations.

Characteristics of the evidence base

Both reviews reveal that the evidence is geographically concentrated. Simpson et al. include 21 studies from the United States, two from the United Kingdom and one each from Australia, Ireland and New Zealand. The continuity review includes ten US studies, three UK studies, two Australian studies and one New Zealand study.

The dominance of US research limits international generalisability. American studies of Medicaid enrolment are particularly dependent on the structure of the US healthcare system. Their findings are relevant to jurisdictions in which health insurance is a prerequisite for accessing treatment, but less directly transferable to tax-funded systems such as the NHS. Nevertheless, the broader principle remains relevant: administrative access to healthcare must be established before or immediately after release. In the United Kingdom, equivalent barriers may involve registration with primary care, transfer of clinical information, referral acceptance, eligibility thresholds or delays in arranging community appointments.

The absence of a substantial European evidence base is notable. Neither review identifies meaningful evidence from continental European prison or probation systems. This restricts conclusions about how transitional interventions operate under different welfare, healthcare and criminal justice arrangements.

The continuity review identifies an additional gap: none of its included studies directly examines the role of probation services, including specialist mental health probation

roles, in continuity planning. This is significant because probation practitioners may be among the professionals maintaining the most regular contact with individuals after release. They may identify deterioration, encourage treatment engagement, coordinate referrals and help address practical barriers. Their absence from the research literature reflects a wider tendency to conceptualise continuity as a transfer between prison and community healthcare rather than as a shared responsibility across health, justice and social-care systems.

Findings concerning service access and engagement

The strongest area of agreement is that access to community mental healthcare following release remains inadequate. The descriptive studies in the continuity review provide direct evidence of limited and inconsistent engagement. In one study, 61% of people with SMI accessed some form of mental health service during the first year following release, but more than 90% received fewer than ten hours of community mental healthcare per month during periods when they were engaged. Average service intensity was only two to five hours per month. Thus, service contact should not automatically be interpreted as adequate care.

The continuity review also highlights inequalities in access. People first diagnosed with psychosis while in prison were more likely to have no post-release mental health contact than those first diagnosed in hospital. This may indicate that prison-based diagnosis is not always followed by effective integration into community treatment pathways.

Simpson et al. reach a similar conclusion through their evaluation of reintegration programmes. Community support and case-management interventions frequently improve initial service engagement and continuity, but their effects on longer-term outcomes are inconsistent. Critical Time Intervention, for example, improved the consistency of contact with community mental health services, although reductions in reoffending were not sustained at later follow-up.

Both reviews therefore suggest that service engagement is the outcome most consistently improved by transitional interventions. However, the continuity review is more critical of the assumption that service use is inherently beneficial. It argues that future studies should measure the quality, appropriateness and experience of care, rather than relying solely on counts of appointments or service contacts. This is an important conceptual contribution: continuity should concern the quality and therapeutic value of care, not merely its administrative presence.

Medicaid and access to healthcare

Both reviews identify expedited Medicaid enrolment as one of the most extensively evaluated interventions. Their conclusions are highly consistent. Expedited enrolment improves insurance coverage and increases access to outpatient treatment, prescription medication and substance-use services. However, it has limited or

inconsistent effects on psychiatric hospital use and does not reliably reduce criminal justice involvement.

The continuity review gives Medicaid a particularly prominent position, devoting one of its three principal evidence categories to six Medicaid studies. It reports that approval rates differed by institutional setting: 91% among psychiatric-hospital referrals, 83% among state-prison referrals and 66% among county-jail referrals. This suggests that the effectiveness of an administrative intervention may depend partly on the organisation making the referral and its capacity to complete the process successfully.

Simpson et al. similarly conclude that expedited Medicaid programmes improve enrolment and service utilisation. However, some studies found no reduction in recidivism, while one identified increased incarceration following release.

The apparent increase in criminal justice contact requires careful interpretation. Both reviews recognise that increased reincarceration may result from closer monitoring and technical violations rather than new criminal behaviour. Improved engagement may expose individuals to more intensive supervision and therefore increase the detection of non-compliance. Consequently, reincarceration is not always a straightforward measure of intervention failure.

Effects of intensive and multicomponent interventions

Both reviews identify greater promise in intensive interventions extending across the transition from custody into the community. Examples include Critical Time Intervention, Forensic Assertive Community Treatment, integrated dual-disorder treatment, therapeutic communities and prison in-reach models.

The continuity review provides a detailed account of an integrated dual-disorders programme lasting up to 2.5 years. Seventy-seven per cent of intervention participants received an engagement-related service within 60 days of release, compared with 18% of controls. Receipt of psychiatric medication was also higher among intervention participants. Although several criminal justice outcomes did not differ significantly between groups, the intervention group experienced fewer incarcerations and did not show the increases in psychiatric hospitalisation and crisis-service use observed among controls.

Forensic Assertive Community Treatment similarly produced increased outpatient contact, fewer psychiatric hospital days and reduced likelihood of imprisonment during the first year, although conviction rates and length of stay following imprisonment were not significantly different.

Simpson et al. place these findings within a wider reintegration framework. They conclude that programmes tend to perform better when support is sustained and accompanied by comprehensive aftercare addressing mental health, housing, employment and social support. Their inclusion of peer mentoring, vocational support

and therapeutic communities broadens the discussion beyond clinical continuity and emphasises the social determinants of successful reintegration.

Both reviews therefore reject the idea that a single referral or brief transitional intervention is likely to be sufficient. The most promising approaches begin before release, actively connect individuals with community services, continue beyond the immediate transition and address multiple areas of need. However, both remain cautious because the evidence is heterogeneous and many studies have substantial risks of bias.

Mental health outcomes and criminal justice outcomes

A further shared finding is the weak and inconsistent relationship between improved healthcare engagement and reduced recidivism. Interventions may increase outpatient contact, medication access or continuity without producing measurable reductions in rearrest or reincarceration.

This does not necessarily indicate programme failure. Criminal justice outcomes are influenced by numerous factors beyond mental healthcare, including poverty, housing instability, substance use, social networks, supervision conditions and policing practices. Mental health treatment alone may therefore be unable to reduce recidivism substantially.

There is also a risk that studies place excessive emphasis on criminal justice outcomes while giving insufficient attention to quality of life, recovery, personal wellbeing and the experience of continuity. The continuity review explicitly criticises the tendency to equate service utilisation with benefit and recommends greater attention to quality of life and flexible continuity. Simpson et al. similarly argue for comprehensive interventions addressing multiple domains of community life.

The reviews therefore support a broader definition of success. Reduced reincarceration is important, but it should not be the sole criterion. Stable housing, sustained treatment, reduced psychiatric distress, improved functioning, social inclusion and personal recovery are also meaningful outcomes.

Overall strengths and limitations

Simpson et al.'s principal strengths are methodological breadth, recency and formal rigour. The review includes more databases, a larger number of studies, grey-literature searching, PROSPERO registration and detailed design-specific risk-of-bias assessment. It also provides a broad understanding of reintegration as a multidimensional process.

Its main limitation is that the breadth of the reintegration concept creates substantial heterogeneity. Interventions with different aims and mechanisms are grouped together, making it difficult to determine which components are responsible for positive outcomes. Furthermore, the broad focus provides less detailed analysis of the extent of routine post-release continuity in the absence of intervention.

The continuity review is more focused and conceptually coherent. Its two research questions clearly distinguish the scale of the continuity problem from the effectiveness of interventions intended to address it. Its use of an established multidimensional definition of continuity is a particular strength. It also offers detailed interpretation of individual studies and gives greater attention to the adequacy and quality of service contact.

However, its search is narrower, includes fewer databases and excludes grey literature. Its evidence base is smaller, and its quality appraisal is less detailed than Simpson et al.'s design-specific risk-of-bias analysis. Some potentially relevant reintegration programmes may also be excluded because continuity of mental healthcare is not their principal focus.

Conclusion

The two reviews are best regarded as complementary rather than competing. Simpson et al. provide a broad and methodologically extensive synthesis of programmes intended to support the reintegration of people with SMI following release from correctional institutions. The continuity review examines a more specific component of reintegration: whether mental healthcare continues after release and whether interventions improve that continuity.

Despite differences in scope and methodology, their conclusions converge. Many people with SMI receive little, delayed or insufficient community mental healthcare following release. Administrative interventions such as expedited Medicaid enrolment improve access to healthcare but do not necessarily improve psychiatric or criminal justice outcomes. More intensive interventions can increase engagement, outpatient service use and medication access and may reduce psychiatric hospitalisation, but their effects on recidivism are inconsistent.

Both reviews suggest that effective practice is likely to require support that begins before release, continues for a meaningful period in the community and combines mental healthcare with assistance relating to substance use, housing, employment, finances and social support. The evidence also indicates that service contact should not be treated as synonymous with effective continuity: future research must examine the quality, intensity and personal value of care.

Finally, both reviews expose major gaps in the evidence. Research remains heavily concentrated in the United States, there is limited evidence from European systems, the contribution of probation services is largely absent, and lived-experience perspectives receive insufficient attention. Future studies should evaluate integrated health, probation and social-care models using outcomes extending beyond recidivism to include quality of life, recovery, stable accommodation, social inclusion and sustained therapeutic engagement. Taken together, the reviews indicate that continuity of mental healthcare is essential to successful reintegration, but that continuity is most

likely to be effective when embedded within a broader, sustained and socially informed model of post-release support.

References

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